Home Health Aide, Personal Care Aide Supervision:

Home Health Aide Supervision will occur as follows:

1. A registered nurse or therapist (for therapy only cases) will make a supervisory visit to all patients with an unstable medical condition (i.e., patient receiving skilled intermittent visits in addition to home health aide care) at least once every two (2) weeks. The visit will be made either when the aide is present to observe the aide in the performance of their duties, or when the aide is absent to determine the relationship of the aide and the patient, whether care is being given according to the assignment and whether goals are being met.

2. A registered nurse will make a supervisory visit at least once every 60 days if care is being provided to a patient with a stable medical condition and no skilled needs. A direct supervisory visit (with the aide present) will occur at least once every 60 days.

3. A registered nurse will make a supervisory visit at least every 60 days to patients receiving homemaker/companion services. A direct supervisory visit (with the aide present) will occur at least every sixty-two days.

Findings of the supervisory visit will be used in the home health aide, personal care aide and homemaker/companion's annual performance review.

The supervisory visit will be documented in the patient record and will include:

1. Observations and assistance given
2. Assessment of relationships between the aide, patient and family
3. Determination if assignment is being appropriately carried out
4. Need for changes in the plan of care or assignment
5. Assessment of the appropriateness of the plan of care
6. Determine the degree to which the plan of care is meeting the patient's needs and the goals are being met

It is the responsibility of the RN as the Case Manager to provide the plan of care and determine that the non-licensed home care provider is capable of carrying out that plan of care.

Cross Reference: ________________________________
HHA Plans of Care:

The plan of care for home health aide services shall be established by the registered nurse. The plan shall conform with the physician’s plan of care, and will be based on a systematic process of assessment, problem and needs identification, identification of goals and development of action steps.

The plan of care for home health aides will be reviewed and updated on an ongoing basis, and within five (5) days of identification of a change, but no less than every 60 days. Updates can occur either in the clinical notes or on the plan of care form through individual dated notations or a signature indicating that the plan has been reviewed by the RN.

Home health aide actions taken and services provided shall be documented in the clinical notes and shall be consistent with the plan of care. As problems resolve, the date of resolution should be noted.

Cross Reference: ________________________________

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