

**CIRCLE OF CARING**  
**AT HOSPICE OF THE GOOD SHEPHERD**

Home Health Aide POC and Care Record  
 Rev. 4/1/08

Client Name:			MR#:		Week Ending:					
HHA Name (print):			NCC Name (print):							
Frequency of Visits: Days/wk _____ Hrs//day _____			NCC Signature:							
Complete items checked off by RN below:			SUN	MON	TUES	WED	THURS	FRI	SAT	NCC COMMENTS/SPECIAL INSTRUCTIONS
<input type="checkbox"/> REPORT ANY EVIDENCE OF PAIN OR CHANGES TO NCC	TIME IN:		/	/	/	/	/	/	/	
<input type="checkbox"/> REPORT & DOCUMENT MISSED/CANCELED VISITS TO NCC	TIME OUT:									
<input type="checkbox"/> REPORT TO FACILITY STAFF PRIOR TO LEAVING UNIT	TOTAL:									

PERSONAL CARE	<input type="checkbox"/> Bath (bed-tub-shower)									Client uses: <input type="checkbox"/> Urinal <input type="checkbox"/> Briefs <input type="checkbox"/> Bathroom <input type="checkbox"/> Commode <input type="checkbox"/> Bedpan
	<input type="checkbox"/> Oral hygiene (routine –dentures)									
	<input type="checkbox"/> Shave									
	<input type="checkbox"/> Shampoo/Hair Care									
	<input type="checkbox"/> Assist with Dressing									
SKIN CARE	<input type="checkbox"/> Inspect condition of skin									
	<input type="checkbox"/> Back care									
	<input type="checkbox"/> Foot care									
	<input type="checkbox"/> Wound care (w/RN instruction)									
ELIMINATION	<input type="checkbox"/> Note Urine output (Y or N)									
	<input type="checkbox"/> Note Bowel movement (S / M / L )									
	<input type="checkbox"/> Incontinence Care									
	<input type="checkbox"/> Catheter care									
	<input type="checkbox"/> Ostomy care (w/RN instruction)									
ACTIVITIES	<input type="checkbox"/> Ambulation assist (walker, cane)									
	<input type="checkbox"/> Assist with transfer									
	<input type="checkbox"/> Up in chair									
	<input type="checkbox"/> Range of Motion Exercises									
	<input type="checkbox"/> Reposition every _____									
	<input type="checkbox"/> Weigh every _____									
INTAKE	<input type="checkbox"/> Meal preparation									
	<input type="checkbox"/> Feeding/serving									
	<input type="checkbox"/> Appetite (% of adult meal consumed)									
MISC	<input type="checkbox"/> Change client's bed linens									
	<input type="checkbox"/> Wash client's laundry									
	<input type="checkbox"/> Light housekeeping									
	<input type="checkbox"/> Remind to take meds									
	<input type="checkbox"/> Caregiver Respite/Support									
OTHER	<input type="checkbox"/>									
	<input type="checkbox"/>									
HHA COMMENTS (with date):										

I confirm that the above hours shown are true and correct. They represent actual hours spent for this assignment.

Home Health Aide Signature

Date