|  |  |  |
| --- | --- | --- |
| Home Health Aide Care Plan and Visit Documentation Process | Last Revision: | February 2020 |
| Last Reviewed | February 2020 |
| Applies to the following THA Group of companies: | * Island Health Care * Island Hospice * RightHealth® * Palliation Choices |
| Included in the following THA Manual: | Administrative Policies & Procedures  Provision of Care, Treatment,  and Services |

PROCESS

1. Field clinicians have blank Home Health Aide (HHA) care plans either from Start of Care Booklet or collect blank forms from their community office to carry with them. The field clinician will complete a HHA care plan at the time of initial assessment or when it is identified that the patient will need HHA services. Field Clinician may also request referral for Occupational Therapist. The Director of Patient Centered Care (State Director)/Hospice Patient Care Coordinator (HPCC) may complete the form in collaboration with the field clinician. The State Director/HPCC/field clinician will update the plan of care as needed based on changes in patient condition.
2. The field clinician will review the HHA care plan with the State Director/HPCC.
3. A copy of the care plan will be left in the patient’s home in the THA Group folder. The completed HHA care plan will be turned in to the community office within 24 hours.
4. The State Director/HPCC completes the Home Health Aide admission and care plan in the Electronic Health Record (EHR), including the specific tasks and visit order frequency.
5. The HHA Care Plan will be scanned into the patient’s Electronic Health Record (EHR) by the Scheduling Coordinator.
6. The Scheduling Coordinator (S/OC) is responsible for assigning/entering the primary clinician’s name for each discipline in the EHR at the time of the initial assignment to ensure continued flagging for Supervisory visits required.
7. Forms for Home Health Aide care plans and visit notes will be located on the THA G drive: [\\Tha-fs1\2006\Policies and Procedures 2020\Clinical Policies and Procedures Manual\Home Health Aide](file:///\\Tha-fs1\2006\Policies%20and%20Procedures%202020\Clinical%20Policies%20and%20Procedures%20Manual\Home%20Health%20Aide)
8. The Scheduler/Coordinator is responsible for ensuring care plans and forms are printed and available to field staff in their community offices.
9. The HHA will enter time in, time out, and documentation of the visit in the Telephony system or paper documentation In the event of a system shutdown or error, the HHA will complete the paper form of the HHA visit note and submit the note within 24 hours of the visit to the community office. The Scheduling Coordinator will scan the document into the patient’s record.
10. The HHA will notify the Scheduling Coordinator of the need to reschedule visits. In the event of a missed visit, the State Director/HPCC will complete the HHA Missed Visit Note.