Documentation Instructions

1. Documentation to be done on iPad or Computer
2. Log in at Axxess.com
3. Axxess training videos and tips can be found at elitecaremanagement.com
4. Notes highly recommend being completed by the end of shift.
    a. All initial assessments must be submitted within 48 hours or next business day. **All nursing and home health aide visit notes must be submitted with signature within 72 hours of providing services**. All return notes from QA must be corrected and resubmitted with signature within 72hours.

HHA's -Notify the office if:

1. You have any questions about the assignment, which is on the Home Health Aide Care Plan found under Orders and Care Plans in Axxess.
2. You need the instructions on patient transfers, performing ROM exercises, or performing any tasks.
3. Make sure you follow and document your note in accordance with the Home Health Aide Care Plan.
4. Call if you identify any skin breakdown 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 you are following the patients Physician's Plan of Care and your compliance is reflected in your notes. Notify your Supervisor, if changes to the Plan of Care/new Physician's orders/corrections are needed. Document all catheterizations done, the size of catheter used, results, and how the patients tolerated the procedure along with the changes, problems, etc.

1. Observe/monitor 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 currents 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, etcetera. These reports can be done on a Communication Log form for information that is not part of the patients note or clinical record.
7. Report when changes are needed to the Plan of Care or Home Health Aide Care Plan to ensure appropriate care and supervision.

RN's

1. Document all PT/INR results, coumadin doses, and any new orders obtained.
2. Document name of RN or Physician that results were reported to, and any order(s) received. Document order read back and verified.
3. Document any s/s bleeding or that none is observed, and all instructions provided.
4. Make sure that medication lists are updated appropriately with any new orders.
5. Document your supervision of HHA'S & LPN's involved in patients care and reporting any instructions, problems, observations to the Nursing Supervisor.
6. Report when any changes are needed to the Plan of Care or Home Health Aide Care Plan to ensure appropriate care and supervision.
7. Document Instructions to LPN's and HHA's on ROM, positioning, skin care, etc. to ensure proper orientation training of staff for each patient.
8. TED or JOBST stockings should be included on orders and applied in accordance with Plan of Care. These should be on Home Health Aide Care 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:_____

Employee Signature:_____ Date:_____