

Where: The form is located under the Agent *Main Menu* for an individual patient. Under the header *Shared Forms*, at the far right side of the Menu, you should see "Patient Status Update Alert" listed.

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Logged in as: Rosansky, David (RN) | Profile | Logout | Contact Support | Training

NOTE: This is your list of Patients that have been assigned to you. If the Patient you are looking for is not in the list, please contact the office.

My Patients: [Test, Patient 1] - MR0000004 | Patient Profile | Patient Chart | Patient Schedule | My Schedule | Map

NOTE: This section is for starting new forms for a Patient.

My Forms:

My Forms	• Oasis Forms	• Nursing Clinical Forms	• Physician's Orders	★ • Shared Forms	• Dual Coding Forms	My Reports:
Start of Care (SOC) Packet	OASIS Nurse Start of Care	Skilled Nurse Visit Note	Physician Order - SCIC	Care Coordination Note	Dual Coding Worksheet	Episode Analytics
Recertification Packet	OASIS Nurse Resumption of Care	Skilled Nursing Initial Evaluation/Assessment	Physician Order - SN Management and Evaluation	Clinic Assisted Living Facility Patient		
RN Resumption of Care Packet	OASIS Nurse Recert	Skilled Nurse Patient Missed Visit	Physician's Order	Inter-Office Communication Note		
RN Discharge Packet	OASIS Transfer / Death	60 Day Progress Note	Physician's Order - Late SOC	Interdisciplinary Progress Notes		
	OASIS Discharge	Admission Consent	Physician's Order - ROC	Medication Profile		
	OASIS Nurse ROC/Recert	Agency Disclosure Notice	Physician's Order - Recert	Patient Information Report		
	OASIS SCIC	Bridges Scale	Physician's Order - SOC	Patient Status Update Alert		
		Clinical Summary	Physician's Order - Wound Care			
		SN Discharge Summary	Physician's Order - Caumatrix PT/WR			
		Fall Risk Assessment	Physician's Order - Discharge			
		Notice of Medicare Provider Non-Coverage	Physician's Order - Hold Care			
		Pain Assessment	Physician's Order - Medication Change			
		Patient Emergency Plan	Physician's Order - Therapy			
		Report Of Incident - Patient Specific				
		Skilled Nurse Supervisory Visit - Non Face to Face				
		Wound Care Addendum				
		Wound Vac Addendum				
		Written Notice of Home Care Consumer Rights				
		26 Questions of Fall Prevention				
		Home Health Aide Plan of Care				
		Home Health Aide Plan of Care - PM				
		Skilled Nurse Supervisory Visit - Face to Face				
		Resumption of Care Orders				
		Advance Beneficiary Notice of Noncoverage (ABN)				
		Emergency Office Communication				
		Home Health Change of Care Notice (HHCN)				
		Wound Consultation Visit Report				
		Fall Report / Fall Response form				
		Patient Infection Report				

Filters: From: 03/01/2015 To: 03/29/2016
 Date Filters: Form Date, Date Created, Date Sent To Office, Date Modified
 Form Statuses: To Be Corrected, Pushed Forms To Sign, Pending, Shared, Completed

Page 1 of 1

This page was generated on 03/29/2016 09:56:58 AM

Where Continued: Within the patient's chart, the *PSUA* will appear under the header *Team Communication*. It will list as *Pending* until all clinicians who have received the form have commented on the form and signed it. Once completed, and sent to office, the form will list as *Sent to Office*, and then no longer be modifiable.

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Patient Chart

Chart #3 - (Start Date: 05/29/2014) - Patient Profile

Episode #5 - (Start Date: 01/24/2015 - End Date: 03/24/2015)

