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| ILAHDocumentation of Services | **Last Revision:** | June 2019 |
| **Last Reviewed:** | June 2019 |
| **Applies to the following THA Group of Companies:** | * Independent Life at Home |
| **Included in the following THA Manuals:** | Administrative Policies & Procedures Provision of Care, Treatment, & Service |

### PURPOSE

The purpose of this policy is for THA Group, Independent Life at Home (ILAH) to have complete and accurate patient record documentation to foster quality and continuity of care. In addition, to create a means of communication between caregivers and between caregivers and clients about health status, preventive health services, treatment, planning, and delivery of care.

### POLICY

Timely and accurately reporting and documentation is required for all involved in providing services to THA Group’s clients.

### PROCEDURE

1. When a client is referred to THA Group, Independent Life at Home (ILAH) for services, the ILAH Director and Registered Nurse (RN) or assigned personnel will initially contact the client to gather preliminary information such as, client(s) or responsible party’s name, address, telephone number, desired services, etc.
2. When the service agreement has been accepted by the client or client’s responsible party, the Director and RN or assigned personnel will review the service agreement with the client for clarity of purpose. It will then be signed and dated by both the Director and RN and the client or client’s responsible party. A copy of the service agreement will be given to the client or client’s responsible party. The original will then be filed in the company’s secured office filing cabinet and retained for a minimum of six (6) years.
3. The service plan will be completed within seven working days by the Director and RN or assigned personnel. If the service requested by the client is Nursing Service, the Director and RN will go over the service plan with the client. A copy of the service plan will be given to the client or client’s responsible party. The service plan will then be filed in the company’s secured office filing cabinet and retained for a minimum of six (6) years.
4. When there are new findings during the home supervisory visits about the client or something in the client’s home, it is required to be documented by the Director and RN. The Director and RN will document the changes, sign, date, and retain the document in the client’s folder and in the company’s secured office filing cabinet.
5. The Director and RN is required to document information about the client’s primary physician. The Director and RN will complete one section of the service plan at a time and list the client’s physician name, telephone number, address and retain the document in the client’s folder and in the secured office filing cabinet.
6. The Director and RN is required to accurately document all dates and sources of referrals. When a client is referred to ILAH, the Director and RN or assigned personnel will make initial contact with the client and listen to the needs of the client and share how the agency’s services may assist meeting their needs. Upon a service agreement being executed with the client, the Director and RN will enter the date of referral and the source of referral in the agency’s service agreement form and retain the document in the client’s folder and in the company’s secured office filing cabinet.
7. During the supervisory visit, the Director and RN will assess the client, as well as, the performance of the personal care assistant (PCA) or certified nursing assistant (CNA). The PCA’s and CNA’s are required to complete the scheduled tasks per the required times outlined in the Service Plan of Care. The Director and RN reviews the performance of the PCA(s) and/or CNA(s) to identify and resolve any concerns in service delivery. The Director and RN is required to document any revisions or concerns observed or communicated to the Director and RN and retain the document in the client’s folder and in the company’s secured office filing cabinet.
8. Each caregiver uses the Telephony System to clock in and clock out of each client’s residence as scheduled, utilizing the client’s phone. Tasks are recorded via the automated telephony system per the service plan of care.