

# myUnity

## Resource Booklet

*with Documentation Tips*

Aveanna Compliance and Integrity  
Help Line:

1-800-408-4442



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## DOCUMENTATION REQUIREMENTS

### G/GJ/SITE CARE: POLICY 4.26.07

- Condition of skin and tissue at the tube site
- Site care provided
- Tube patency
- Amount and type of flush solutions and ease of flushing
- Length of venting and results
- Volume in the balloon when checked and the tube change, if performed
- Patient and family education
- Unexpected outcomes and related nursing interventions

### G-TUBE CHANGE: POLICY 4.26.08

- Size and type of tube in place
- Length of tube placed
- Condition at tube site
- Tube patency
- Client's tolerance of procedure
- Client and family involvement in care
- Additional interventions and related outcomes
- Unexpected outcomes and related treatment
- Patient and family education

### TRACH TUBE CARE: POLICY 4.43.03

- Date and time of procedure
- Pre- and Post- procedure assessment
- Presence/role of others
- Presence/absence of drainage, type of drainage or odor
- Integrity of the inner cannula/ tube/ flanges (if applicable)
- Integrity of the tracheostomy stoma
- Type of dressing applied; MD ordered medication
- Patient tolerance of the procedure

### TRACH CHANGE: POLICY 4.43.01

- Record exact time that the procedure was initiated
- Assessment of tracheal stoma site, including skin condition (note the presence and extent of granulation tissue or breakdown) and the presence of any drainage at the stoma site, including amount, color, odor, and consistency
- Type/size of tracheostomy tube removed and inserted
- Pre- and post-procedure assessment. Note ease or difficulty in placement of new tracheostomy tube
- Type of trach ties applied
- Type of dressing applied and MD ordered medication
- Presence/role of others
- Additional interventions necessary before, during, and after tracheostomy tube change
- Patient tolerance of procedure
- Patient and family education
- Unexpected outcomes and related treatment

#### **TRACH SUCTIONING:** POLICY 4.43.04

- Date and time of procedure
- Pre- and post-procedure respiratory assessment
- Color, consistency, odor and amount of secretions
- Use of PRN Oxygen
- Patient tolerance of the procedure
- Size and depth of suction cath
- Number of passes

#### **STRAIGHT CATH:** POLICY 4.39.08

- Date and time and size of catheter placed
- Patient's response to procedure
- Appearance of urine: amount, color, clarity, odor and presence of sediment
- Specimen(s) collected and taken to lab. (IF APPLICABLE)
- Patient/family education

#### **CHEST VEST:** POLICY 4.37.08

- Pre and post procedure respiratory assessment
- Date and time
- Positions used
- Cough effectiveness
- Color, amount, and consistency of sputum
- Patient's tolerance of the procedure
- Unexpected outcomes and related nursing interventions
- Patient and family education

#### **RANGE OF MOTION:** POLICY 4.25.06

- Date and time
- Joints exercised
- Type of exercise (AROM, PROM, AAROM)
- Extent to which joints can be moved
- Joint abnormalities
- Pain with appropriate scale
- Patient and family education
- Nurse's objective observation of patient's tolerance
- Patient's subjective statements regarding tolerance of activity
- Unexpected outcomes and related nursing interventions

#### **VENT:** POLICY 4.37.12

- All elements listed on the PDN invasive ventilation flowsheet
- Ventilator settings/patient readings at the start of every shift and a minimum of every four hours for the ventilator in use and any time ventilator settings are changed with physician orders. Back up ventilator (if applicable) settings should be documented at the beginning of the shift
- Circuit changes (documented in the nurse's notes)
- Unexpected outcomes and related nursing interventions
- Patient and family education
- Communication with physician, supervisor, and the DME company

#### **BATH:** POLICY 4.18.02

- Date and time of bath
- How patient tolerated bath
- Any skin irritations, markings, or sores

#### **COUGH ASSIST:** POLICY 4.37.02

- Date and time equipment is used
- Response/tolerance to therapy
- Cough effort
- Duration of treatment
- Quality of secretions
- Suctioning, if appropriate

#### **MEDICATION ADMINISTRATION VIA FEEDING TUBE:** POLICY 4.24.10

- Date, time of administration
- Volume of gastric aspirate, if applicable
- pH of stomach aspirate, if NG tube is used
- Any withheld drug and reason
- Amount of water flush used
- Patient's response to medication, including adverse effects
- Unexpected outcomes and related nursing interventions
- Patient and family education if applicable

#### **MEDICATION ADMINISTRATION NEBULIZED:** POLICY 4.24.11

- Date, time of administration
- Medication dosage, concentration and route
- Patient's response to the medication
- Reason drug withheld (if withheld)
- Patient and family education
- Unexpected outcomes and related nursing interventions

#### **WOUND CLEANSING, IRRIGATING, DRESSING:** POLICY 4.46.01

- Patient's tolerance of procedure and response to pain medication
- Medication administered
- Procedure(s) performed, such as cleaning or irrigation
- Date and time of dressing change
- Type of dressing applied
- Wound assessment
- Description of drainage including quantity, color, consistency, and odor
- Appearance of wound before and after cleansing or irrigation
- Presence of pocket or tunnel
- Wound size
- Status of granulation or necrotic tissue
- Status of surrounding skin, including color, moisture, and integrity
- Unexpected outcomes and related nursing interventions
- Patient and family education

### WOUND ASSESSMENT: POLICY 4.46.03

Documentation regarding wound assessment, care and treatment should be done at each visit or shift and/or with each dressing change as appropriate.

Documentation should be detailed and include:

- An initial diagram of the wound in detail or a photograph (with patient consent) of the wound with a disposable camera is best and place in the office clinical record
- Skilled observation and assessment of the wound. Wound staging, location, size and depth of wound. Wound measurements are documented in the clinical record at least weekly or as physician order. Nature of drainage (amount, odor, color). Condition of surrounding skin.
- Date and time of wound care treatment (procedural) to include the specifics of the specifics of the treatment process. Example: "9/18/19 @ 4:15 pm Irrigated wound with 30 mL of 0.9% sodium chloride solution. Allowed to air dry for 10 minutes, dry dressing with 4x4 gauze and paper tape applied."
- Patient/caregiver education regarding treatment and interventions to include verbal understanding and return demonstration as appropriate.

### CPAP/BIPAP: POLICY 4.37.03

- Date and time therapy is initiated and stopped
- Response to the procedure
- Skin integrity, including skin assessment, eye irritation, and nasal irritation
- Assessment of cardiopulmonary status, respiratory rate, saturations
- Pain or anxiety assessment and any specific interventions provided
- Patient and family education
- CPAP/BiPAP settings per physician order

Everything you do for the patient requires a pre- and post-assessment. How was the patient before the meds/cpt/neb tx, etc... How was the patient after? Did we get the desired response (was the med/treatment effective?)

## **Trach documentation guidelines for patients who have Tracheostomy orders**

Review Plan of Care for specific orders. Follow your orders as written on Plan of Care

### **Stoma Care** (Example of an order written on Plan of Care)

*SN to perform trach care using warm H<sub>2</sub>O and mild soap or 1/2 strength mixture of H<sub>2</sub>O<sub>2</sub> and H<sub>2</sub>O daily and prn soilage*

Documentation should include:

- Document care performed. What was used? Should reflect as orders are written on the Plan of Care (*using warm water and mild soap*)
- Pre/post respiratory assessment findings
- Patient tolerance of the procedure

### **Tracheostomy Tie change**

Documentation should include:

- Date/time of procedure
- How was it performed
- Pre/post procedure assessment, was suctioning needed
- Presence/role of others
- Presence/Absence of drainage. If drainage-type of drainage or odor
- Integrity of the inner cannula/tube/flanges (if applicable)
- Integrity of tracheostomy stoma
- Type of dressing applied; or ordered medication by MD
- If ordered, document if split gauze was placed
- Document if any ordered oxygen was replaced after change
- Patient tolerance of procedure

### **Trach suctioning**

Documentation should include:

- Pre/Post Respiratory Assessment. Assess patient breath sounds, HR, RR, O<sub>2</sub> saturations before and after suctioning.
- Depth (follow orders on POC) if missing, notify your Clinical Supervisor
- # of passes when suctioning - Each pass should not exceed 10 seconds and should be limited to no more than three passes. Allow the patient to recover and take deep breaths, about 20-30 seconds between each pass.
- Document the size of the catheter being used
- Clean suction catheter and connecting tubes with rinse solution.
- Chart secretions- (COACH) **C**olor, **O**dor, **A**mount, **C**onsistency, **H**ow did the patient tolerate

Let's get it together people!



# CHARTING BODY FLUIDS

"Coach"



**C** • Color



**O** • Odor



**A** • Amount



**C** • Consistency



**H** • How The Patient is Tolerating It.

Put me in coach





Charting samples for page 5/6 on flowsheet (or you can use the alternative pages discussed)

**G-button care:** "0921 Gauze removed. Small amount of clear secretions noted on gauze. Stoma area intact, not red. Area cleaned with mild soap and water. Area patted dry. New gauze applied. Pt tolerated well."

**Trach care:** "1022 Trach gauze removed. Small amount of clear secretions noted on gauze with no odor. Stoma area intact, not red. Area cleaned with mild soap and water with sterile Q-Tips. Area dried. New gauze applied. Pt tolerated well."

**Trach suctioning:** "1416 Lungs coarse. Suction performed with a 10 Fr catheter down to 10cm x 3. Thick yellow secretions noted. Pt tolerated well. Lungs now clear. Will continue to monitor."

**Chest vest:** "0945 Lungs clear. Chest vest performed at 11hz, 4, for 5 minutes. Pt tolerated entire session well. No suction needed. Lungs clear in all lobes. Vest removed, skin intact, not red. Will continue to monitor."

"0945 Lungs coarse. Chest vest performed at 11hz, 4, for 5 minutes. Pt tolerated entire session well. Lungs clear in all lobes. Vest removed, skin intact, not red. Will continue to monitor." Therapy effective as evidenced by oral suctioning needed. Clear thick secretions retrieved. Lungs now clear. Will continue to monitor."

**Cough assist:** "0925 Lungs clear. Cough assist performed at +40/-40 x 2 cycles. No suction needed. Lungs still clear. HME attached to trach. Will continue to monitor."

"0925 Lungs coarse. Cough assist performed at +40/-40 x 2 cycles. Cough effective as evidenced by oral suctioning needed. Clear thick secretions retrieved. Lungs now clear. Pt tolerated well. Will continue to monitor."

**Diaper change:** "0832 Urine diaper changed. Yellow urine noted. Peritoneal area care performed. Skin intact not red. Dry diaper applied. Will continue to monitor."

**ROM/PROM:** "0845 PROM performed to upper extremities (elbows and wrists) for 2 minutes. Pt able to extend arms to full extent with my effort. No pain indicated. Pt tolerated well."

**Turn/ Reposition:** "0821 Pt turned from left side to right side. Wedge in between legs. Pt seems comfortable. Left side skin intact not red."

**Feeding:** "0903 Pt sitting upright in wheelchair with safety belts attached. G-Button accessed and extension attached. Stomach contents noted coming back in extension for placement verification. Feeding started via pump. Aspiration precautions maintained. Pt tolerating well, will continue to monitor."

