AIDE SUPERVISORY VISIT/TELEHEALTH

Aide supervision using virtual assessment may not exceed 2 virtual visits per HH Aide in a 60-day period, and should be limited to unusual circumstances when a scheduled on-site, in-person visit is not possible within the required 14-day time frame.

Date of telehealth contact:_____ Time:_____ to _____

Call completed using audio/video device, device type (i.e., via smartphone app):_____ providing real-time 2-way communication.

Aide(s) supervised (full name):_____ Aide present: ❍ Yes ❍ No

Participants during this interaction: ❑ Patient ❑ Representative (if any):_____

❑ Other:_____ Relationship to patient:_____

Reason for virtual visit: ❑ Weather ❑ Patient request ❑ Staff illness/absence ❑ Other:_____

Patient problem(s) as stated by patient/representative:

Any changes in medical condition since last contact? ❍ Yes ❍ No If Yes, explain:

COMMENTS AND/OR COMMUNICATIONS REPORTED BY PATIENT/REPRESENTATIVE/AIDE

Is the aide completing tasks assigned/ordered? ❍ Yes ❍ No If No, explain:

Is the aide maintaining open communication with the patient, representative (if any), other caregivers (if applicable), and family? ❍ Yes ❍ No If No, explain:

Does the aide demonstrate competency with assigned tasks? ❍ Yes ❍ No If No, explain:

Is the aide complying with infection prevention and control policies and procedures? ❍ Yes ❍ No If No, explain:

Is the aide honoring patient rights? ❍ Yes ❍ No If No, explain:

Changes to frequency/duration requested/needed? ❍ Yes ❍ No If Yes, explain:

Changes to assignment requested/needed? ❍ Yes ❍ No If Yes, obtain verbal order as necessary and update Aide Care Plan.

Aide(s) notified of changes? ❍ Yes ❍ No If No, explain:_____

If an area of concern in the aide services is noted by the supervising clinician, then the supervising clinician will need to make an on-site visit in order to observe and assess the aide while he or she is performing care.

Was there reason for concern requiring an on-site visit? ❍ Yes ❍ No If Yes, explain:

Aide requires additional training: ❍ Yes ❍ No If Yes, explain:_____

Scheduled on-site visit date:_____ Patient agrees: ❍ Yes ❍ No Representative agrees: ❍ Yes ❍ No ❍ N/A

SIGNATURE/DATE

Signature of Supervising Clinician:_____ **Date:**_____

PATIENT NAME - Last, First, Middle Initial	ID#