Form	Form Date	User	Status	(Select an Action)	Delete
• Notice of Medicare Provider Non-Coverage		Guerra, Bill (RN)	Pending		
• Patient Data:					
• Physician's Orders:					
• Physician's Order - Recert	02/23/2016	Rosansky, David (RN)	Pending		[Delete]
• Clinical Notes:					
• Patient Employee Infection Report	01/12/2016	Dohm, Susan (SuperAdmin)	Completed		
• Patient Employee Infection Report	01/13/2016	Dohm, Susan (RN)	Completed		
• Wound Vac Addendum	01/14/2016	Rosansky, David (RN)	Pending		[Delete]
• Patient Employee Infection Report	01/28/2016	Dohm, Susan (RN)	Sent To Office		
• Plan of Care/OASIS:					
• Plan of Care		(System)	Pending		
• OASIS-CI Discharge	01/12/2016	Guerra, Bill (RN)	Pending		
• OASIS-CI Nurse Start of Care	01/14/2016	Rosansky, David (RN)	Pending		[Delete]
• Medication:					
★ • Team Communication:					
• Patient Status Update Alert	02/23/2016	Rosansky, David (RN)	Sent To Office		
• Patient Status Update Alert	02/23/2016	Rosansky, David (RN)	Sent To Office		
• Patient Status Update Alert	02/23/2016	Rosansky, David (RN)	Sent To Office		
• Patient Status Update Alert	02/23/2016	Rosansky, David (RN)	Pending		[Delete]
• Patient Status Update Alert	02/23/2016	Barragan, Rosio (HHA)	Sent To Office		
• Nurses Clinical Notes:					
• Wound Care Addendum		Rosansky, David (RN)	Pending		[Delete]
• Skilled Nurse Visit Note	02/11/2016	Dohm, Susan (RN)	Completed		
• Skilled Nurse Visit Note	02/11/2016	Dohm, Susan (RN)	Completed		
• Skilled Nurse Visit Note	02/11/2016	Dohm, Susan (RN)	Completed		
• Skilled Nurse Visit Note	02/11/2016	Dohm, Susan (RN)	Completed		
• Physical Therapy Notes:					

Who: The form is designed for use by any member of the care team. Any field clinician, no matter what their discipline, can create one of these **PSUA** forms. All team members will be held accountable to their contribution. ****At the **Admin level, we will be able to track when a form is created, who has received it, who has signed/acknowledged it and who has not.******

Hopefully, we will not have to provide too many reminders as the form itself, once pushed to a clinician, will sit in their **To Be Signed Box**.

Importantly, the person who initiates this form must be responsible for:

- **Creation** of the Form
- **Distribution** of the Form to appropriate members of the team using the **Push** function
- **Monitoring** for acknowledgement/signature of the Form by the other team members who received the **PSUA**
- **Sending** the Completed Form to the Office

Why: As you are already aware, we have been focusing heavily on the role of adequate documentation regarding Intra-Team Communication. I think we can all agree that the **Care Coordination Note** is under-utilized, sometimes burdensome, requires an actual computer screen for optimal reading/review, and difficult to orient in a Topical fashion.

So, the amazing and persistent ****Carla**** reached out to **Devero** and worked diligently with their staff to create the **PSUA** tool. The aim of this tool is to provide you guys with a vehicle for communication that can be more functionally integrated into your normal workflow. It is crucial, I repeat **crucial** that any significant communication taking place between team members regarding your **patient** be documented in the patient's chart.

We understand that text-messages, phone calls, and email have become the norm for exchanging ideas, information, assessment findings, and updates. We are not asking you to stop that all together, for sometimes, it is the best option, especially for time-sensitive exchanges of information.

However, our goal is to have you guys shift a significant amount of that communication onto the **Patient Status Update Alert Tool**. This will ensure that in the event of an adverse patient outcome, early re-hospitalization, death-at-home, or other significant event →→→ anyone reviewing the patient's chart will be able to clearly identify how CHHC clinicians: **ANTICIPATED, EVALUATED, INTERVENED AND COMMUNICATED** about changes in a patient's plan of care, condition, caregiver/social situation, or presentation.

When: So, as stated earlier, the **PSUA** is not meant to replace the **CCN** entirely, rather the goal is for the new tool to serve as a **topical and direct clinician-to-clinician communication**. Here is a guidance list outlining when each form (**CCN or PSUA**) should be used.