"1005 Feeding complete. Extension flushed and detached from G-Button. G-Button clamped. Pt tolerated well with no complaints. Will remain upright."

*Amount and Formula name goes on page 3- under Intake*

**Opening note:** Pt asleep, easily aroused by sound, parent at side and states no changes and no morning care or medications were performed yet. Pt in bed with siderails up. No respiratory distress noted. Trach midline and patent, secured by ties, HME attached.

**Closing note:** Pt awake up in wheelchair with safety belts attached. No respiratory distress noted. Trach midline and patent, secured by ties, HME attached. Pt has productive cough. Lungs clear in all lobes post cough. Respirations even and unlabored. Heart sounds WNL. Abdomen soft and round with active bowel sounds. G-button LUQ clamped, site WNL. Skin WNL. Family updated on daily events and all care turned over to them. **GoBag at pt side stocked for parent.**

### **Do not word charting**

“per MD orders”

Just putting “T”- you must explain your intervention

“Done” This explains nothing.

Random abbreviations. Refer to your approved abbreviations

## AVEANNA APPROVED ABBREVIATIONS

& = and	Maint = Maintain
ā = before	MAR = medication administration record
a.m. = before noon	MaxA = maximal assistance
ac = before meals	mcg = micrograms
ad lib = at liberty, freely	med = medication
ADL = activities of daily living	Med Dir = Medical Director
AFO = ankle foot orthosis	mEq = milliequivalent
Appt = Appointment	mg = milligram
AROM = active range of motion	MinA= minimal assistance
ax. = axillary, axis	mL = milliliter
b.i.d. = twice a day	mm = millimeter
BBS = bilateral breath sounds	ModA = moderate assistance
BG = blood glucose	ModI = Modified Independent
BIPAP = bilevel positive airway pressure	n/a = not applicable
BKA = below knee amputation	NC = nasal cannula
BLE = bilateral lower extremities	ND = not done
BLS = basic life support	NG = nasogastric
BM = bowel movement	
BP = blood pressure	
BS = breath sounds or bowel sounds	NJ = nasojejunal
BST = bedside table	
BSC = bedside commode	
BUE = bilateral upper extremities	NKA = no known allergies
c = with, line over top	NKDA = no known drug allergies
C/D/I = clean, dry & intact	NOE= notice of election
c/o = complains of	NPO = nothing by mouth
C= centigrade	NP = Nurse Practitioner
cath = catheter	NS = normal saline
CG = contact guard	O <sub>2</sub> = oxygen
CGA = Contact guard assistance	OBT = over bed table
cg = caregiver	OG = oral glucose
cm = centimeter	OOB = Out of bed
CNA = certified nursing assistant	OT = occupational therapy
CNS = central nervous system	OTC = over the counter
CO <sub>2</sub> = carbon dioxide	oz = ounce
CoPs = conditions of participation	p = post, after
CPAP = constant positive airway pressure	pc = after meals
CPR = cardiopulmonary resuscitation	PC = pressure control
CPT = chest percussion therapy	PCG = Parent Caregiver
	PCO <sub>2</sub> = partial pressure of carbon dioxide
	PCP = primary care physician

## AVEANNA APPROVED ABBREVIATIONS

CTA = clear to auscultation	PDN = private duty nursing
CTI = certification of terminal illness	PEEP = positive end expiratory pressure
CVL = central venous line	PERRL/PERRLA = pupils equal and reactive to light (accommodate)
CXR = chest x-ray	PICC = peripheral inserted central catheter
DTR = daughter	PIP = proxinterphalangeal
D/C = discharge; discontinue	PIV = peripheral inserted venous
d/t = due to	pm = afternoon/night
DME = durable medical equipment	PMH- past medical history
DNR = do not resuscitate	po = by mouth
DOB = date of birth	POA = power of attorney
Dx = diagnosis	POC = plan of care
EENT = eye, ear, nose & throat	PPOT = Physician Plan of Treatment
EMT = emergency medical technician	POT = plan of treatment
ENT = ear, nose & throat	PRN = as often as necessary
EPAP= expiratory positive airway pressure	PROM = passive range of motion
ER = emergency room	PS = pressure support
ER = external rotation	PT = Physical Therapy
EOL = End of Life	pt = patient
ETCO2 = end tidal carbon dioxide	PWB- partial weight bearing
ETT = endotracheal tube	q/Q = each; every; line over
F = Fahrenheit	QID = four times daily
F2F = Face to Face	R = right
F/U = follow up	RA = room air
Fr = French	Resp = Respiratory
FWB = full weight bearing	RLE = right lower extremity
FWW = front wheeled walker	RN= registered nurse
FX= fracture	ROM = range of motion
GERD = gastro esophageal reflux disease	RR = respiratory rate
GI = Gastrointestinal	RUE = right upper extremity
GJ = gastrostomy-jejunostomy tube	S = without, line over
gm. = gram	SIL = son in law
GT = gastrostomy tube	s/p = status post
gtt = drops	s/s = signs & symptoms
GU = genitourinary	Sat = saturated
h.s. = bedtime	SBA = Stand by assistance
H/O = history of	SIMV = synchronized intermittent mechanical ventilation
H <sub>2</sub> O = water	SLP/ST = Speech Language Pathologist/Therapist
HCS = Healthcare surrogate	SL = sublingual
HEP = home exercise program	SMO = Supra-Malleolar Orthosis
HHA = Home Health Aide	SOB = shortness of breath
HHA = hand hold assist	

## AVEANNA APPROVED ABBREVIATIONS

HME = heat moisture exchanger	SpO <sub>2</sub> = pulse oximetry
HOB = head of bed	SQ = subcutaneous
HoH = hard of hearing	SX- symptoms
HOH =Hand over hand	sxn = suction
HOHA =Hand over hand assistance	TB = tuberculosis
HR = heart rate	TID = three times a day
HRRR = heart rate and rhythm regular	TLSO = thoracolumbosacral orthosis
hr. = hour	TO = telephone order
HX= history	TOL = tolerated
hz = Hertz	TPN = total parenteral nutrition
I/O = intake/output	TPR = temperature pulse respiration
IADLs = instrumental activities of daily living	TTS = tight to the shaft
IM = intramuscular	TTWB = Toe touch weight bearing
IMV= intermittent mandatory ventilation	Tx = treatment
IND= independently	UE = upper extremity
IPAP = inspiratory positive airway pressure	URI = upper respiratory infection
IPPB = intermittent positive pressure breathing	UTI = urinary tract infection
IR = internal rotation	v.o. = verbal order
IU = international unit	VP = ventriculoperitoneal
IV = intravenous; intraventricular	VS = vital signs
KAFO = knee ankle foot orthosis	VSS = vital signs stable
kg = kilogram	Vt = ventilation tube
L = left	VT = ventricular tachycardia
lb = pound	W/C = wheelchair
LCTA = lungs clear to auscultation	WBAT= Weight bearing as tolerated
LE = lower extremity	WNL = within normal limits
LLE = left lower extremity	WOB = work of breathing
LMN = letter of medical necessity	Wt. = weight
LOB = loss of balance	x = except, line over
LOC = level of consciousness	X = times, e.g., "suction x 4"
LPM = liters per minute	
LUE = left upper extremity	
MAEW = moves all extremities well	



## Introduction to myUnity Clinical Bedside

This document will guide you through navigating myUnity Clinical Bedside.

### Logging in to the myUnity Clinical Bedside

From the myUnity Clinical Bedside application:

- Enter your **username** and **password**.
- Select **Login**.

The screenshot shows the login interface for the myUnity Clinical Bedside application. On the left, there is a white panel with the Aveanna Healthcare logo at the top, followed by the Netsmart myUnity logo. Below the logos are two input fields: 'Username' and 'Password', both outlined in red. A checkbox labeled 'Remember username' is located between the two fields. At the bottom of the panel is a dark blue 'Login' button, with a red arrow pointing to it from the left. On the right, a white panel displays the text 'Welcome to Aveanna Healthcare!!!' in green.

- Username will mirror your **Workday** Log in
- Passwords will be 10 characters
  - 1<sup>st</sup> character - Capitalized first letter of the employee's first name
  - 2<sup>nd</sup> character - Lower case first letter of the employee's last name
  - 3<sup>rd</sup>-6<sup>th</sup> characters - Last four numbers of the employee's SSN
  - 7<sup>th</sup>-8<sup>th</sup> characters - Two digit birth month
  - 9<sup>th</sup>-10<sup>th</sup> characters - Two digit birth day of month
    - Example: Nancy Nurse, SSN ends in 1234, birthday is January 1<sup>st</sup>
    - Password: Nn12340101



## Navigating myUnity Clinical Bedside

The myUnity Clinical Bedside homepage access will vary based on your user role.

**\*\*A patient must be selected before navigating to features such as Patient Profile, Patient Chart, and Forms.\*\***

The screenshot shows the Aveanna Healthcare myUnity Clinical Bedside homepage. At the top left is the Aveanna Healthcare logo. The main navigation bar includes a home icon, a patient selection dropdown menu (currently showing "(Select a Patient)"), and links for "Patient Profile", "Patient Chart", "Patient MAR", and "Patient Schedule". On the right side of the navigation bar, there are links for "My Schedule", "Map", and "Inbound Documents". Below the navigation bar, a note states: "NOTE: This section is for starting new forms for a patient." Underneath this note is a "Forms" section with a "Field Documentation" table. The table lists various forms: Skilled Nursing Flow Sheet, Continuous Infusion Therapy Flowsheet, Controlled Substance Record, Intermittent Visit Note, Invasive Ventilation Flowsheet, Non-Invasive Ventilation Flowsheet, Wound Assessment, and Field Physician Orders. On the left side, there is a "Filters" panel with options for "From" and "To" dates (09/04/2020 to 12/03/2020), "Date Filters" (Form Date, Date Created, Date Sent To Office, Date Modified), and "Form Statuses" (To Be Corrected, Pushed Forms To Sign, Pending, Shared, Completed). On the right side of the filters panel, there are four expandable filter categories: "To Be Corrected", "To Be Signed", "Pending", and "Shared".

To select a patient:

- Tap the box and enter the patients name,medical records number, or tap the dropdown.

This screenshot is similar to the previous one but highlights the patient selection dropdown menu with a red rectangular box. The dropdown menu currently displays "(Select a Patient)". The rest of the page layout, including the navigation bar, filters, and forms section, remains the same.

## Navigating myUnity Clinical Bedside - Patient Profile

The **Patient Profile** houses patient demographic information, along with the status of the patient. You can also view the patient’s physician and insurance information.

- To access the patient profile, tap **Patient Profile**.

This screenshot shows the Aveanna Healthcare myUnity Clinical Bedside homepage with a patient selected. The patient selection dropdown menu now displays "TEST, AVEANNA - T-42666". The "Patient Profile" link in the main navigation bar is highlighted with a red rectangular box. The other elements of the page, such as the filters and forms section, are visible but not the focus of this specific instruction.



