Supervisory/Service Verification/Evaluation Note

CLIENT NAME/RESPONSIBLE PARTY NAME_____
EMPLOYEE'S FIRST NAME (if applicable):_____
SUPERVISOR/STAFF NAME:_____
Type of Supervision:

____ Home Visit **_____Announced** **_____Unannounced**

____ Phone Visit **____ Phone Call** **____ Staff Training**

Call Start Time_____ **Call End Time**_____ **Date:**_____

Assistant Performance	**Supervisory Action**	**PCA Action/ Response**	**Comments**
a. Supervision for Safety	_____	_____	_____
b. Dressing	_____	_____	_____
c. Grooming	_____	_____	_____
d. Bathing	_____	_____	_____
e. Eating	_____	_____	_____
f. Transfers	_____	_____	_____
g. Mobility	_____	_____	_____
h. Positioning	_____	_____	_____
i. Toileting	_____	_____	_____
j. Medications	_____	_____	_____
k. Maintenance Exercises	_____	_____	_____
l. Medical Apts.	_____	_____	_____
m. Skin Care	_____	_____	_____
n. Prosthetics	_____	_____	_____
o. Medical Equipment	_____	_____	_____
p. Seizures	_____	_____	_____
q. Behaviors	_____	_____	_____
r. Housekeeping	_____	_____	_____
Supervisory Nursing Assessment of Employee Duties			
a. Adherence to Policy Manual	_____	_____	_____
b. Reliability	_____	_____	_____
c. Client/Family Rapport (Boundaries)	_____	_____	_____
d. OSHA compliance	_____	_____	_____
e. Body Mechanics	_____	_____	_____

Legend: Sup. Action---0=observed; R= report from client; ID=instruct via demo; IV=instruct via verbal
PCA Action---DC=demonstrates competency; VU=verbalizes understanding; DI=demonstrates incompetence
NA=not assessable or not applicable

_____ Care Plan Reviewed _____ Client Home Chart checked/updated _____Gloves given
_____ OSHA box checked/refilled

Supervisor/QP Comments: _____

_____

_____

_____

_____

Supervisor/QP Signature_____ Date _____

Verify copy of employee's timesheet for this pay period attached:_____

All above information to be considered confidential and is to be treated in accordance with agency policy.