**PCS: INITIAL OR 60 DAY CLINICAL SUPERVISION** (**PERSONNEL RECORD)**

EMPLOYEE NAME/TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TYPE**: \_\_\_\_\_ Initial \_\_\_\_\_60 day \_\_\_\_\_ 30 day (Medicaid) \_\_\_\_\_ Other

START OF CARE DATE:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

INITIAL SUPERVISION: (NEWLY HIRED CHHA) IS SUPERVISION ON OR BEFORE SECOND DAY OF SERVICE? YES NO IF NOT, WHY NOT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WAS SUPERVISION CONDUCTED IN CLIENT’S HOME? YES NO

WAS THE NURISNG CARE PLAN REVIEWED WITH THE CHHA? YES NO

**SKILLS OBSERVED DURING CLINICAL SUPERVISION**: (*Circle all that apply)*

HAND WASHING BATHING GROOMING TRANSFER

FEEDING MEAL PREP TOILETING SKIN CARE

AMBULATION FOOT CARE ROM ORAL HYGIENE

NAIL CARE HOYER LIFT VITAL SIGNS BLOOD PRESSURE

PULSE OX OXYGEN TUBING OTHER

INSTRUCITONS GIVEN TO CHHA/LPN RELATED TO PLAN OF CARE: YES

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

WERE ALL APPLICABLE CLINICAL SKILLS OBSERVED? YES NO

WERE THERE REVISIONS MADE TO THE PLAN OF CARE? YES NO

IF SO, WERE THEY REVIEWED WITH CHHA/LPN? YES NO N/A

CHHA/LPN IS COMPETENT TO CARRY OUT THE PLAN OF CARE YES NO

*I have supervised the CHHA and found him/her to be* ***competent/not******competent*** *(circle one) to carry out the duties required based on the client’s care plan.*

NAME OF NURSING SUPERVISOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print)

SIGNATURE/TITLE OF NURS SUPERVISOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF CHHA/LPN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Print)

SIGNATURE OF CHHA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_