EMR TEAM (TEST)  
PATIENT PROFILE

Patient: TEST, AVEANNA - T-42666  
Chart: 1 Episode: 1

Patient Information		Referral Information	
SOC Date: 04/18/2018	Medical Record #: T-42666	Referral Date: 04/18/2018	
Verbal SOC:	Status: Admitted	Referrer: Unknown, Unknown (Unknown)	
	Discharge Reason:	Referrer's First Name: Unknown	Referrer's Company Name: Unknown
	Non-Admit Reason:	Referrer's Last Name: Unknown	Referrer's Phone: Unknown
First Name: AVEANNA	Last Name: TEST M.I.	Referral Memo:	Referrer's Group Name:
Address: 400 INTERSTATE NORTH PARKWAY	Address 2: SUITE 1500	Referral Source:	
City: ATLANTA State: GA	Zip Code: 30339 - MA	Facility Name:	
County:		Type:	
Home Phone:	Cell Phone:	Phone:	
Email:	Major Cross Street:	Fax:	
Sex: <input type="radio"/> Male <input checked="" type="radio"/> Female	Birth Date: Jan 1 1900 Age: 120	Comments:	
Soc. Sec. #:	Medicaid #: 1234567	Admission Source: Information Not Available	
Medicare #:		Marker:	
Patient lives with: <input type="radio"/> Alone <input type="radio"/> Spouse <input type="radio"/> Family <input type="checkbox"/> Other		Episode Timing Override (First 30 Day): <input type="radio"/> Early <input type="radio"/> Late	
Allergies:		Last inpatient stay Information	
Marital Status:		Name:	Phone #:
Race:		Address 1:	Address 2:
Language Spoken:	Patient Resuscitate:	State:	Zip Code:
Religion:	Acuity: 2	Admit Date:	D/C Date:
Comments:		Comments:	Hospital MR #
		Location of Care:	
		Location of Care: Location of Care: (Home)	
		Start Date:	End Date:
		Street:	
		Suite/Apt #:	
		City:	State:
		Phone:	Zip Code:
		Facility Type:	Phone:
			Fax:
			NPI #:
Other Patient ID: T-42666		Physician Information	



## Navigating myUnity Clinical Bedside - Patient Chart

The **Patient Chart** provides a comprehensive record for all users working with a patient; this includes electronic documentation, attached files, physicians' contact information, and key patient demographics.

- To access the Patient Chart, tap **Patient Chart**.

The screenshot shows the 'Patient Chart' interface for patient TEST, AVEANNA - T-42666. On the left, there is a 'Patient Information' sidebar with details like agency (EMR TEAM (TEST)), status (Admitted), insurance (BCBS PPO/POS, TRADITIONAL), policy number (TEST), secondary insurance (MEDICAID), and address (400 INTERSTATE NORTH PARKWAY, SUITE 1500, ATLANTA, GA, 30339). The main area shows a list of episodes, with 'Episode #2 - (Start date: 10/31/2020 - End Date: 12/29/2020)' selected. Below the episode list is a table of forms organized by category:

Form	Form Date	User	Status	Mark
<b>Patient Data</b>				
<b>Admission Paperwork</b>				
<b>Comprehensive Assessments</b>				
<b>POT/POC</b>				
<b>Physicians Orders</b>				
Field Physician Orders %	11/08/2020	LPNTest, Hybrid (LPN)	Sent To Office	<input type="checkbox"/>
Field Physician Orders	11/08/2020	LPNTest, Hybrid (LPN)	Sent To Office	<input type="checkbox"/>
Field Physician Orders %	11/15/2020	LPNTest, Hybrid (LPN)	Sent To Office	<input type="checkbox"/>
Field Physician Orders %	11/16/2020	LPNTest, Hybrid (LPN)	Sent To Office	<input type="checkbox"/>
<b>Coordination of Care</b>				
<b>Medication</b>				
Medication Profile	10/31/2020	LPNTest, Hybrid (LPN)	Pending	<input type="checkbox"/>
<b>Nurses Clinical Notes</b>				
Skilled Nursing Flow Sheet	11/04/2020	LPNTest, Hybrid (LPN)	Completed	<input type="checkbox"/>
Skilled Nursing Flow Sheet	11/12/2020	LPNTest, Hybrid (LPN)	Sent To Office	<input type="checkbox"/>
<b>Progress Notes</b>				
<b>MSW Notes</b>				
<b>Miscellaneous</b>				
<b>Discharge/Transfer</b>				

- The patient's current **Episode** (certification period) will display.
  - To view forms and documentation in previous certification periods, click on the episode to expand it.
- Forms** in the Patient Chart will be automatically organized into their assigned category.
  - Within a category, forms appear in chronological order.
- The **Patient Information** section on the left-hand side of the Patient Chart will display key demographic information from the Patient Profile form.

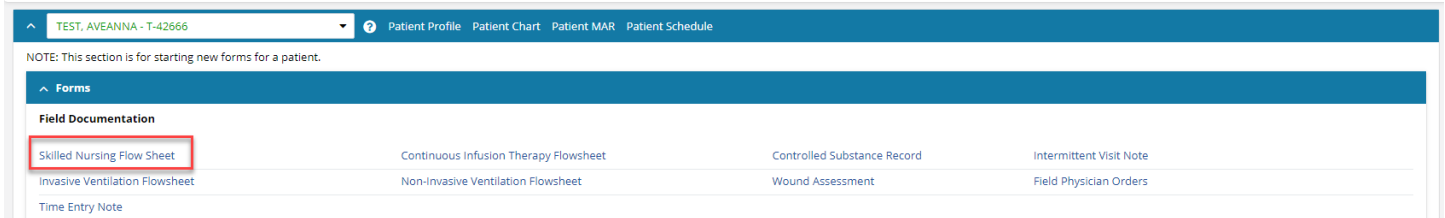




## Navigating myUnity Clinical Bedside - Forms

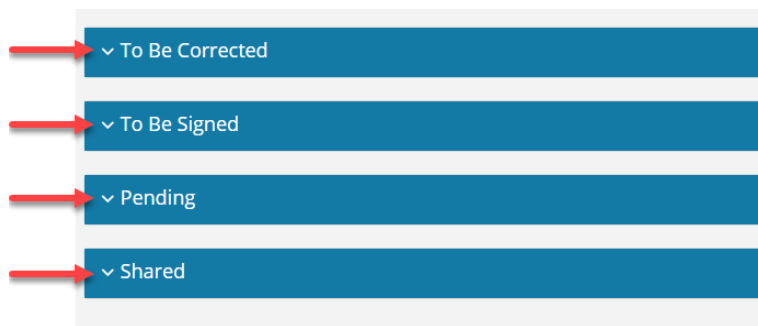
The Forms are divided into different sections and user role drives what sections and forms a user has access to.

- To begin documentation on a form, you must have a patient selected. Once the patient is selected, tap the form to open and begin documentation.



## Navigating myUnity Clinical Bedside- Form Status

Existing forms are also accessed under the form status **Filters** on the home page.

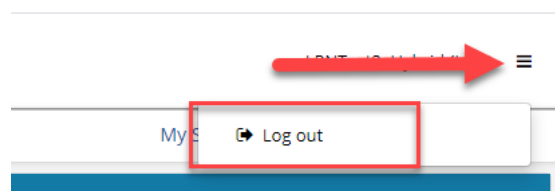


- To Be Corrected Forms** have been returned to the field caregiver by the agency for correction. Field caregivers can update the form to correct errors and send the form back to the office for review.
- Pending** forms have been opened/started and can be freely updated by the creator. Forms will remain in the Pending status until the field caregiver “sends form to office”.
- Shared** status will not be used.
- To Be Signed** status will not be used.

## Navigating myUnity Clinical Bedside - Logging out

Logging out signs the user out of the myUnity Clinical Bedside application. To log out:

- Be sure all forms for the shift have been Sent to Office.
- Hold the tablet in landscape position.
- Select to the three lines in the upper right corner on the myUnity Clinical home page.
- Select **Log out**.





# Skilled Nursing Flow Sheet - Documentation

This guide will provide an overview of clinical documentation tips for the Skilled Nursing Flow Sheet.

## Tips for Documenting Pages 1-2

- Document the initial assessment within the first 30 minutes of the shift.

## Page 3

- Document pain, physician/supervisor contact, education, travel and I & O at appropriate times.

## Page 4

- Document seizure activity if it occurs.

- Continue to document each treatment performed using pages 5 and/or 6, at minimum, Q2 hours throughout shift.

EMR TEAM (TEST)  
**SKILLED NURSING FLOW SHEET**

Notes, Patient Chart

Patient: TEST, - T-58939  
 Medicaid #: 1234567  
 Chart: 1 Episode: 1

Caregiver: LPNTest, Hybrid (LPN) Visit Date: 11/01/2020

Document each treatment performed with your initials in the box below the time involved.  
 \*\*\*Remember to document all care provided, at minimum, Q2 hours throughout shift (including narrative entries)\*\*\* If any treatment ordered on POC or subsequent/supplementary physician's order is NOT performed, document reason in exception note/narrative. T/NF: Tolerated/NOT Tolerated.

TREATMENT	12 am	1 am	2 am	3 am	4 am	5 am	6 am	7 am	8 am	9 am	10 am	11 am
Monitors On/Audible	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select	Select
Pulse Ox Reading %												
O2 Administered (Document LPM)	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment
Turn/Reposition	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment
ROM/PROM	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment
Daily Care	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment
Bath: <input type="checkbox"/> Tub <input type="checkbox"/> Shower <input type="checkbox"/> Bed	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment	O T O N T Comment

- Cleaning and Maintenance: Document at appropriate times.
- Narrative: Time and Sign all entries. Document your arrival note, any narratives for change in condition, etc., and a departure note.

EMR TEAM (TEST)  
**SKILLED NURSING FLOW SHEET**

Notes, Patient Chart

Patient: TEST, - T-58939  
 Medicaid #: 1234567  
 Chart: 1 Episode: 1

Caregiver: LPNTest, Hybrid (LPN) Visit Date: 11/01/2020

Saved 5:29:16 pm

\*\*\* Document each task performed with time and initials \*\*\*

Cleaning and Maintenance		Time	Time
Suction Canister Cleaned			Vent Circuit Changed
Suction Catheter Changed			IV Tubing Changed
Suction Tubing Changed			Cleaning Solution Changed
Nebulizer Tubing Changed			Equipment Cleaned
Nebulizer Filter Changed			Linens Changed (Per PCG schedule)
Oxygen Tubing Changed			Travel Bag Restocked
Feeding Bag/Tubing Changed			Supplies Restocked
Ostomy Bag Changed			Patient Area Cleaned

NURSING NARRATIVE DOCUMENTATION: Open charting with patient status and report received from. Close charting with patient status and report given to. All changes in your patient's status must be detailed.

8:10 AM	REPORT AND CARE REC'D FROM.....	LPNTest, Hybrid (LPN) LPN 11/02/2020 05:46:59 PM EST Sign
4:45 PM	REPORT AND CARES GIVEN TO.....	LPNTest, Hybrid (LPN) LPN 11/02/2020 05:47:16 PM EST Sign

Fields within the Skilled Nursing Flow Sheet

Non-Editable

- Grayed-out fields cannot be updated. The data that is displayed populates from another source (i.e. Patient Profile).

Patient: TEST, - T-58939  
 Medicaid #: 1234567  
 Chart: 1 Episode: 1

DOB 10/10/2018  
 Time In: 7:54 AM

Caregiver: LPNTest, Hybrid (LPN) Visit Date: 11/01/2020



## Text Box

- Select the text box by clicking or tapping; enter letters, numbers, or appropriate value for the text box.