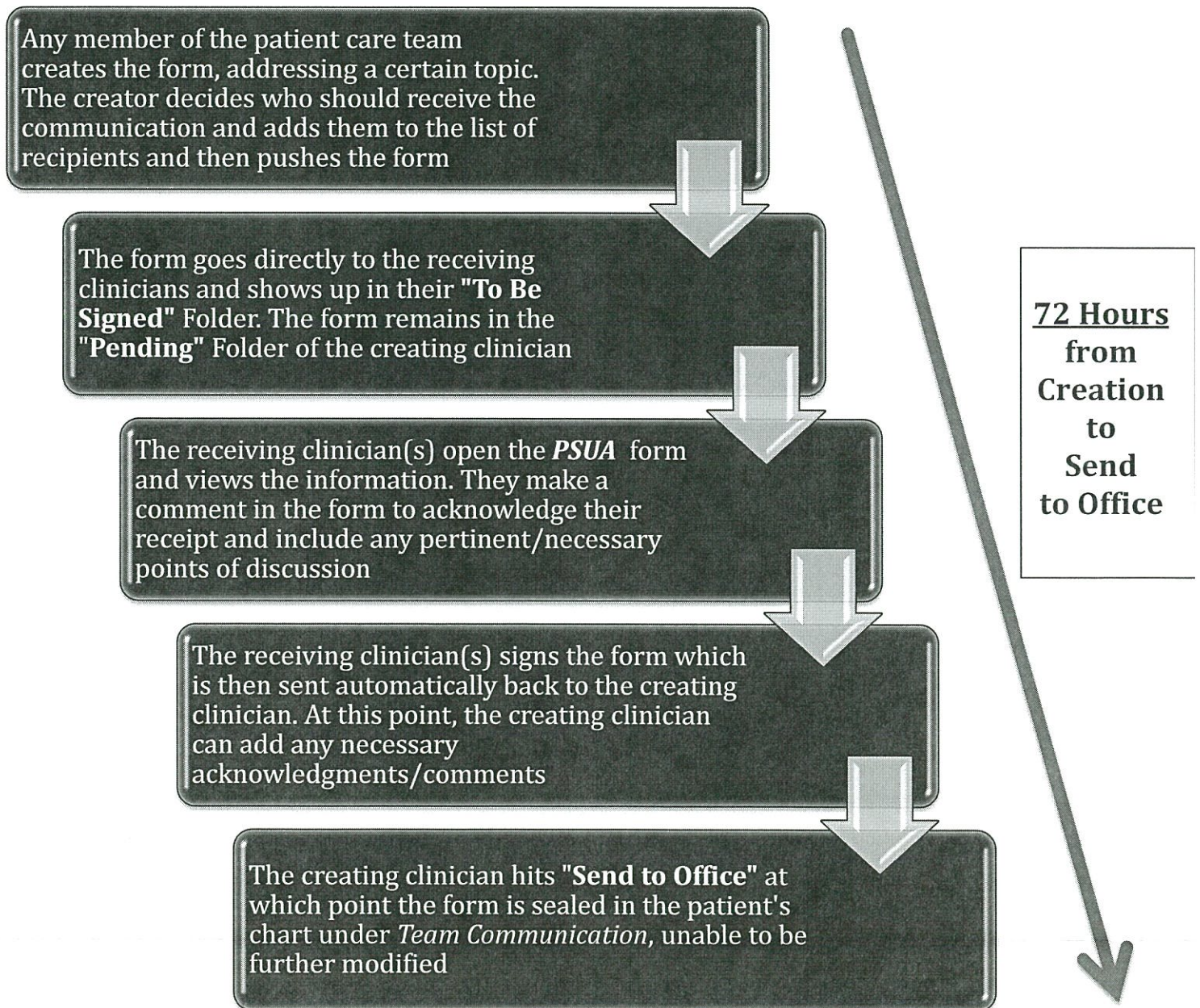
This list is by no means **comprehensive**, but hopefully covers useful examples. Furthermore, communicating something on the **PSUA** does not take the place of expected documentation: (**Fall Report, Med Profile, Infection Report, Physicians Order, etc..**) Nor does this form replace the need for you to **contact the Physician as appropriate in the event of an acute change in patient status.**

