

Level of Care

- PCA
- HHA



QUALITY
HEALTHCARE, Inc.
A LICENSED HOME CARE AGENCY

3512 QUENTIN RD. BROOKLYN, NY 11234

HOME HEALTH AIDE ACTIVITY SHEET

Employee's Name: _____

Client's Name: _____

This form is to be completed and signed by the client and Home Health Aide at every client visit.

	S	M	T	W	TH	F	S
BATH							
Tub/Shower/Bed <input type="checkbox"/> Partial <input type="checkbox"/> Complete							
<input type="checkbox"/> Shower <input type="checkbox"/> Assist Bath-Chair							
Hygiene and Grooming							
Oral Care: <input type="checkbox"/> Routine <input type="checkbox"/> Dentures							
<input type="checkbox"/> Hair Care: Assist with Shampoo							
<input type="checkbox"/> Assist with Shaving							
<input type="checkbox"/> Skin Care							
<input type="checkbox"/> Nail Care (file/clean only)							
<input type="checkbox"/> Foot Care							
<input type="checkbox"/> Assist with Dressing							
<input type="checkbox"/> Check Pressure Areas							
Procedures							
<input type="checkbox"/> Catheter Care							
<input type="checkbox"/> Ostomy Care							
<input type="checkbox"/> Record Intake and Output							
<input type="checkbox"/> Medication Reminder							
<input type="checkbox"/> Assist w/ daily blood glucose testing							
Activity							
Assist with Ambulation							
<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair							
Assist with Mobility							
<input type="checkbox"/> Chair <input type="checkbox"/> Bed Dangle <input type="checkbox"/> Commode							
<input type="checkbox"/> Shower <input type="checkbox"/> Tub							
Positioning-Encourage Asst every ___ hrs							
Nutrition							
<input type="checkbox"/> Meal Preparation							
<input type="checkbox"/> Assist with Feeding							
<input type="checkbox"/> Limit/Encourage Fluids							
___ fluid restriction							

	S	M	T	W	TH	F	S
<input type="checkbox"/> Grocery Shopping							
Homemaking							
<input type="checkbox"/> Laundry							
Light HouseKeeping							
<input type="checkbox"/> Bedroom <input type="checkbox"/> Bathroom							
<input type="checkbox"/> Kitchen <input type="checkbox"/> Change Bed linen							
<input type="checkbox"/> Equipment Care							
<input type="checkbox"/> Other							
PATIENT ACTIVITY							
<input type="checkbox"/> Bedbound <input type="checkbox"/> Chairfast <input type="checkbox"/> Ambulatory							
Transfers							
<input type="checkbox"/> Self <input type="checkbox"/> Assist <input type="checkbox"/> Hoyer lift							
Assistive Devices							
<input type="checkbox"/> Wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> Rollator							
<input type="checkbox"/> Hospital bed <input type="checkbox"/> Crutches <input type="checkbox"/> Cane							
Range of motion exercises							
<input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Contracture							
Toileting							
<input type="checkbox"/> Bedpan <input type="checkbox"/> Toilet <input type="checkbox"/> Urinal							
<input type="checkbox"/> Commode <input type="checkbox"/> Diapers <input type="checkbox"/> Catheter							
<input type="checkbox"/> Empty drainage bag							
<input type="checkbox"/> Colostomy <input type="checkbox"/> Urostomy							
Medication/Medication Reminders							
<input type="checkbox"/> Crush meds <input type="checkbox"/> RN to prepour							
<input type="checkbox"/> Other <input type="checkbox"/> Mix with food							
<input type="checkbox"/> Liquids only							
Reinforce dressing: Location: _____							
<input type="checkbox"/> Report changes							
Accompany to medical appointments							
Record <input type="checkbox"/> T <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/> BP							

	Date	Time Started	Time Ended	Total Daily Hrs	Client's Signature	Employee's Signature
SUN						
MON						
TUES						
WED						
THR						
FRI						
SAT						
Total hours worked this week:						

IMPORTANT: In case of an emergency: call 911 immediately: then call Quality Healthcare at (718) 338-8500