SAILS WASHINGTON

Shift Log

February 2024

Client Last Name _____ **Client** First Name _____

Caregiver Last Name _____ **Caregiver** First Name _____

Feb		Shift 1 Service Type	Shift 1 Time In	Shift 1 Circle AM or PM	Shift 1 Time Out	Shift 1 Circle AM or PM	Shift 2 Service Type	Shift 2 Time In	Shift 2 Circle AM or PM	Shift 2 Time Out	Shift 2 Circle AM or PM	Total Daily Hours*	Calendar Week Hours	COVID PROTOCOL (Initial each box): I wash my hands frequently during my shift and assist the client I am working with to do so.	COVID PROTOCOL: I screened myself and each client for COVID-19 symptoms at the start of each shift.	COVID PROTOCOL: I have my mask and know that I am required to wear it during each shift.
1	Thu			am pm		am pm			am pm		am pm					
2	Fri			am pm		am pm			am pm		am pm					
3	Sat			am pm		am pm			am pm		am pm					
4	Sun			am pm		am pm			am pm		am pm					
5	Mon			am pm		am pm			am pm		am pm					
6	Tue			am pm		am pm			am pm		am pm					
7	Wed			am pm		am pm			am pm		am pm					
8	Thu			am pm		am pm			am pm		am pm					
9	Fri			am pm		am pm			am pm		am pm					
10	Sat			am pm		am pm			am pm		am pm					
11	Sun			am pm		am pm			am pm		am pm					
12	Mon			am pm		am pm			am pm		am pm					
13	Tue			am pm		am pm			am pm		am pm					
14	Wed			am pm		am pm			am pm		am pm					
15	Thu			am pm		am pm			am pm		am pm					
16	Fri			am pm		am pm			am pm		am pm					
17	Sat			am pm		am pm			am pm		am pm					
18	Sun			am pm		am pm			am pm		am pm					
19	Mon			am pm		am pm			am pm		am pm					
20	Tue			am pm		am pm			am pm		am pm					
21	Wed			am pm		am pm			am pm		am pm					
22	Thu			am pm		am pm			am pm		am pm					
23	Fri			am pm		am pm			am pm		am pm					
24	Sat			am pm		am pm			am pm		am pm					
25	Sun			am pm		am pm			am pm		am pm					
26	Mon			am pm		am pm			am pm		am pm					
27	Tue			am pm		am pm			am pm		am pm					
28	Wed			am pm		am pm			am pm		am pm					
29	Thu			am pm		am pm			am pm		am pm					

Authorized Tasks

1-A Locomotion In	1-B Locomotion Out	2 Bed Mobility	3 Transfers	4 Eating	5 Toileting	6 Dressing	7 Personal Hygiene	8 Bathing	15 Walk In Room	16 Telephone Use	17 Skin Care/Foot Care	Adult Tasks Only: 10 Meal Prep	11 House Work	12 Essential Shopping	13 Transportation	14 Medication Reminder	Respite	*FAMILY INITIALS*

Total Daily Hours in quarter hour increments only. (.00, .25, .50 or .75)

# of hours allocated to _____ (Service Type) is _____

# of hours allocated to _____ (Service Type) is _____

Service Type Examples: Personal Care, Respite, Private Pay

Caregiver Signature _____

Client/Family Signature _____

Shift Log Fax: 1-866-865-3583
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Monthly Schedules: Please note that schedules for the month are due to the supervisor at least five business days before the month starts. Example: If you are working with a client in February 2024 , please submit your entire February schedule by February 21, 2024 to your supervisor. This will help to ensure supervisors are aware of when staff are working, if we are within the amount of hours authorized by the state, and allow time to offer more services to the client/family or the caregiver before the month begins. Please note that clocking in and out of Therap is mandatory for EVV compliance. If your schedule changes, please alert your supervisor immediately so Therap is up to date and has a scheduled slot for you to clock in and out of.

Shift Log: Please note that your shift logs are due weekly. They should be sent directly to your supervisor. Please also note that you are paid for the hours that are clocked in and out in Therap. It is the staff's responsibility to ensure that their clock in/outs are accurate. Staff should be checking their clock in/outs in Therap daily & weekly and requesting changes to their supervisor ASAP. If changes are not made prior to payroll, this could cause discrepenices in pay. Staff should not be relying on supervisors cross referencing their shift logs with Therap.

COVID-19 Protocols: Three statements are included on the shift log for HCA's to initial every shift. The screening questions to ask yourself and the client are listed on the SAILS Washington Home Care COVID – 19 Screening Questions form. You should also be taking your temperature prior to starting every shift, wearing your mask throughout your shift, and washing your hands prior to starting and frequently throughout the day. If you do not have a mask or your mask is worn out, SAILS Washington has a stock of masks and PPE available for all employees, free of charge.

SAILS Washington Home Care COVID – 19 Screening Questions:

Staff and Client Screening Questions:

1. Do you have any of these symptoms that are not caused by another condition? Fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, recent loss of taste or smell, sore throat, congestion, nausea, vomiting, or diarrhea.
2. Within the past 14 days have you been in close contact with anyone that you know had COVID-19 or COVID-like symptoms?
3. Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of a COVID-19 test?
4. Have you traveled outside of Washington State in the past 14 days?
5. Within the past 14 days, has another employer, public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?
6. Have you worked with a client at another agency, have a coworker at another agency or have someone close to you that has symptoms of COVID 19 or has had a positive test result?

** If you have answered yes to any of these questions please return to your automobile contact your supervisor immediately. If your client answers yes to any of the questions above, contact your supervisor immediately.