PCA Supervision Sheet

Rx TEAM Home Health Care LLC

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Client Name _____ Client MA # _____

Date of Birth _____ Diagnosis _____

Responsible Party Name _____ Responsible Party Phone # _____

ASSESSMENT

PCA present: ◯ Yes ◯ No PCA Name(s) _____

PCA OBSERVED

☐ Meal prep ☐ Ambulation/ Transfer ☐ Check ins ☐ ROM/ Repositioning ☐ Laundry

☐ Emotional needs ☐ Emergency ☐ Med administration ☐ Med reminders

☐ Infection control ☐ Charting/ Reporting

PCA/ Client rapport

Client comments

Client care plan updated: ◯ Yes ◯ No PCA follows care plan: ◯ Yes ◯ No

Comments

INTERVENTIONS

Care plan reviewed: ☐ Oriented ☐ Procedures ☐ Teaching ☐ Demonstrated to PCA

PCA: ◯ Verbalized understanding ◯ Return demonstration Other: _____

Comments

LIST CHANGES

PLAN OF CARE

Return for supervisory visit:

SUPERVISORY NOTES

Client/ Responsible Party Signature _____ Date _____

PCA Signature _____ Date _____

QP/ RN Signature _____ Date _____

Interpreter Signature _____ Date _____