VITAL SIGNS			
Time	Temp/Route	Heart Rate	Resp Rate
8:01 AM	<input type="text" value="98.6"/> F / Temporal	90 <input checked="" type="radio"/> Regular / <input type="radio"/> Irregular <input type="button" value="Clear"/> <input checked="" type="radio"/> AP <input type="radio"/> Radial <input type="radio"/> Other <input type="button" value="Clear"/>	24 <input checked="" type="radio"/> Regular / <input type="radio"/> Irregular <input type="button" value="Clear"/>

## Radio Button

- Select the radio button by clicking or tapping on the circle. Radio buttons are common for Yes/No questions or any other questions that require only one selection from the available responses.

VITAL SIGNS			
Time	Temp/Route	Heart Rate	Resp Rate
8:01 AM	98.6 F / Temporal	90 <input checked="" type="radio"/> Regular / <input type="radio"/> Irregular <input type="button" value="Clear"/> <input checked="" type="radio"/> AP <input type="radio"/> Radial <input type="radio"/> Other <input type="button" value="Clear"/>	24 <input checked="" type="radio"/> Regular / <input type="radio"/> Irregular <input type="button" value="Clear"/>

## Date Box

- Select a date by clicking within the date box, and then selecting the appropriate date from the calendar.
- The arrows skip back or forward one month at a time, while the drop down allows you to update the year.

Location of IV: SITE

Site Condition:  Intact  Redness  Swelling  Drain

Dressing:  No  Yes

Date of Last IV Dressing Change: 11/01/2020

Type of IV Dressing:  Occlusive  Non-Occlusive

COMMENTS

---

ENDOCRINE

N/A  Hypoglycemia  Hyperglycemia  Insulin Pur

GASTROINTESTINAL

Continent  Incontinent Date of Last Bowel Movement: 11/02/2020

Stool Color/Consistency:

Abdomen:  Soft  Tense/Hard  Flat/Rounded  Distended  Colostomy/Ileostomy Site:

Bowel Sounds:  Present  Hyperactive  Hypoactive  Absent

Nutritional Intake:  NPO  Regular  Restricted

## Check Box

- Select the check box by clicking or tapping on the box to check or uncheck. Select multiple options as needed.
- At least one check box is required to be selected.

**NEUROLOGICAL**

Awake  Oriented  Asleep  Alert  Verbal  Non-Verbal  Vocalizes

Lethargic  Developmental Delay  Cognitive Impairment

Fontanels:  Flat  Soft  Sunken  Bulging  N/A

Reflexes:  Suck  Startle  Gag  Blink  Grasp  N/A

Seizure Activity Present:  No  Yes (See Seizure Flow Sheet)



## Dropdown

- Select the dropdown by clicking or tapping on the arrow. The dropdown provides multiple options for selection; only one option may be selected.

**MUSCULOSKELETAL** (check R for Right or L for Left)

Full ROM  Passive  Active

Ambulatory  Non-Ambulatory  Crawls/Walks  Ambulatory with Assistance  Bedbound  Chairbound

Contractures:  Upper  R  L  Lower  R  L

Adaptive Aids Required (please identify below)

N/A  Wheelchair  Stander  Walker/Crutches  Belts  Cane  Gait Trainer  Helmet

Transfer: **INDEPENDENT** ▼


Lift (t) \_\_\_\_\_

AFO: **1 PERSON ASSIST**  N/A Location: \_\_\_\_\_

Comments: \_\_\_\_\_

## Blue Clock “Inline Reporting”

- View historical data collected from the previous five Skilled Nursing Flow Sheets by tapping the blue clock.

VITAL SIGNS 

oute

DV Standard Vital Signs

Form Name	Form Owner	Visit Date	Temperature	Pulse	Respirations	Weight	Height	Blood Pressure Systolic	Blood Pressure Diastolic
Skilled Nursing Flow Sheet	LPNTest, Hybrid (LPN)	11/03/2020	98.6		50				
Skilled Nursing Flow Sheet	LPNTest, Hybrid (LPN)	11/02/2020	98.6		56				
Skilled Nursing Flow Sheet	LPNTest, Hybrid (LPN)	11/01/2020	98.6		24				
Skilled Nursing Flow Sheet	LPNTest2, Hybrid (LPN)	11/01/2020	98.6		60				

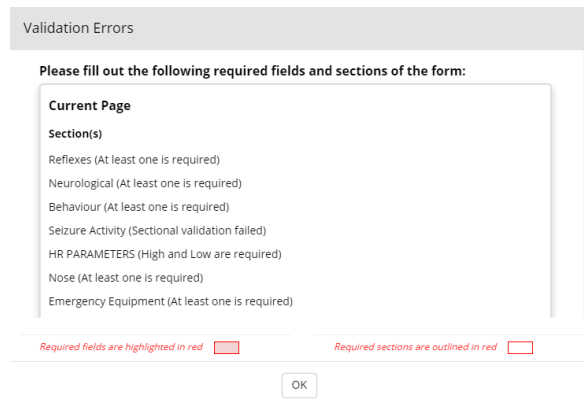
AP Radial Other Clear

## Required Fields within the Skilled Nursing Flow Sheet

Some areas of the Skilled Nursing Flowsheet require documentation, even if it’s just to say the item is N/A and does not apply to the patient. If a required field has not been filled out and the user uses the Send to Office button, they will be prompted with a Validation Error screen and must complete the documentation before the system will permit them to send the form to the office.

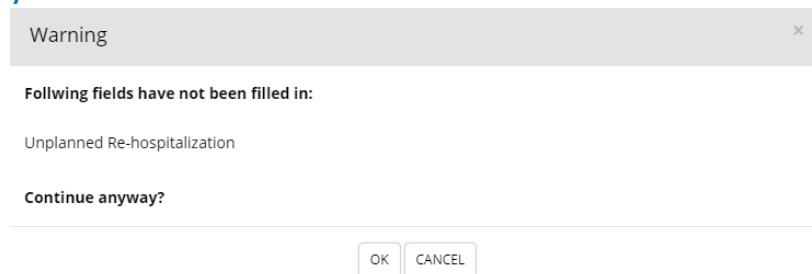
## Errors

- Require correction** before a form can be sent to the office.



## Warnings

- **Read, and verify** if area needs to be documented or if the user can move forward without documentation.



## Time in/Time out

- Exact time of arrival and completion of shift is required, no rounding.

## Patient/PCG/Other Printed Name (Pg.1)

- Free text **first and last name of the person signing** in the signature box.

## Patient/PCG/Other Signature (Pg.1)

- Tap or click on the box, use finger for signature. Once saved, it cannot be edited or removed.

## Vitals:

- Red fields indicate required fields.
- Time - Enter the time vital signs were taken.
- Temp/Route - Free text and drop down are required.
- Heart rate - Two radio buttons are required.
- Respirations - One radio button is required.
- Pulse Ox - Document if ordered.
- BP - Document if ordered.

## Unplanned Re-hospitalization since last shift (Pg. 1)

- Has the patient been hospitalized since the last shift?
  - This is referring to the last shift that provided services for the patient, not your last shift.

## Decannulation this shift (Pg. 2)

- If the patient has a trach, was there a decannulation at any time during the current shift?



## Recannulation (Pg. 2)

- If there was a decannulation, was the trach successfully reinserted?

## Endocrine (Pg. 2)

- Requires one entry and may be N/A.

## Seizure Log (Pg. 4)

- Log each patient seizure in a horizontal row. Select all boxes in the row that describe the seizure activity. Best practice is to always complete: Time, Duration, all dropdowns that apply, O2 if used, Post-Ictal response, V/S During and After and any pertinent comments.

## Hourly Flowsheets

- Document all treatments on flowsheets by selecting T (tolerated) or **NT** (not tolerated). If NT is selected, a comment is required.
- Clinical documentation should occur at a minimum of every two hours throughout the shift.

## Nursing Narrative Documentation

- **Arrival Note (required):** Document a brief statement of the patient's current condition and the name of the person from whom you received report. Arrival note requires time and signature.
- All changes in your patient's status (from initial assessment) must be documented in Narrative field with times and signature.
- **Departure Note (required):** Document the patient's condition on departure and the name of the person to whom you gave report. Departure note requires time and signature.

**NURSING NARRATIVE DOCUMENTATION:** Open charting with patient status and report received from. Close charting with patient status and report given to. All changes in your patient's status must be detailed.

7:05 AM	0705 Arrived to shift and assumed care from mother of patient. Patient in stable condition, sleeping in bed, vital signs stable, MOC reports patient had a quiet night and tolerated continuous G-tube feed without difficulty.
7:17 AM	Head to toe assessment completed, incontinence care provided, patient repositioned and still resting quietly.
9:15 AM	Medications administered as ordered after G-tube placement confirmed. Incontinence care provided, changed patient clothes, patient repositioned in bouncy seat with proper support.
10:00 AM	G-tube feeding started according to MD orders, patient tolerating well.
12:00 PM	Patient receiving PT provided by therapist, nurse remains at bedside to provide support and intervention as necessary, tolerating therapy well.
1:45 PM	Head to toe assessment completed, report provided to mother of child, patient resting in bed for afternoon nap in stable condition

**Example:** Upon arrival, and completing initial assessment, the patient's respirations were documented easy and unlabored with clear breath sounds and no cough. Later in the shift the patient experienced coughing, labored breathing with expiratory wheezes. This change in condition would be documented in **Narrative Documentation with time and signature.**

If documentation is expected to exceed the number of lines on the form, multiple entries can be documented in each space. Be sure to include times.

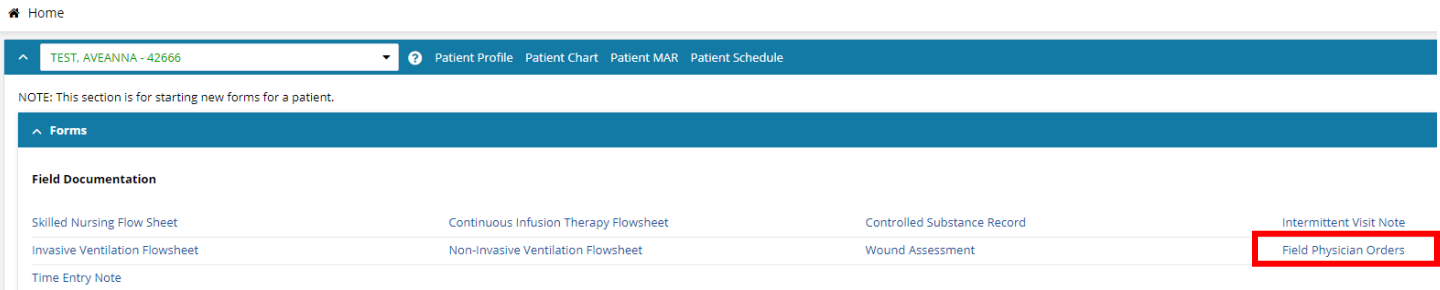


# myUnity Clinical Bedside – Updating the Medication Profile and Physician Orders

Adding, changing or discontinuing medications and patient allergies will be done through Field Physician Orders. Do not access the Medication Profile directly from the Patient Chart to make changes. All changes must have orders.

## Accessing Field Physician Orders

- From the **Home** screen select the patient and choose the **Field Physician Orders** form.