Patient Status Update Alert (PSUA): Used to document Dynamic Information, which may have a direct impact on one or more members of the care team. Used to notify your team members of new/significant developments	Care Coordination Note (CCN): Used to document Static Information or individual clinician-provider/caregiver/family discussions that Do Not Largely Impact the other Team Members
ADL Scoring Discussion	Referral/ F2F Information
Discovery of a New Wound	Notes about obtaining/awaiting paperwork (H&P, Med List etc..)
Abnormal Vital Signs	SOC, RCT, ROC Summary
Addition of a New Medication	Therapy Eval Summary: Plan of Care, Frequency/Duration and Documentation of MD Clarification Order Obtained
Discontinuation of an Existing Medication	Nurse Eval Summary
Patient and/or caregiver reports Problems with Medication (adverse reaction, new allergy, etc..)	Conversations with PCP or other Providers (Pharmacist/Dietician/Wound Care Specialist) regarding general information: new orders, special requests, faxes going or incoming
Change in Medication Dosage	Caregiver Information: special contact #'s, best time to call, who to call for what
Changes in Mental or Physical Presentation via <i>assessment findings</i>	Discussions between CHHC clinicians and Caregivers/Family (<i>Information may be cut and pasted from this into a PSUA</i>) and pushed to team members whom this information may directly impact
Changes in the Plan of Care (Skilled Focus, Frequency, Duration, etc..)	Documentation of your efforts to contact PCP or other providers and the follow-up, if received
Concern regarding patient living/social situation; Discussion with MSW	Patient/Family Conference Discussion Notes (<i>Information may be cut and pasted from this into a PSUA</i>) and pushed to any team members who were not present.
Abnormal or Unusual findings of any kind	Notification regarding upload of Medication Discrepancy Form by QA RNs
Request for another discipline to assess a certain change/finding and then provide their feedback	Any communication with the CHHC Office Staff
High Risk Patients: Within 48 hours of open, note goes out all disciplines highlighting the	Addition of Other Disciplines

biggest areas of focus/concern	
Notifying Team Members of a Fall	Discipline Specific Discharge

How: The workflow for the *PSUA* may seem confusing at first, but we believe/hope that once you start to incorporate the *PSUA* into your charting, the process will be easy.

Patient Status Update Alert *Intra-Team Workflow:*



Any member of the patient care team creates the form, addressing a certain topic. The creator decides who should receive the communication and adds them to the list of recipients and then pushes the form

The form goes directly to the receiving clinicians and shows up in their "To Be Signed" Folder. The form remains in the "Pending" Folder of the creating clinician

The receiving clinician(s) open the *PSUA* form and views the information. They make a comment in the form to acknowledge their receipt and include any pertinent/necessary points of discussion

The receiving clinician(s) signs the form which is then sent automatically back to the creating clinician. At this point, the creating clinician can add any necessary acknowledgments/comments

The creating clinician hits "Send to Office" at which point the form is sealed in the patient's chart under *Team Communication*, unable to be further modified

Example: Creating a new PSUA and Pushing it off to other Clinicians

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PATIENT STATUS UPDATE ALERT

Saving ... This is taking longer than normal, please check your connectivity. Do not close your browser.

Patient Chart Notes (Select an Action)

Patient: Test, Patient J. - MR0000004 Caregiver: Rosansky, David (RN) Visit Date: 02/29/2016

DISCIPLINE	SN	PT	OT	ST	SW	Other
2/29/2016 During SN visit on 2/29/16, patient was observed with altered gait and balance, favoring his right leg. Assessment of the right leg revealed no acute injury. PT verbalized an insistence on using his wheelchair today, although he has been encouraging safety with his 4WH for over 2 weeks. Pt denies fatigue and is asymptomatic, denying pain in his legs. Patient's VSS and no other significant abnormal findings observed. Has the PT or OT on the team observed this finding as well during your visit? Can the Physical Therapist (Name) please assess the patient's right leg, his gait, and further investigate the patient's insistence on using the wheel chair instead of the walker during your visit on tomorrow 3.1.16 and then report back with any new information. Thanks						

Person Completing Form: Rosansky, David
Caregiver Signature: This form has not been electronically signed by you.

Saving ... This is taking longer than normal, please check your connectivity. Do not close your browser.

