aveanna healthcare

myUnity

Resource Booklet

with Documentation Tips

Aveanna Compliance and Integrity Help Line:

1-800-408-4442

Table of Contents

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 ADMINSTRATION 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 H2O and mild soap or 1/2 strength mixture of H202 and H20 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

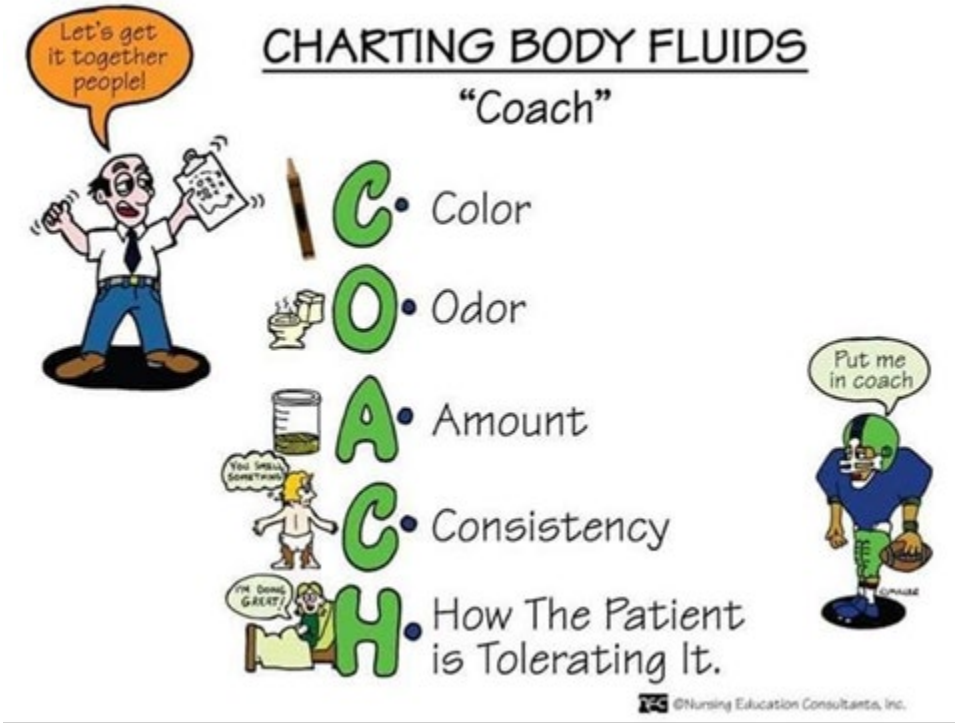
Documentation should include:

- 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, O2 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
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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
ā = before
a.m. = before noon
ac = before meals
ad lib = at liberty, freely
ADL = activities of daily living
AFO = ankle foot orthosis
Appt = Appointment
AROM = active range of motion
ax. = axillary, axis
b.i.d. = twice a day
BBS = bilateral breath sounds
BG = blood glucose
BIPAP = bilevel positive airway pressure
BKA = below knee amputation
BLE = bilateral lower extremities
BLS = basic life support
BM = bowel movement
BP = blood pressure
BS = breath sounds or bowel sounds
BST = bedside table
BSC = bedside commode
BUE = bilateral upper extremities
c = with, line over top
C/D/I = clean, dry & intact
c/o = complains of
C= centigrade
cath = catheter
CG = contact guard
CGA = Contact guard assistance
cg = caregiver
cm = centimeter
CNA = certified nursing assistant
CNS = central nervous system
CO_2 = carbon dioxide
CoPs = conditions of participation
CPAP = constant positive airway pressure
CPR = cardiopulmonary resuscitation
CPT = chest percussion therapy
Maint = Maintain
MAR = medication administration record
MaxA = maximal assistance
mcg = micrograms
med = medication
Med Dir = Medical Director
mEq = milliequivalent
mg = milligram
MinA= minimal assistance
mL = milliliter
mm = millimeter
ModA = moderate assistance
ModI = Modified Independent
n/a = not applicable
NC = nasal cannula
ND = not done
NG = nasogastric
NJ = nasojejunal
NKA = no known allergies
NKDA = no known drug allergies
NOE= notice of election
NPO = nothing by mouth
NP = Nurse Practitioner
NS = normal saline
O_2 = oxygen
OBT = over bed table
OG = oral glucose
OOB = Out of bed
OT = occupational therapy
OTC = over the counter
oz = ounce
p = post, after
pc = after meals
PC = pressure control
PCG = Parent Caregiver
PCO_2 = partial pressure of carbon dioxide
PCP = primary care physician

