All Heart Homecare Agency DUTY SHEET

Instructions: Check () off all competed tasks. Complete all tasks which are either checked or noted on patient Plan of Care

Employee's Name: ______________________________ Patient's Name: ______________________________

Employee # ______ Coordinator: _________________ Address: ______________________________________

1. USE BLACK INK ONLY
2. Fill this form out every day you visit this patient.
3. You and the patient must sign daily.
4. In case of a patient emergency, call 911 and then notify Agency at **718-627-0300**.
5. **Mail, email or bring this form to your Agency every Friday.**

Day	Date M / D	Time Arrived	Time Left	Total Hours	Patient's signature	Employee's signature
Saturday	/					
Sunday	/					
Monday	/					
Tuesday	/					
Wednesday	/					
Thursday	/					
Friday	/					

Plan of Care

Task	Duty	S	S	M	T	W	T	F
Personal Care								
100 / 1	Bath-Tub							
101 / 2	Bath-Shower							
102 / 3	Bath-Bed							
103 / 69 / 802	Patient requires Total Care							
106 / 7 / 588	Mouth Care/Denture Care							
107 / 8	Hair Care-Comb							
108 / 9	Hair Care-Shampoo							
109 / 10	Grooming-Shave							
110 / 11	Grooming-Nails							
111 / 12	Dressing							
112 / 13	Skin Care							
113 / 14	Foot Care							
114 / 15	Toileting-Diaper							
115 / 16	Toileting-Commode							
116 / 17	Toileting-Bedpan/Urinal							
117 / 18	Toileting-Toilet							
Nutrition								
201 / 20	Patient is on a prescribed diet							
202 / 21	Prepare-Breakfast							
203 / 22	Prepare-Lunch							
204 / 23	Prepare-Dinner							
205 / 24	Prepare Snack							
206 / 25	Assist with feeding							
529 / 129 / 67 / 644	Diet-Regular							
530 / 130 / 68 / 530	Diet-Low salt/no added salt							
532 / 132 / 70 / 647	Diet-Low fat							
533 / 133 / 71 / 648	Diet-Low cholesterol							
534 / 134 / 72 / 649	Diet-No concentrated sweets							
536 / 136 / 74 / 651	Diet-Renal							

Task	Duty	S	S	M	T	W	T	F
537 / 137 / 75 / 652	Diet-Fluid restriction							
538 / 138 / 76 / 653	Diet-Other							
Activity								
300 / 28	Transferring							
301 / 32	Assist with walking							
302 / 29	Patient walks with assistive devices							
305 / 33	Assist with home exercise program							
306 / 70	Range of Motion Exercises							
311 / 107	Turning and positioning (At least Q2)							
Treatment / Special Needs								
405 / 101	Take Blood Pressure							
408 / 114	Assist with catheter care							
409 / 48	Empty foley bag							
411 / 50	Remind to take medication							
412 / 51	Assist with Treatment							
Patient Support Activities								
500 / 502	Change bed linen							
501 / 53	Patient Laundry							
502 / 54	Light Housekeeping							
505 / 71	Clean Patient Care Equ							
506 / 57	Do Patient shopping and errands							
508 / 58	Accompany Patient to medical appointment							
509 / 59	Diversional Activities-Speak/Read							
511 / 61	Monitor Patient Safety							
539 / 139 / 77 / 638	Fall precautions							
540 / 140 / 78 / 637	Seizure Precautions							
541 / 141 / 79 / 639	Bleeding Precautions							
542 / 142 / 80 / 640	Standard Precautions							
543 / 143 / 81 / 641	Oxygen Safety Precautions							
544 / 145 / 413 / 657	Observation of skin Condition							

By my signature I certify that I have been oriented to this patient's plan of care. I have reviewed the Aide Care Plan for any changes or updates and that this client received the services checked above. The information documented here is true and correct.

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All Heart Homecare Agency