



SUPERVISION OF PCA

Client Name: _____ **Client Number:** _____

☐ Direct Supervision ☐ Indirect Supervision

ASSESSMENT:

PCA Present: ☐ Yes ☐ No **PCA Name:** _____

Observation of: ☐ Personal Care ☐ Ambulation/Transfer ☐ TPR/BP ☐ ROM Positioning ☐ Escort
☐ Meal Prep ☐ Linen Change ☐ Laundry ☐ Check-Ins ☐ Emergency ☐ Emotional Needs
☐ Med Reminders ☐ Med Administration ☐ Infection Control Techniques ☐ Charting, Reporting

Comments: _____

PCA/Client Rapport: _____

Client Comments: _____

PCA Follows Client's Care Plan: ☐ Yes ☐ No

Comments: _____

INTERVENTIONS:

☐ Client Cares ☐ Skills ☐ Procedures ☐ Techniques ☐ Practices such as:

☐ Oriented ☐ Reviewed ☐ Taught ☐ Demonstrated to Home Health Aide

Home Health Aide: ☐ Returned Demonstration ☐ Verbalized Understanding
☐ Other

PLAN OF CARE UPDATE:

Client Care Plan Reviewed: ☐ Yes ☐ No **Care Plan Update:** ☐ Yes ☐ No

Services Appropriate: ☐ Yes ☐ No **Services Changed:** ☐ Yes ☐ No

List Changes/Updates: _____

Plan: ☐ Return for Supervisory Visit: _____
☐ Other: _____

SUPERVISORY NOTES:

RN Signature _____ **Client/RP** _____

Date _____ **Time in** _____ **Time out** _____