

VNA Care Network

HOME HEALTH AIDE DOCUMENTATION SHEET

Pt Name _____

MRN # _____

Diagnosis _____

Reviewed In Home Plan of Care Weekly

- Circle Care ordered
- Check off (✓) when care provided in day column
- Note if care is refused

| VISIT DATE: Month _____ year _____ Date _____ | CARE PROVIDED | | | | | | |
|--|---------------|-----|------|-----|-------|-----|-----|
| | SUN | MON | TUES | WED | THURS | FRI | SAT |
| TIME ARRIVED | | | | | | | |
| TIME LEFT | | | | | | | |
| Personal Care | | | | | | | |
| BATH – bed, sponge shower with bench | | | | | | | |
| HAIR CARE – shampoo, comb, brush | | | | | | | |
| SKIN CARE – lotion, back, inspect pressure areas/extremities | | | | | | | |
| ORAL CARE – brush teeth/denture care/swab | | | | | | | |
| FOOT CARE – soak in tepid water, dry well DO NOT CUT NAILS | | | | | | | |
| NAIL CARE – FINGERNAILS soak/clean/file | | | | | | | |
| SHAVING – electric/safety razor | | | | | | | |
| DRESSING – assist/dress patient | | | | | | | |
| ASSISTN WITH – elastic stocking/ace bandages/splint/brace as instructed | | | | | | | |
| Elimination | | | | | | | |
| TOILET ASSIST – bathroom, bedpan, commode, urinal, disposable brief, condom catheter | | | | | | | |
| CATHETER CARE/pericare – empty drainage bag/record output | | | | | | | |
| OSTOMY CARE – Colostomy/ileostomy care, G-tube, dressing change | | | | | | | |
| Simple Non Sterile Dressing/See Specific Instruction Sheet | | | | | | | |
| Remind to Take Medication/See Specific Instruction Sheet | | | | | | | |
| Activity/Exercise/Position | | | | | | | |
| BEDBOUND – turn in bed q2 hours + PRN | | | | | | | |
| TRANSFER – assist, pivot, sliding board, gait belt, Hoyer | | | | | | | |
| AMBULATION - assist, walker, crutches/cane/wheelchair | | | | | | | |
| ROM/EXERCISES - as taught by clinician. Frequency: Arm R/L Leg R/L | | | | | | | |
| Nutrition/Feeding: | | | | | | | |
| PREPARE/SERVE – breakfast, lunch, dinner, snack | | | | | | | |
| ASSIST/FEED – soft food, pureed, bottle feed, specify diet: | | | | | | | |
| FLUIDS – encourage, restrict: _____ cc: measure intake Record cc's: | | | | | | | |
| WEIGHT/RECORD – frequency _____ Record _____ | | | | | | | |
| Housekeeping | | | | | | | |
| MAKE/CHANGE BED LINEN | | | | | | | |
| PERSONAL LAUNDRY – WASH | | | | | | | |
| ROOMS USED BY HHA FOR PATIENT - WIPE, DUST, TIDY– kitchen, bathroom, bedroom PRN | | | | | | | |
| Safety/Observation | | | | | | | |
| HOSPITAL BED – siderails, up/handrails/grab bars, crib sides | | | | | | | |
| PRECAUTIONS: Standard, Bleeding (anticoagulant), Oxygen | | | | | | | |
| EMERGENCY PHONE NUMBER POSTED? YES NO | | | | | | | |
| Encourage Self-help to Level of capacity as instructed | | | | | | | |
| Other | | | | | | | |
| Telephone call to: RN/Therapist/Supervisor →→HHA to initial daily Pt. to initial daily | | | | | | | |

Visit time change due to: _____

HHA's Comments: _____

HHA's Signature: _____ Contract Agency: _____

Client/Caregiver's Signature: _____ (represents client's acceptance of this plan) ___ Check if unable to sign