The top portion of the order should auto-populate with the current date and information from the patient profile:

- Patient name, MR Number, DOB
- The office name, address, phone, and fax
- The physician's name, address, phone and fax (it defaults to the Primary physician)

Patient Name: Last	TEST	First	AVEANNA	MR Number:	42666	DOB:	01/01/1900
Location Name:	EMR TEAM (TEST)						
Location Address:	3400 W Girard Ave	Suite 100	City: Philadelphia	State: PA	Zip: 19104	Location Phone:	(555) 555-5555
Location Fax:	(999)999-9999						
Physician Name:	FIELDING, DENNIS P (MD)			Physician Address:	17 STATE RT 23 N		
Physician Phone:	973-827-7800	Fax:	973-209-7855	City:	HAMBURG	State:	NJ Zip: 07419-1419

- If the ordering physician is not the one that defaulted to the form, use the dropdown to make a different selection:

Physician Name: (Select a Physician)

Physician Phone: (Select a Physician)

Physician Community: (Select a Physician)

Orders: (Select a Physician)

- ABBASI, SORAYA - 3401 CIVIC CENTER BLVD PHILA PA 19104
- ABBRUZZI, ANTHONY - 5000 FRANKFORD AVE PHILADELPHIA PA 19124
- ABDELMASEEH, TONY (DR) - 5 WASHINGTON AVE JERMYN PA 18433
- ABDELMOUMEN, IMANE (MD) - 160 W ERIE AVE PHILADELPHIA PA 19134
- ABHULIMEN, REGINA - 2003 E. MARKET STREET YORK PA 17402
- ACHARYA, FALGUNI - 4700 UNION DEPOSIT RD., SUITE 220 HARRISBURG PA 17111
- ADAMS, DAVID R (MD) - 500 UNIVERSITY DRIVE HERSHEY PA 17033

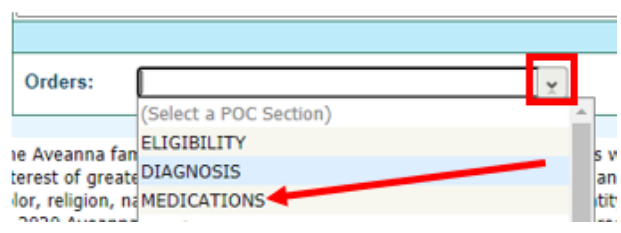




2. If the physician you are searching for cannot be located:
  - a. **Remove** the incorrect physician.
  - b. In the **Physician Communication** field, document the name, phone and fax information for the correct, ordering physician along with any non-medication orders you may have received.
    - i. An office nurse will enter the new physician into another system when they QA this order. Once completed, you will have access to the new physician in the dropdown.

Physician Name: (Select a Physician) ▼	Physician Address: _____
Physician Phone: _____ Fax: _____	City: _____ State: _____ Zip: _____
Physician Communication: Dr. Fictitious phone 555-444-1212 fax 555-444-1213	

3. If the order is for a medication or a new patient allergy, proceed to the **Orders** dropdown and select **MEDICATIONS**.



- a. This action will open a list-view of the patient's medications in a popup window:

**MEDICATIONS**

Patient: TEST, AVEANNA - 42666  
Chart # 1 | Admitted

Update Medication profile

Active

Start Date	Code	Medications	Route	Dose	Frequency	Class	Indication	D/C Date
10/31/2020		Multiple Vitamins-Minerals (Whole Food Multivitamin) Tab(s)	G-Tube	1 tablet	Daily	Multivitamin Preparations		

Discontinued

[Insert to form](#) [Cancel](#)

4. Select the **Update Medication profile** link.

**MEDICATIONS**

Patient: TEST, AVEANNA - 42666  
Chart # 1 | Admitted

**Update Medication profile**

Active

Start Date	Code	Medications	Route
10/31/2020		Multiple Vitamins-Minerals (Whole Food Multivitamin) Tab(s)	G-Tube



- a. This action will open the active **Medication Profile** in a new browser tab.

Printer-Friendly Version |

EHR TEAM (TEST)  
**MEDICATION PROFILE**

Patient Chart Notes  
Patient: TEST, AVEANNA - 42666  
Chart: 1 Episode: 2

(Select an Action) | Caregiver: Wayne, Bruce (RN) | Visit Date: 11/08/2020

SOC: 04/18/2018 D.O.B 1/1/1900  
Height: Weight: Certification Period From 10/31/2020 To 12/29/2020

DX:

Allergies	Start Effective Date	Discontinued Date	Pharmacy Name	Pharmacy Address
Add 1 Allergy(s) Add			Pharmacy Phone	Pharmacy Fax
			Physician Name: FIELDING, DENNIS P (MD)	
			Physician Phone: 973-827-7800	Physician Fax: 973-209-7855

Insulin Sliding Scale:

List all medications and treatments (include over-the-counter medications, herbal, and other alternative treatments).

Start Date	Code	Medications [ Info   Interactions ]	Route	Dose	Frequency	Class	Indication	Date Teaching Performed	D/C Date	Clinical Signature/Date	Clear Row
10/31/2020		Multiple Vitamins-Minerals (Whole Food Multivitamin)	G-Tube	1 tablet	Daily	Multivitamin Preparations				Sign	Clear
		(Select a Medication)								Sign	Clear
		(Select a Medication)								Sign	Clear
		(Select a Medication)								Sign	Clear
		(Select a Medication)								Sign	Clear

Add 3 Medication(s) Add

Please note:

- On the right side of the screen, the red hyperlink for **Printer-Friendly Version** is for **office-use only**.
- The dropdown for **“Select an Action”** is also for **office use only**.
- **Visit Date** will default to today’s date.
- On the left side of the screen
  - The **Patient Chart** hyperlink will navigate to the patient’s chart in a new browser tab.
  - The **Notes** hyperlink is for office use only unless it is highlighted in yellow. This feature will be discussed more in the job aid, Documentation Corrections.
- The patient’s **SOC** date, **DOB**, and **Certification Period From** dates will auto-populate.
- **Height** and **Weight** should be added if known and are for reference only. Adding them will not perform any system action.
- The **DX** field should be left blank. Adding a diagnosis here will not perform any system action and is not required.
- Pharmacy information may be added, if desired.
- The Primary **Physician Name**, **Physician Phone** and **Physician Fax** numbers will pull from the patient profile.

Leave the primary physician selected as this is the physician that is signing the Plan of Care authorizing medications in the Med Profile. Changing the physician here will not perform any system action in the chart, profile, or order.

## 5. Allergies

- a. To add a new allergy, begin typing the allergen in the **Allergies** text field and select from the choices presented.

Patient Chart Notes  
Patient: TEST, AVEANNA - 42666  
Chart: 1 Episode: 2

SOC: 04/18/2018 D.O.B 1/1/1900  
Height: 60 Weight: 120  
DX:

Allergies	Start Effective Date	Discontinued Date
Penicillin		
Penicillin		
Penicillin		
Penicillins		



- b. Once a selection is made, the allergy and today's date will populate.
- c. If you are not able to locate the correct allergen, **as a last resort**, you may free text the allergy.
  - i. **FREE TEXT ALLERGIES WILL BE EXCLUDED FROM DRUG INTERACTION RESULTS.**
- d. To discontinue an existing allergy, enter a Discontinued Date.

Allergies	Start Effective Date	Discontinued Date
Soaps	10/31/2020	11/15/2020

- e. If more fields are required for additional Allergies, use the Add button to add another row.

Allergies	Start Effective Date	Discontinued Date
Penicillins	11/08/2020	
Peanuts	11/08/2020	
Add 1 Allergy(s) Add		

- **Insulin Sliding Scale** field: Do Not Use.
  - It will not write them to the physician's order or the Patient MAR.
  - All Sliding Scale information must be included in the Medication section.

Insulin Sliding Scale:

## 6. MEDICATIONS

- a. **NOTE:**

List all medications and treatments (include over-the-counter medications, herbal, and other alternative treatments).								
Medications [ Info   Interactions ]	<input type="checkbox"/>	Route	Dose	Frequency	Class	Indication	Date Teaching Performed	D/C Date

- i. The statement above medications says to 'List all medications and treatments', but Aveanna only includes medications in the Med Profile.
    - Example: Oxygen, Pedialyte, medicated topicals, OTC medications, Rx medications
  - ii. Treatments are listed on the Plan of Care and should be documented on the **Skilled Nursing Flowsheet** on the **Treatment** page.
  - iii. Nutritional formulas, juices, including prune juice, etc., and water/water flushes are also on the Plan of Care and should be documented in I & O on the **Skilled Nursing Flowsheet**.
  - iv. Please refer to the Patient MAR course for documenting Medication Administration.
- b. The **Start Date** must be entered in MM/DD/YYYY format. You may tap the **calendar icon** and select the medication start date.

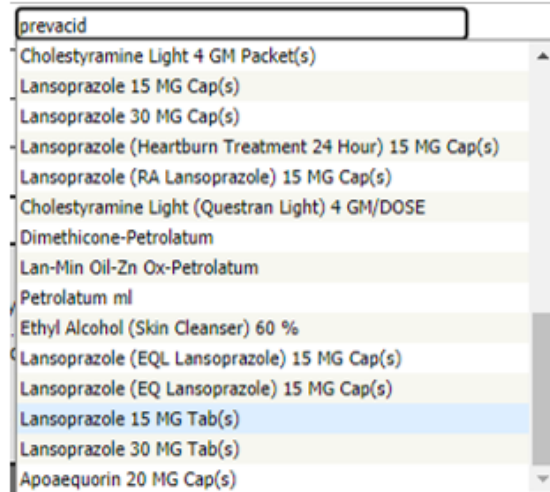
Start Date	Code
10/31/2020	
Add 1 Medication	

November, 2020

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	1	2	3	4	5
6	7	8	9	10	11	12



- c. Leave the **Code** field blank.
  - i. Optional: You may use the Code field to flag a medication as **OTC**, **Existing** or **Hold only** please. Do not use **New**, **Change** or **LS** and there is no need to flag all prescriptions as RX unless otherwise directed by a Nursing Supervisor.
- d. Begin typing the name of the medication in the **Medications** field and select the appropriate concentration and form from the dropdown. You may need to scroll down to find the strength you are searching for.



- e. When selecting medications, you may need to try brand or generic names to find the appropriate form or dosage.
  - i. Example: Prevacid will yield only capsules and tablets whereas the generic Lansoprazole has a liquid option.
- f. Once a medication has been selected the **Route** and **Class** will auto-populate based on the drug choice and form selected per the manufacturer’s intended route.
  - i. Example 1: If you choose Acetaminophen capsule, tablet or liquid it will default to an Oral route.
    - NOTE: Based on the route of actual administration, you may select a different route by using the dropdown.
  - ii. Example 2: If you choose Acetaminophen suppository, the route will default to rectal.
    - NOTE: This route may also be edited if needed, for instance via an ostomy.
- g. If you are not able to locate the medication at all, **as a last resort** the medication may be free texted into the field.
  - i. **FREE TEXT MEDICATIONS WILL BE EXCLUDED FROM DRUG INTERACTION RESULTS.**
  - ii. The **Route** will be a free text field.
- h. ROUTE NOTE: NGT is not currently an option in the system. If the patient takes oral medication via an NGT:
  - i. Select the medication as usual.
  - ii. Select G-Tube as the route.
  - iii. Make a note in the Frequency field of “Route is NGT” followed by the frequency.