AVEANNA APPROVED ABBREVIATIONS

CTA = clear to auscultation
CTI = certification of terminal illness
CVL = central venous line
CXR = chest x-ray
DTR = daughter
D/C = discharge; discontinue
d/t = due to
DME = durable medical equipment
DNR = do not resuscitate
DOB = date of birth
Dx = diagnosis
EENT = eye, ear, nose & throat
EMT = emergency medical technician
ENT = ear, nose & throat
EPAP= expiratory positive airway pressure
ER = emergency room
ER = external rotation
EOL = End of Life
ETCO2 = end tidal carbon dioxide
ETT = endotracheal tube
F = Fahrenheit
F2F = Face to Face
F/U = follow up
Fr = French
FWB = full weight bearing
FWW = front wheeled walker
FX= fracture
GERD = gastro esophageal reflux disease
GI = Gastrointestinal
GJ = gastrostomy-jejunostomy tube
gm. = gram
GT = gastrostomy tube
gtt = drops
GU = genitourinary
h.s. = bedtime
H/O = history of
H_20 = water
HCS = Healthcare surrogate
HEP = home exercise program
HHA = Home Health Aide
HHA = hand hold assist
PDN = private duty nursing
PEEP = positive end expiratory pressure
PERRL/PERRLA = pupils equal and reactive to light (accommodate)
PICC = peripheral inserted central catheter
PIP = proxinterphalangeal
PIV = peripheral inserted venous
pm = afternoon/night
PMH- past medical history
po = by mouth
POA = power of attorney
POC = plan of care
PPOT = Physician Plan of Treatment
POT = plan of treatment
PRN = as often as necessary
PROM = passive range of motion
PS = pressure support
PT = Physical Therapy
pt = patient
PWB- partial weight bearing
q/Q = each; every; line over
QID = four times daily
R = right
RA = room air
Resp = Respiratory
RLE = right lower extremity
RN= registered nurse
ROM = range of motion
RR = respiratory rate
RUE = right upper extremity
S = without, line over
SIL = son in law
s/p = status post
s/s = signs & symptoms
Sat = saturated
SBA = Stand by assistance
SIMV = synchronized intermittent mechanical ventilation
SLP/ST = Speech Language Pathologist/Therapist
SL = sublingual
SMO = Supra-Malleolar Orthosis
SOB = shortness of breath

AVEANNA APPROVED ABBREVIATIONS

HME = heat moisture exchanger
HOB = head of bed
HoH = hard of hearing
HOH =Hand over hand
HOHA =Hand over hand assistance
HR = heart rate
HRRR = heart rate and rhythm regular
hr. = hour
HX= history
hz = Hertz
I/O = intake/output
IADLs = instrumental activities of daily living
IM = intramuscular
IMV= intermittent mandatory ventilation
IND= independently
IPAP = inspiratory positive airway pressure
IPPB = intermittent positive pressure breathing
IR = internal rotation
IU = international unit
IV = intravenous; intraventricular
KAFO = knee ankle foot orthosis
kg = kilogram
L = left
lb = pound
LCTA = lungs clear to auscultation
LE = lower extremity
LLE = left lower extremity
LMN = letter of medical necessity
LOB = loss of balance
LOC = level of consciousness
LPM = liters per minute
LUE = left upper extremity
MAEW = moves all extremities well
Sp02 = pulse oximetry
SQ = subcutaneous
SX- symptoms
sxn = suction
TB = tuberculosis
TID = three times a day
TLSO = thoracolumbosacral orthosis
TO = telephone order
TOL = tolerated
TPN = total parenteral nutrition
TPR = temperature pulse respiration
TTS = tight to the shaft
TTWB = Toe touch weight bearing
Tx = treatment
UE = upper extremity
URI = upper respiratory infection
UTI = urinary tract infection
v.o. = verbal order
VP = ventriculoperitoneal
VS = vital signs
VSS = vital signs stable
Vt = ventilation tube
VT = ventricular tachycardia
W/C = wheelchair
WBAT= Weight bearing as tolerated
WNL = within normal limits
WOB = work of breathing
Wt. = weight
x = except, line over
X = times, e.g., “suction x 4”

