



**TRUE CARE PROFESSIONALS INC**

**SUPERVISORY VISIT RECORD**

Patient Name	Record #
Aide(s) being supervised	Date of supervision visit

**HOME HEALTH AIDE PERFORMANCE**

- 1. The aide(s) follows and implements the care plan  Yes  No
- 2. The aide(s) maintains and implements Universal Precaution per agency policy  Yes  No
- 3. The aide(s) is prompt, stays required length of time and is reliable  Yes  No
- 4. The aide(s) appears competent in the delivery of service  Yes  No
- 5. The aide(s) performs tasks as requested by the client within job description  Yes  No
- 6. The aide(s) relates well with the patient/family  Yes  No
- 7. The aide(s) adheres to the dress code  Yes  No
- 8. The aide(s) reports complications and problems to case manager/supervisor  Yes  No
- 9. The aide(s) is caring and sympathetic to the client's needs  Yes  No
- 10. \_\_\_\_\_  Yes  No

Patient comments

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**HOME HEALTH AIDE PLAN SUPERVISION**

- 1. Is the agency admit folder readily available?  Yes  No
- 2. Does the client have a continued need for aide services?  Yes  No
- 3. Has the home health aide care plan been updated as required?  Yes  No
- 4. \_\_\_\_\_  Yes  No

New needs identified/change in plan

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Instruction/Training given to aide(s)

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_____ <b>Supervisor's Signature &amp; Title</b>	_____ <b>Signature of Aide (Optional)</b>
_____ <b>Patient's Signature (optional)</b>	