ELITE CARE MANAGEMENT- 9/14/15 DOCUMENTATION INSTRUCTIONS

1. Please make sure that you fax the front and back of the note to the office for payroll. A complete note is needed to process payroll.
2. Make sure your note and signature are legible, credentials listed, and correct date and time.
3. Never use white-out on notes. Correct an error with one line through the error and initial.
4. Do not write personal information such as bonus, PTO information on your clinical notes.

CNAs- Notify the office if:

1. You have any questions about your assignment, which is on the Client Service Plan in the home, if you did not receive a copy.
2. You need instructions on patient transfers, performing ROM exercises, or performing any task(s).
3. Make sure you follow and document your note in accordance with the Client Service Plan.
4. Call if you identify any skin break down or patient has new complaints or problems identified.

NURSES – Please make sure you are using the appropriate nursing note. There is a shift note and a visit note to help differentiate the type of visit being made.

Please make sure that you are following the patient's Physician's Plan of Treatment and your compliance is reflected in your notes. Notify your Supervisor, if changes to the POT/new physician's orders/corrections are needed. Document all catheterizations done, the size of catheter used, results, and how the patient tolerated the procedure along with any changes, problems, etc.

1. Observe/monitor for skin breakdown - document no problems noted, or any observations made
2. Document any wounds identified and measurements at least weekly
3. Document all wound care provided – it should be done in accordance with current orders
4. Document all reports to supervisor and/or physician and any new orders obtained.
5. Document all PT/INR results, current coumadin dose, and RN that results were reported to
6. Document all significant changes or reports made to supervisory/management staff and any follow-up actions for coordination of care or reporting of falls, incidents, complaints, personnel issues, etc. These reports can be done on a Communication Log form for information that is not part of the patient's note or clinical record.
7. Report when changes are needed to the Plan of Care or Client Service Plan–aide assignment to ensure appropriate care and supervision.
8. Document name of specific drug, not Magic Bullet, etc.

RNs

9. Document all PT/INR results, coumadin dose, and any new orders obtained.
10. Document name of RN or physician that results were reported to and any orders received. Document verbal read back (VORB) to verify correct orders.
11. Document any s/s bleeding or that none observed, and all instructions provided.
12. Make sure that medication lists are updated appropriately with any new orders.
13. Document your supervision of LPNs and CNAs - it is expected that RNs are providing leadership and supervision of the LPNs and CNAs involved in the patient's care and reporting any instructions, problems, observations, etc. to the Nursing Supervisor.
14. Report when changes are needed to the Plan of Care or Client Service Plan-aide assignment to ensure appropriate care and supervision.
15. Document instructions to LPNs and CNAs on ROM positioning, skincare, etc. to ensure proper orientation and training of staff for each patient.
16. TED or JOBST stockings should be included in orders and applied in accordance with POC. These should be on aide assignment-Client Service Plan, as appropriate with frequency and duration. Aides should be supervised that they are following assignment, which should be updated, as indicated. Patient refusals should be documented and reported to RN/Supervisor.

Employee Name (Print): _____ Date: _____