



**SUPERVISORY AND OBSERVATION SHEET REPORT**

CLIENT'S NAME: \_\_\_\_\_

This is to confirm that \_\_\_\_\_ has been evaluated on  
\_\_\_\_/\_\_\_\_/\_\_\_\_ and the services have been found to be as follows:

<b>SERVICES</b>	<b>Observed</b>	<b>Satisfactory</b>	<b>Non Satisfactory</b>
<b>Personal Tasks</b>	( )	( )	( )
<b>Housekeeping Tasks</b>	( )	( )	( )
<b>Home Management</b>	( )	( )	( )
<b>Ambulation &amp; Transfer</b>	( )	( )	( )
<b>Nutritional Needs</b>	( )	( )	( )
<b>Medically Related Activity</b>	( )	( )	( )
<b>Satisfactory: No corrective action necessary</b>		( )	
<b>Non-satisfactory: The following issues have been resolved</b>			( )

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**AIDE**

**EXCELLENT ( )    GOOD ( )    FAIR ( )    POOR ( )**

**RN/CASE MGR.:** \_\_\_\_\_ **DATE** \_\_\_\_\_



## CLIENT'S AIDE EVALUATION FORM

Aide: \_\_\_\_\_

Client / Client Representative: \_\_\_\_\_

**Date of Last Review:** \_\_\_\_\_

	<b>EXCELLENT</b>	<b>GOOD</b>	<b>FAIR</b>	<b>POOR</b>
Attendance	( )	( )	( )	( )
Attitude	( )	( )	( )	( )
Communication Skills	( )	( )	( )	( )
Cooperation	( )	( )	( )	( )
Creativity	( )	( )	( )	( )
Dependability	( )	( )	( )	( )
Enthusiasm	( )	( )	( )	( )
Honesty	( )	( )	( )	( )
Initiative	( )	( )	( )	( )
Productivity	( )	( )	( )	( )
Punctuality	( )	( )	( )	( )
Technical Skills	( )	( )	( )	( )
Work Quality	( )	( )	( )	( )
Work Consistency	( )	( )	( )	( )
Working Relations	( )	( )	( )	( )

Others

Comments:

\_\_\_\_\_

\_\_\_\_\_

RN Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**PROGRESS NOTE**

**CLIENT:** \_\_\_\_\_ **DATE OF VISIT:** \_\_\_\_\_

**SUPERVISOR'S OBSERVATIONS AND COMMENTS**

**CLIENTS GENERAL CONDITION:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SKIN:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**FUNCTIONAL LIMITATION:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**BOWEL/BLADDER:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**HOSPITALIZATION/ER VISITS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLIENT'S VITAL SIGNS: BP:** \_\_\_\_\_ **TEMP:** \_\_\_\_\_ **HR:** \_\_\_\_\_ **RR:** \_\_\_\_\_ **WT:** \_\_\_\_\_ **HT:** \_\_\_\_\_

RN signature: \_\_\_\_\_ Date: \_\_\_\_\_



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PURPOSE: To ensure that the assigned caregiver is properly caring for the client according to the plan of care and to ensure the quality of the care provided by the agency's caregiver. Indicate on the note if the caregiver was present during the supervisory visit.

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PLAN OF CARE REVIEWED ( ) YES ( ) NO

PLAN OF CARE REVISED ( ) YES ( ) NO

PROGRESS MADE BY CLIENT: - \_\_\_\_\_

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TYPES OF SERVICES REQUESTED/NEEDED: \_\_\_ PSS \_\_\_ PSSX (CCSP)

\_\_\_ PS LEVEL 1 \_\_\_ PS LEVEL 2 \_\_\_ PS LEVEL 3 (ICWP)

\_\_\_ PRIVATE PAY

\_\_\_ INSURANCE NETWORK

**DETAILS:**

\_\_\_ PERSONAL CARE TASKS

\_\_\_ HOMEMAKER TASKS

\_\_\_ HOME MANAGEMENT

\_\_\_ AMBULATION AND TRANSFER

\_\_\_ NUTRITIONAL NEED

\_\_\_ MEDICALLY RELATED ACTIVITIES

\_\_\_ RESPITE SERVICES

\_\_\_ NURSING SERVICES

\_\_\_ PHYSICAL THERAPY

APPROPRIATENESS AND RESULTS OF THE LEVEL OF CARE AND SERVICES BEING OFFERED TO CLIENT:

*(TIME/FREQUENCY/DURATION)* \_\_\_\_\_

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CLIENT'S RATING OF QUALITY OF SERVICES ( ) GOOD ( ) FAIR ( ) POOR

CLIENT'S SATISFACTION WITH SERVICES AND QUALITY OF CARE \_\_\_\_\_

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**VERBALIZED UNMET NEEDS/PROBLEMS OR ISSUES BETWEEN NOW AND PAST SUPERVISORY**

**VISIT: YES ( ) NO ( )**

FALLS ( ) INJURIES ( ) HOSPITALIZATIONS ( ) OTHER PROBLEMS ( )

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CAREGIVER PRESENT? \_\_\_ Yes \_\_\_ No AID PRESENT? \_\_\_ Yes \_\_\_ No

THE CLIENT IS RECEIVING THE SERVICES AND THE CARE IS SUFFICIENT: ( ) Yes ( ) No

RN/LPN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_



## CLIENT'S MEDICATION RECORD

**Patient** \_\_\_\_\_ **Nurse** \_\_\_\_\_

**Physician** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Pharmacy** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Update client medication at each visit; (c) = current, (d) = discontinued, (n) = new**

Date	Drug Name	Strength	Direction	Frequency	Indication	Updates @ visit			

**MEDICATION PROFILE COMPLETED:** YES NO ( ) NO CURRENT CHANGES IN MEDICATION  
 ( ) YES/SEE CHANGES ON MEDICATION SHEET

Notes:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_