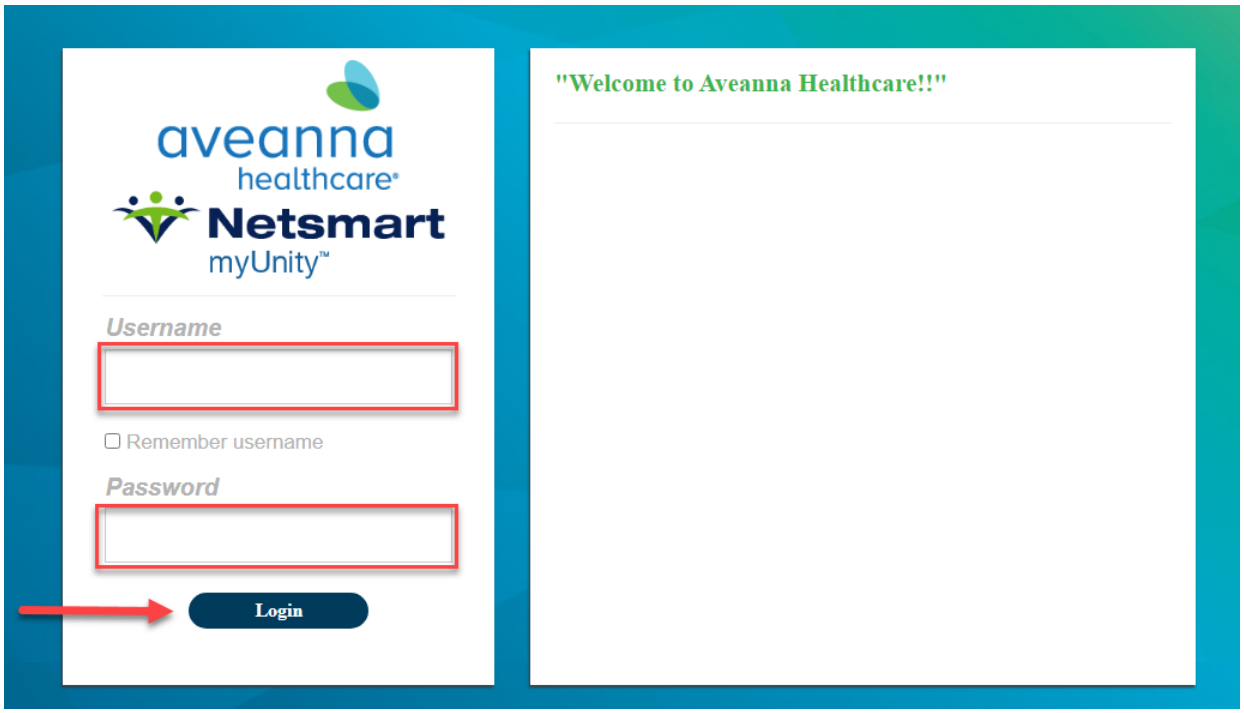
Introduction to myUnity Clinical Bedside

This document will guide you thourgh navigating myUnity Clinical Bedside.

Logging in to the myUnity Clinical Bedside

From the myUnity Clinical Bedside application:

