



Company Name

LPN SUPERVISORY REPORT

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Patient: \_\_\_\_\_ ID#: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Please respond with Yes, No or NA to the following questions	Yes	No	NA
1 Did the LPN identify herself/himself and explain his/her duties at the first visit with you? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Did the LPN explain your illness and medications so you could understand? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Did the LPN check your temperature, pulse, respiration and blood pressure at each visit and your weight as ordered by your physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Did you feel the LPN was concerned with your health? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Were you able to express your feelings and opinions without reservation to the LPN? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 Were you able to participate in the care planning process and in your care? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 Was the LPN following dress code? Using ID badge? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 Was the LPN prepared with appropriate supplies and equipment (i.e. blood pressure cuff, stethoscope, CPR shield)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 Was the LPN on time for the visit and did he/she contact the client to change time? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 Did the LPN follow universal precaution and safety precaution? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 Did the LPN maintain confidentiality while providing care to you in your home? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 Did the LPN follow correct bag technique? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CLINICAL RECORD SUPERVISION	Yes	No	NA
1 Did the LPN adequately document assessment, teaching and treatments performed in the home record? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 Did the LPN notify the MD, DON or Case Manager when abnormal signs and symptoms were present and was it noted in the home record? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 Is the LPN carrying out the established Plan of Care? Use the comment section to identify areas not addressed and the reason. ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 Does the LPN report and document in the medication sheet any changes or new orders regarding the medications ordered by the MD? Do the medications match the medication sheet and the Plan of Care? If not, is there a modification to the Plan of Care for medication changes? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 Does the LPN report changes regarding the patient's condition to the MD as per agency policy? (Physician supervision) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client information packet is present in the home?  Yes  No

Client understands rights/home health complaint and abuse toll-free hotline phone numbers?  Yes  No

Client Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Supervisor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_