Lansoprazole 15 MG Tab(s)	<input type="checkbox"/>	G-Tube	▼	15 mg (1 tablet)	Route: NGT, give twice a day 0!
---------------------------	--------------------------	--------	---	------------------	---------------------------------



**i. DOSE:**

- i. Should be written in MG when possible. You may add the amount to administer in parenthesis and include a delivery method such as nebulizer or nasal cannula if applicable.

- Dose Example:

Dose
1 tablet
15 mg (1 tablet)
650 mg (1 suppository)
125 mg (5 ml)
1 LPM via N/C

**j. FREQUENCY AND TIMES:**

- i. Tap the **Frequency** field and a dropdown of common choices will appear. You may select a frequency from the dropdown or free type the appropriate frequency.

Frequency	Class
<input type="text"/>	Multivitamin Prej
Daily	
Twice per day	
Three times per day	
Four times per day	
Every morning	
Every afternoon	
Every night at bedtime	
Every other day	
Weekly	
PRN/As Needed	

- ii. For the Patient MAR to show times of administration, add the times in the **Frequency** field.

Frequency
Daily 0900
Route: NGT, give twice a day 0900
PRN/As Needed Q 6 hrs
Twice per day 0900 and 2100
Continuous

- iii. \*\*\*Times listed for the MAR are recommended or suggested times of administration based on medication frequency. These can be changed without a physician's order *unless the times were specified by the physician.*



**k. PRN MEDICATIONS:**

- i. PRN/As Needed must also have a PRN frequency.
  - Example: PRN/As Needed Every 6 hours
- ii. PRN meds must also have an **Indication**.
  - Examples: mild pain, moderate pain, nausea, SOB, fever >100.3, indigestion, etc.
- iii. Dose ranges are NOT best practice. Best practice is single dose using multiple lines.
  - Example:

Acetaminophen (Acetaminophen Extra Strength) 50	<input type="checkbox"/>	G-Tube	500 mg (1 tab)	PRN Q 6 hrs	Antimigraine Agents, Miscellaneous	mild pain
Acetaminophen (RA Pain Relief Acetaminophen) 50	<input type="checkbox"/>	G-Tube	1000 mg (2 tabs)	PRN Q 6 hrs	Antimigraine Agents, Miscellaneous	moderate pain

- iv. If an order is received for a dose range, indications for high and low doses should be provided for both, as in the above example.
- v. NEVER write a medication order with dose or frequency as ‘per package directions’, ‘per box instructions’, ‘per parent discretion’, ‘as directed,’ etc.
- vi. Doses cannot be written as MG/KG, they must specify the current dose. When the dose changes, the physician should be contacted for a new order.

**l. DATE TEACHING PERFORMED – leave blank**

- i. Do not use. Teaching is addressed on Supervisor’s assessments and the Skilled Nursing Flowsheet.

**m. D/C DATE**

- i. If the medication order is to discontinue an existing medication, enter the date into the **D/C Date** field.

D/C Date
11/10/2020

- n. Once the med profile is saved, discontinued meds will be highlighted in blue.

Start Date	Code	Medications [ Info   Interactions ]	Route	Dose	Frequency	Class	Indication	Date Teaching Performed	D/C Date	Clinical Signature/Date
11/01/2020		Gabapentin (Neurontin) 100 MG Cap(s)	G-Tube	100	Daily at 14	Antic			12/06/2020	LPNTest, Hybrid (LPN) LPN 12/06/2020 02:25:55 PM EST Sign

**o. CLINICAL SIGNATURE/DATE**

- i. Use the **Sign** button to electronically sign each medication you have added.
- ii. Use the **Sign** button to electronically sign each medication you have discontinued.
  - Your signature will be date and time stamped.

Clinical Signature/Date
LPNTest, Hybrid (LPN) LPN 12/06/2020 02:25:55 PM EST Sign

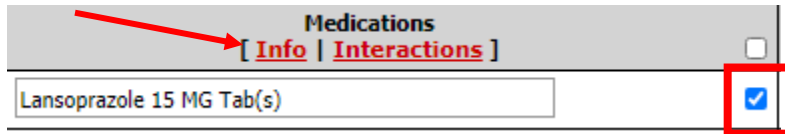
**p. DRUG REGIMEN REVIEW**

- i. Do not complete the **Drug Regimen Review/Medication Reconciliation** in the lower half of the Med Profile.
- ii. Supervisors will complete medication reconciliations every 60 days and when new medications are ordered.

Drug Regimen Review						
	Review / Revise Dates					
	Date:	Date:	Date:	Date:	Date:	Date:
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
1. Potential drug reactions or adverse effects	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear
2. Potential or actual ineffective drug therapy	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear
3. Significant side effects	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear
4. Significant drug interactions	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear
5. Duplicate drug therapy	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear
6. Patient shows potential noncompliance with medications	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear
7. Patient/caregiver understands medications instructions	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear
8. Patient/caregiver requires further instruction on medications	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear	<input type="radio"/> Y <input type="radio"/> N Clear

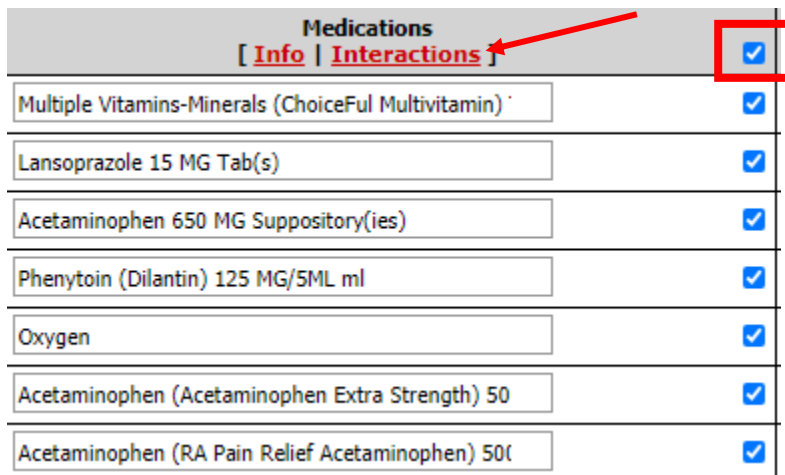
**q. INFO | INTERACTIONS**

- i. Drug Information is available in the system for many medications.
  - First, place a check in the box next to the new medication(s) or all medication(s) you wish to see information on.
  - Then, select the **Info** hyperlink.



- A new browser tab will launch displaying drug information for the medication(s) selected. The information sheet is similar to what a pharmacy would have distributed when the Rx was filled. It includes information such as, but not limited to: generic name, common uses, cautions, and possible side effects. Information is also available for OTC medications.

- ii. Drug Interactions should be checked every time new medication orders are received.
  - Check the box for all medications.
  - Then, select the Interactions hyperlink.





- iii. A new browser tab will launch displaying drug interactions
  - The top left area will list all meds and notification of any that are not being factored in due to manual entry of the medication. Best practice is to always select medications from the database when available.
  - Also listed are the patient allergies.
  - The system calculates **Allergy to Drug Interactions** as well as **Drug-to-Drug Interactions**.

**Drug Interaction Results**

Patient: TEST, AVEANNA - T-42666

Medications:

- Gabapentin Oral
- Phenytoin Oral
- Lansoprazole Oral
- Acetaminophen Rectal
- oxygen inhalation (Not Checked – Select valid Medication or Route)
- Acetaminophen Oral
- Acetaminophen Oral
- Warfarin Sodium Oral
- Aspirin Oral
- Multiple Vitamin Oral
- Gabapentin (Once-Daily) Oral

Allergies:

- Soaps (Not Checked - Select valid Allergy)
- Penicillins
- Peanut-containing Drug Products
- Gluten (Not Checked - Select valid Allergy)
- Red Dye

- iv. Any significant (major) drug interactions/contraindications must be reported to the physician and the Nursing Supervisor.
  - Interactions are color coded and labeled as to the severity.
    - a. Examples:

**Adverse Reaction - Drug: Lansoprazole Oral, Allergy: Red Dye**

**\* Major Drug Interaction - Warfarin Sodium Oral and Aspirin Oral \***

**Moderate Drug Interaction - Aspirin Oral and Amphetamine-Dextroamphetamine Oral**

**Minor Drug Interaction - Aspirin Oral and Acetaminophen Oral**

**\*\*REMINDER: ALL SIGNIFICANT (MAJOR) DRUG INTERACTIONS/CONTRAINDICATIONS MUST BE REPORTED TO PHYSICIAN AND NURSING SUPERVISOR.\*\***

- r. CHANGE MEDICATION DOSE OR FREQUENCY
  - i. If the medication order is for a change to the dose or frequency:
    - Discontinue the current dose/frequency by entering a **D/C Date**. Be sure to sign the DC entry.

D/C Date

- ii. Use the **Add** button below medications and add a new entry with the new dose/frequency. Be sure to sign each entry.

Add

Medication(s)
Add

- iii. You may add more than 1 line at a time by entering a number before using the Add button.





s. Save the Med Profile

- i. When you have completed adding and discontinuing all medications and/or new allergy orders, scroll to the bottom and select **Sign/Save this form**. This action will close the Med Profile returning to the Medications popup.
- ii. On the Medications page, select the new medications you want to appear on the Order by selecting the check box in the appropriate rows. Then use the 'Insert to form' button.

MEDICATIONS

Patient: TEST, AVEANNA - T-42666  
Chart # 1 | Admitted

Update Medication profile

Active

<input type="checkbox"/>	Start Date	Code	Medications	Route	Dose	Frequency	Class	Indication	D/C Date
<input type="checkbox"/>	10/31/2020		Pediatric Multivit-Minerals	G-Tube	10 ml	Daily at 0900	Multivitamin Preparations		
<input checked="" type="checkbox"/>	11/08/2020		Phenytoin (Dilantin) 125 MG/5ML ml	G-Tube	125 mg (5 ml)	Twice a day at 0900 and 2100	Hydantoins		
<input checked="" type="checkbox"/>	11/08/2020		Lansoprazole (First-Lansoprazole) 3 MG/ML ml	G-Tube	15mg (5 ml)	Twice per day route is NGT at 0900 and 2100	Proton-pump Inhibitors		
<input checked="" type="checkbox"/>	11/08/2020		Acetaminophen (FeverAll Adults) 650 MG Suppository(ies)	Rectal	650 mg (1 supp)	PRN/As Needed Q 6 hrs	Antimigraine Agents, Miscellaneous	Fever >101.3	
<input checked="" type="checkbox"/>	11/08/2020		oxygen	Inhalation	1 LPM via NC	Continuous	medical gas		

- iii. This action will populate the Field Physician Order with the Medication orders.

**Orders**

Orders:

**MEDICATIONS**

Active

Lansoprazole 15 MG Tab(s) Oral 15 mg (1 tab) Route: NGT, give twice a day 0900 and 1700 Start Effective Date: 11/08/2020

Acetaminophen 650 MG Suppository(ies) Rectal 650 mg (1 suppository) PRN/As Needed Q 6 hrs Fever above 100.3 Start Effective Date: 11/08/2020

Phenytoin (Dilantin) 125 MG/5ML ml G-Tube 125 mg (5 ml) Twice per day 0900 and 2100 Start Effective Date: 11/08/2020

Oxygen Inhalation 1 LPM via N/C Continuous Start Effective Date: 11/08/2020

- iv. If your order included new allergies as well, select **Allergies** in the **Orders** dropdown.

