

SUPERVISORY VISITS OF HOME HEALTH CARE STAFF (Onsite Visit)

| I. CLIENT INFORMATION | | |
|--|---|--|
| Name of Client (Last, First, Middle) | Agency Provides <input type="checkbox"/> Skilled <input type="checkbox"/> Unskilled Care | Clinical Record No. |
| Name of Staff Member Being Supervised (Last, First, Middle) | Discipline | Staff Person In Home During Supervisory Visit <input type="radio"/> Yes <input type="radio"/> No |
| Signature of Clinician Supervisor Doing Supervisory Visit | | Date of Supervisory Visit |
| (Please detach short copy (Part 1) and attach in client's clinical record.) | | |

| II. STAFF INFORMATION | | | | | |
|--|-----------------------|---|----------------------------|-----------------------|-------------------|
| (Please place Part 2 of this form in employee personnel file.) | | | | | |
| ITEM | STAFF MEMBER | | | | COMMENTS |
| | EXCEEDS REQUIREMENTS | MEETS REQUIREMENTS | DOES NOT MEET REQUIREMENTS | NOT OBSERVED | |
| 1. Reports for work assignments as scheduled. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 2. Identifies self by name and title to the client, wears name badge. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 3. Demonstrates courteous behavior toward the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 4. Demonstrates cooperative behavior with the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 5. Demonstrates positive and helpful attitude toward the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 6. Demonstrates competent skills and expertise. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 7. Demonstrates adequate communication skills, with patient/family/caregiver. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 8. Follows client care plan, and completes assigned tasks. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 9. Home health care services are provided safely and effectively and documented appropriately. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 10. Informs nurse supervisor of client needs and condition as appropriate, in a timely manner. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 11. Adheres to home health care agency policies and procedures. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 12. Demonstrates adherence to agency's infection prevention and control policies & procedures. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 13. Utilizes proper body mechanics. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 14. Complies with home health care agency dress code. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 15. Other. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| <input type="checkbox"/> Care plan/services meet patient needs | | <input type="checkbox"/> Care plan revised Date revised _____ | | | |
| Signature of Staff Member Being Supervised | | | | | Date of Signature |
| Signature of Director of Nursing/Therapy | | | | | Date of Signature |