This is an example of the creation of a PSUA. As you can see, I checked off SN (credential), dated my entry, included specific detail in an "SBAR" type format. I also directly addressed the team members whom I need to respond to my finding. At the end, you see my initials and my credential. At the bottom of the page is the "Push" option. When you are finished, you will hit that and a list of clinicians with access to the patient's chart will populate. Choose who you want to receive the form and then send :)

Once you hit **PUSH**, you will see this window: Please just check the boxes next to the name of the clinicians whom you would like to receive the **PSUA** form and then click **PUSH** again in that window.

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PATIENT STATUS UPDATE ALERT

Saving ... This is taking longer than normal, please check your connectivity. Do not close your browser.

Patient Chart Notes (Select an Action)

Patient: Test, Patient J. - MR0000004 Caregiver: Rosansky, David (RN) Visit Date: 02/29/2016

DISCIPLINE	SN	PT	OT	ST	SW	Other
2/29/2016 During SN visit on 2/29/16, patient was observed with altered gait and balance, favoring his right leg. Assessment of the right leg revealed no acute injury. PT verbalized an insistence on using his wheelchair today, although he has been encouraging safety with his 4WH for over 2 weeks. Pt denies fatigue and is asymptomatic, denying pain in his legs. Patient's VSS and no other significant abnormal findings observed. Has the PT or OT on the team observed this finding as well during your visit? Can the Physical Therapist (Name) please assess the patient's right leg, his gait, and further investigate the patient's insistence on using the wheel chair instead of the walker during your visit on tomorrow 3.1.16 and then report back with any new information. Thanks						

Save and push this form to the selected user(s)

Push to user(s)

- Beragan, Basia (RN)
- Burgess, George (RN)
- Carr, Gae (Nurse)
- Doherty, Susan (PT)
- Doherty, Susan (OT)
- Doherty, Susan (RN)
- Doherty, Susan (PT)
- Gilbert, Loretta (RN)
- Guerra, Bill (RN)
- Hauck, Carla (OT)
- Hauck, Carla (PT)
- Hauck-Pompano, Dana (ST)
- Kennedy, Jessica (RN)
- Parkinski, Anita (RN)
- Pt. J. (PT)
- Rosansky, David (RN)
- Thompson, Ann (RN)

Person Completing Form: Rosansky, David
Caregiver Signature: This form has not been electronically signed by you.

Saving ... This is taking longer than normal, please check your connectivity. Do not close your browser.

The rest is easy: Everyone here knows how to view their “To Be Signed Folder,” open a document, add an entry, and then sign the document. For the creators, once you notice that everyone involved has made an entry and signed the form, go back into the form (which is sitting in your “Pending Folder,”) add an entry if needed, then hit “Send to Office” and you’re DONE.

What are the Caveats? The *PSUA* is not perfect; please take note of the following:

- The *PSUA* cannot be “pushed” by anyone except the clinician who created the form
- This means the discussion is more linear than circular. If the creating clinician wants to continue the conversation, they can push the *PSUA* back out prior to sending it to the office. **Or, if a member of the team wants to edit/modify/or add more to their comment, they can call the creator clinician and ask them to push the *PSUA* back, as long as it has not been sent to office. The other team-members can then add to the *PSUA* and sign it again.**
- Otherwise, once all requested team members have commented and signed the form, they are no longer able to access the *PSUA*
- It will likely become quite common to see a number of these forms, perhaps in excess of 10 *PSUAs*, created and listed in the patient’s chart by end of episode, especially for a complex patient
- The clinician who creates the form must remember to check their pending box regularly to monitor whether the form has been commented on and is ready to be sent to office
- Team members receiving the form must prioritize addressing the issue at hand (as this is one of the main purposes of the *PSUA*), so that the creating clinician can get acknowledgement and/or resolution and then send the form to the office in a timely manner
- A new *PSUA* form will have to be developed if there is further follow-up or communication needed once the form has been submitted to the office

Entries in the Patient Status Update Alert Form are expected to Mirror the Format of those Entries in the CCN

Entries are to Include:

- Date
- Identification of yourself and your Credential
- Directly address other disciplines/clinicians
- Detailed explanation of the topic at hand