Patient Name: Last  First

Location Name:

Location Address:  Suite

Location Fax:

Physician Name:

Physician Phone:

Physician Communication:

Orders:

(Select a POC Section)

- MEDICATION
- Active
- Phenytoin (Dilantin) 125 MG/5ML ml G-Tube 125 mg (5 ml) Twice per day 0900 and 2100
- Lansoprazole 15 MG Tab(s) Oral 15 mg (1 tab) Route: NGT, give twice a day 0900 and 1700
- Acetaminophen 650 MG Suppository(ies) Rectal 650 mg (1 suppository) PRN/As Needed Q 6 hrs Fever above 100.3
- oxygen inhalation 1 LPM via N/C Continuous
- ELIGIBILITY
- DIAGNOSIS
- MEDICATIONS
- DME/SUPPLIES
- SAFETY MEASURES
- NUTRITIONAL REQUIREMENTS
- ALLERGIES
- FUNCTIONAL LIMITATIONS
- ACTIVITIES PERMITTED
- MENTAL STATUS
- PROGNOSIS
- INTERVENTIONS

The Aveanna family manages or controls the use of the Aveanna logo. © 2020 Aveanna Healthcare. Caregiver Signature Physician Signature

- On the **Allergies** screen, place a check by the allergy(s) that you added and use the **Insert to form** button again.

ALLERGIES	Start Effective Date	Discontinue
<input type="checkbox"/> Soaps	10/31/2020	
<input checked="" type="checkbox"/> Penicillins	11/08/2020	
<input checked="" type="checkbox"/> Peanut-containing Drug Products	11/08/2020	

- This action will add an Allergies section to the orders and populate with the allergies that were selected in the previous screen.

- If you notice an error that needs to be corrected before you submit the order:
  - Use the **Clear** hyperlink on the right to clear the affected field.
  - Use the **Orders** dropdown to return to the the appropriate area. In this example, Medications:

- Make the correction and re-insert to form.
- If the order is complete, scroll the the bottom and use the **Send to Office** button to submit the order to the office.



## Correcting Documentation- Bedside Caregiver

This document is used to provide instruction on correcting forms that were sent back to the bedside caregiver from the agency.

Forms sent back to for correction will be found in the **To Be Corrected** area (known as the **To Be Corrected queue**) of the myUnity Clinical Bedside Home page.

### Correcting Documentation

- Locate the Form in the **To Be Corrected** queue.

^ To Be Corrected									
Patient	MR#	Form	Form Date	User	Date Created	Date Sent to Office	Date Modified	Agency	
TESTING, TEST	59650	Skilled Nursing Flow Sheet	11/09/2020	LPNTest2, Hybrid (LPN)	11/09/2020 02:41 PM EST	11/09/2020 04:43 PM EST	11/12/2020 04:54 PM EST	EMR TEAM (TEST)	

Showing 1 to 1 of 1 results

- To open the form, select its blue title.

^ To Be Corrected					
Patient	MR#	Form	Form Date	User	
TESTING, TEST	59650	Skilled Nursing Flow Sheet	11/09/2020	LPNTest2, Hybrid (LPN)	

Showing 1 to 1 of 1 results

- Once you've opened a form for correction, locate the correction Notes that were added.
- Notes are page specific to the form and will be highlighted to indicate a Note has been added. Multi-page forms will identify which page Notes have been attached to by boxing the page number.

< Previous **1** 2 3 4 5 6 7 Next >

Notes Patient Chart

- Select the highlighted **Notes** hyperlink to view correction notes for the page indicated.

< Previous **1** 2 3 4 5 6 7 Next >

Notes Patient Chart



- Correct the documentation as instructed or select Add Note to explain why the requested change is not being made.

- Once the needed corrections are updated, navigate to the bottom of the form and select **Send To Office**.

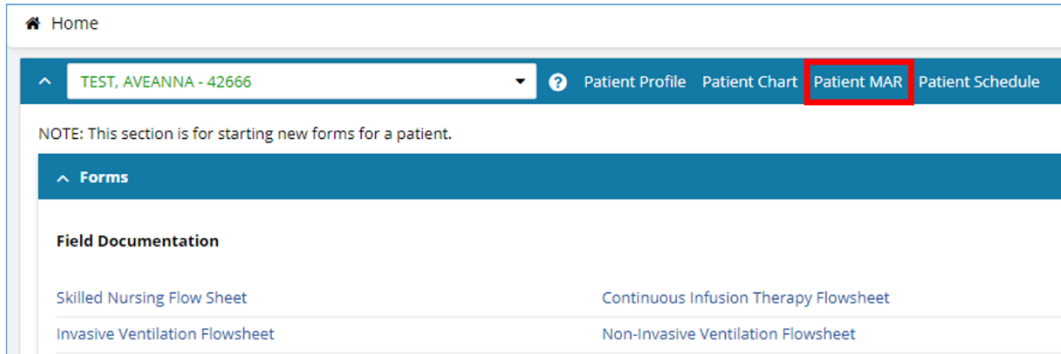


# Patient MAR – Guide to Documenting Medication Administration

Medication Administration is documented using the Patient MAR.

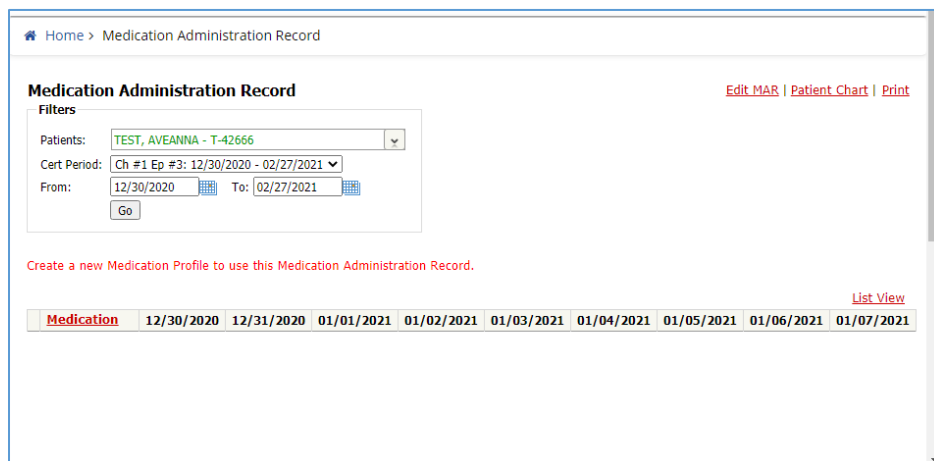
## Patient MAR

- From the Home screen select the Patient, then select Patient MAR.

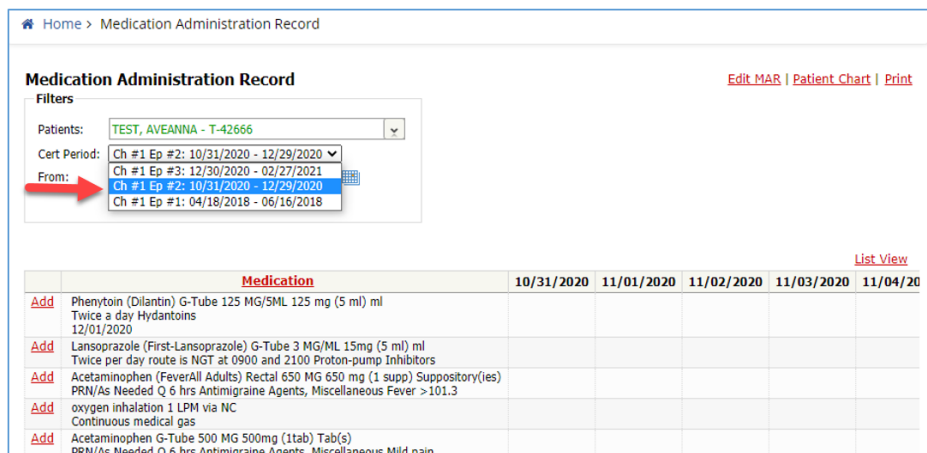


When the Patient MAR opens:

- It defaults to the latest Cert Period that exists in the Patient Chart.
- It defaults to the beginning date of the Cert Period.



- Use Filters to select the current Cert Period, if necessary:





2. To document medication administration, tap the **Add** button

- **Meds that are given when an Aveanna nurse is not on shift:** Clinical documentation represents care provided while Aveanna is on shift and providing care. Aveanna caregivers should not ever document medications that are given when Aveanna caregivers are not providing care.
- **Meds that are given by someone else, most often primary caregiver, when an Aveanna nurse is on shift and does not witness:** If a primary caregiver administers medications while an Aveanna caregiver is on shift and the Aveanna caregiver is out of the room and unable to witness, the Aveanna caregiver should document the medication as given on the MAR and note in the comments that the medication was ‘reported as given by (enter name or relationship here)’
- **Meds that are given by someone else, most often a primary caregiver, when an Aveanna nurse is on shift and does witness:** If a primary caregiver administers medications while an Aveanna caregiver is on shift and the Aveanna caregiver witnesses administration, the Aveanna caregiver should document the medication as given on the MAR and note in the comments that the medication was ‘witnessed as given by (enter name or relationship here)’

<b>Medication</b>	
<b>Add</b>	Lansoprazole (First-Lansoprazole) G-Tube 3 MG/ML 15mg (5 ml) ml Twice per day route is NGT at 0900 and 2100 Proton-pump Inhibitors

3. A popup window opens with the medication order, administration date, time administered, as well as a comments box.

Add to Medication Administration Record

Lansoprazole (First-Lansoprazole) G-Tube 3 MG/ML 15mg (5 ml) ml Twice per day route is NGT at 0900 and 2100 Proton-pump Inhibitors

Date Administered:  Time Administered:

Comments:

- Verify the date is **today’s date**. NEVER document medication administration in the future. Always document medication administration in real time after the med has been given.
- Enter the administration time.
- Always document whether medication administration was tolerated.
  - Cancel: Will close the administration popup and will not save the information.
  - Save/Sign: Will close the administration popup, save the administration documentation, and populate the time and electronic signature on the Patient MAR.

<b>Medication</b>		<b>12/01/2020</b>
<b>Add</b>	Lansoprazole (First-Lansoprazole) G-Tube 3 MG/ML 15mg (5 ml) ml Twice per day route is NGT at 0900 and 2100 Proton-pump Inhibitors	Time: 9:00 AM LPNTest, Hybrid (LPN)

4. To view past medication administration:

- Use the Filters for the date range you wish to view
- Tap the GO button.
  - Example: To view the last time a PRN was administered

**Medication Administration Record**

**Filters**

Patients:

Cert Period:

From:  To:



Medication		11/29/2020	11/30/2020	12/01/2020
<b>Add</b>	Lansoprazole (First-Lansoprazole) G-Tube 3 MG/ML 15mg (5 ml) ml Twice per day route is NGT at 0900 and 2100 Proton-pump Inhibitors	Time: 9:00 PM LPNTest, Hybrid (LPN)	Time: 9:00 PM LPNTest, Hybrid (LPN)	Time: 9:00 AM LPNTest, Hybrid (LPN)
<b>Add</b>	Acetaminophen (FeverAll Adults) Rectal 650 MG 650 mg (1 supp) Suppository(ies) PRN/As Needed Q 6 hrs Antimigraine Agents, Miscellaneous Fever >101.3	Time: 9:00 AM LPNTest, Hybrid (LPN)	Time: 9:00 AM LPNTest, Hybrid (LPN)	Time: 4:00 PM LPNTest, Hybrid (LPN)

5. To be able to view the Comments for medications that have been administered:

- Select the date filters as shown above.
- Tap the List View hyperlink.

**Medication Administration Record** [Edit MAR](#) | [Patient Chart](#) | [Print](#)

**Filters**

Patients:

Cert Period:

From:  To:

[List View](#)

Medication	11/29/2020	11/30/2020	12/01/2020
------------	------------	------------	------------

- Review administration Comments

Medication	Date Administered	Time Administered	User	Comments
Lansoprazole (First-Lansoprazole) G-Tube 3 MG/ML 15mg (5 ml) ml Twice per day route is NGT at 0900 and 2100 Proton-pump Inhibitors	12/01/2020	9:00 AM	LPNTest, Hybrid (LPN) 12/01/2020 07:29 PM EST	Tolerated well.
Lansoprazole (First-Lansoprazole) G-Tube 3 MG/ML 15mg (5 ml) ml Twice per day route is NGT at 0900 and 2100 Proton-pump Inhibitors	11/30/2020	9:00 PM	LPNTest, Hybrid (LPN) 12/01/2020 08:03 PM EST	
Aspirin (Aspirin Childrens) G-Tube 81 MG 81 mg (1 tab) Tab(s) Daily at 2000 Antimigraine Agents, Miscellaneous	11/30/2020	8:10 PM	LPNTest, Hybrid (LPN) 12/01/2020 08:12 PM EST	
Gabapentin (Once-Daily) G-Tube 600 MG 600 mg Tab(s) Q Day at 0800 and 2000 Anticonvulsants, Miscellaneous	11/30/2020	8:10 PM	LPNTest, Hybrid (LPN) 12/01/2020 08:14 PM EST	
Acetaminophen (FeverAll Adults) Rectal 650 MG 650 mg (1 supp) Suppository(ies) PRN/As Needed Q 6 hrs Antimigraine Agents, Miscellaneous Fever >101.3	11/30/2020	4:00 PM	LPNTest, Hybrid (LPN) 12/01/2020 08:09 PM EST	Temp 101.4
oxygen inhalation 1 LPM via NC Continuous medical gas	11/30/2020	3:00 PM	LPNTest, Hybrid (LPN) 12/01/2020 08:08 PM EST	1 LPM



## myUnity Hybrid Field Nurse FAQ

1. What is the name of the new application that the field nurses will be charting on?
  - NetSmart Aveanna Clinical
2. Why am I unable to find the application?
  - You will need to swipe up or down on the home screen to bring up more applications. The devices are no longer in kiosk mode, so you will see more applications than before.
3. Why do I have more than one form at the end of my shift?
  - You will only need to open one form per shift. After the form is initially opened, you will need to re-open the same form in the pending queue to return to the form you started.
4. How do I clock in and clock out?
  - You will now clock in and clock out within a single skilled nursing flow sheet. Clock in is on page one and clock out is on page seven. Note: Best practice is to enter times using military time! Otherwise you must enter the hour and minutes and specify am or pm to avoid time errors.
  - **IMPORTANT:** Reopen the same skilled nursing flowsheet throughout your shift. Do not create multiple notes during one shift.
5. Where is the patient MAR?
  - The patient MAR is electronic. If you are on the home page in the Aveanna Clinical application, you will see the words “Patient MAR” to the right of the patient name. Tap the words to open the Patient MAR.
6. Why do I see a warning requiring signatures every time I navigate from page seven?
  - This warning will always pop-up as a reminder that you have to sign all narrative entries. Once you have confirmed that you have signed the narrative, please choose okay and continue with the process.
7. When do I choose save and when do I choose send to office?
  - You will only choose send to office at the end of your shift, after you finish charting. You will save throughout your shift. This will save your documentation and advance to the next page. The form is not complete until you select send to office.
8. Who is supposed to sign the signature box on page one?
  - The parent, caregiver, or nurse receiving report must sign the signature box on page one and their name must be typed into the printed name field above it.
9. Why am I unable to send to office?
  - You will not be permitted to send anything to the office if errors are still present. Once you choose send to office, an error box will arise in the event that your form is missing key information. These steps must be completed to successfully send to office.
10. How can I log out of the Aveanna Clinical application?
  - You must hold the tablet horizontally/landscape and tap the three lines next to your name in the top right-hand corner. If the tablet is not horizontal/landscape, it will not give you the option to log out.





## myUnity Clinical – Amelia Login Assistance

This job aid will outline the steps to reset your myUnity Clinical password and retrieve your username using Amelia.

### Accessing Amelia

To access Amelia and reset your password:

- Navigate to <https://aveannaclinical.devero.com/>
- Select **Username and Password Help** to begin working with Amelia.

The screenshot shows the login interface for myUnity Clinical. On the left, the Aveanna Healthcare logo is at the top, followed by the Netsmart myUnity logo. Below the logos are two input fields: 'Username' and 'Password'. Under the Username field is a red error message 'Please enter a username.' and a checkbox for 'Remember username'. Under the Password field is a red error message 'Please enter a password.' and a dark blue 'Login' button. On the right side of the page, there is a green header that says '"Welcome to Aveanna Healthcare!!"'. Below this is a section titled 'Announcements' with a red-bordered box containing the text 'Username and Password Help'.

- A new browser tab will open; Amelia will greet you and begin the process.

Hello! I'm Amelia, Aveanna's digital assistant.

Let's get started, please tell me your legal name as it appears in Workday.



Amelia | 3:31:45 PM

⚡ by Amelia

Type your message here...





- Type in your name, as it appears in Workday, and hit Enter.
- Amelia will provide two options, **Forgot password** and **Forgot username**. In this case, we will select **Forgot password**.

For login help, please choose a button below to let me know what you need.



Amelia | 3:38:47 PM

 by Amelia

Forgot password

Forgot username



- Amelia will confirm your identity.

Sure. I can help you reset your password. First I will need to authenticate you and confirm your identity. What is your date of birth?

Please enter as: MM/DD/YYYY or January 1,1991



Amelia | 3:45:31 PM

Format : MM/DD/YYYY or January 01, 1991

 by Amelia

09/16/1983



- Enter your date of birth in the format requested. For this example, 09/16/83 was entered.





- Next, enter the last four digits of your Social Security Number. As seen below, these digits will be masked as they are entered.

And the last 4 digits of your Social Security Number?

Amelia | 10:35:12 AM

Your SSN will be masked for security purpose by Amelia

....  

- Amelia will use your Workday information to verify your identity.

Anonymous | 1:54:02 PM

Thank you. Please wait while I validate your details.


Thank you, I have validated your account. Let's go ahead and select a new password.

Your new password must have 1 uppercase, 1 lowercase and a number. It also must be at least 10 characters long. (Remember, that it can't be one of your recently used passwords).



What would you like your new password to be?

Amelia | 1:54:15 PM

by Amelia

 New Password

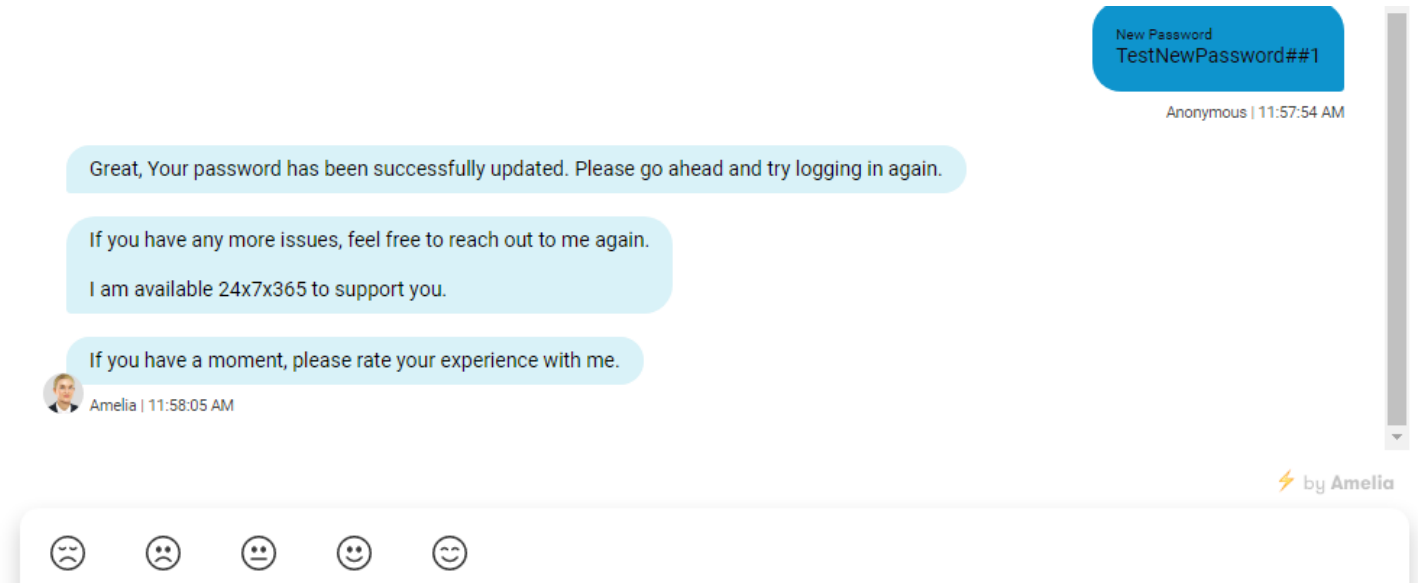
TestNewPassword#1

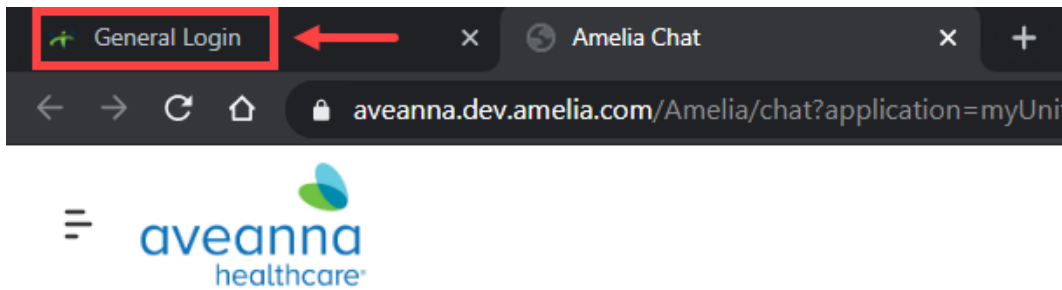
- Once this is complete, you may enter your new password.



- This completes the password reset process, which Amelia will confirm.



- Select the **General Login** tab to return to the myUnity login page.



***\*\*If Amelia is unable to find your account, please reach out to HRIS.\*\****