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



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

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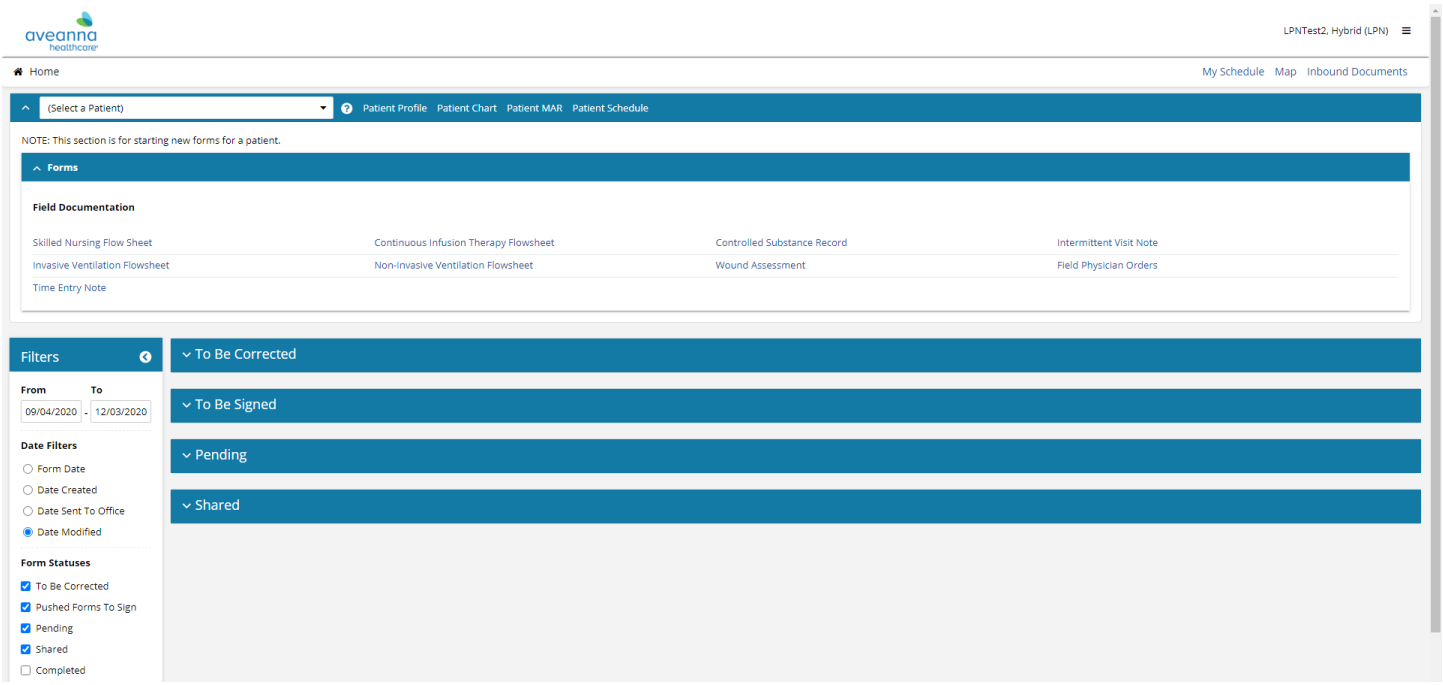
Navigating myUnity Clinical Bedside

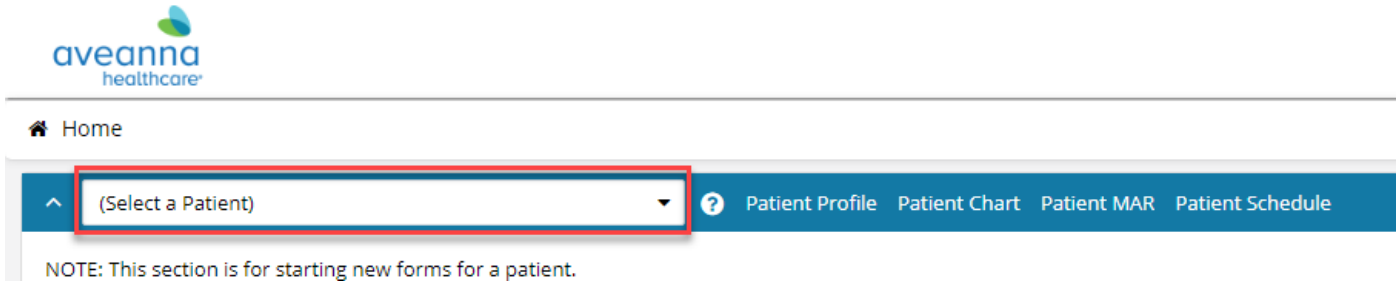
The myUnity Clinical Bedside homepage access will vary based on your user role.

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



To select a patient:

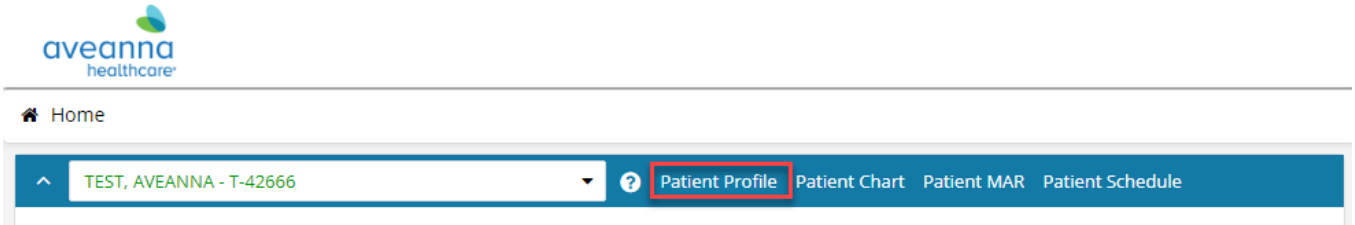
- Tap the box and enter the patients name,medical records number, or tap the dropdown.



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**.



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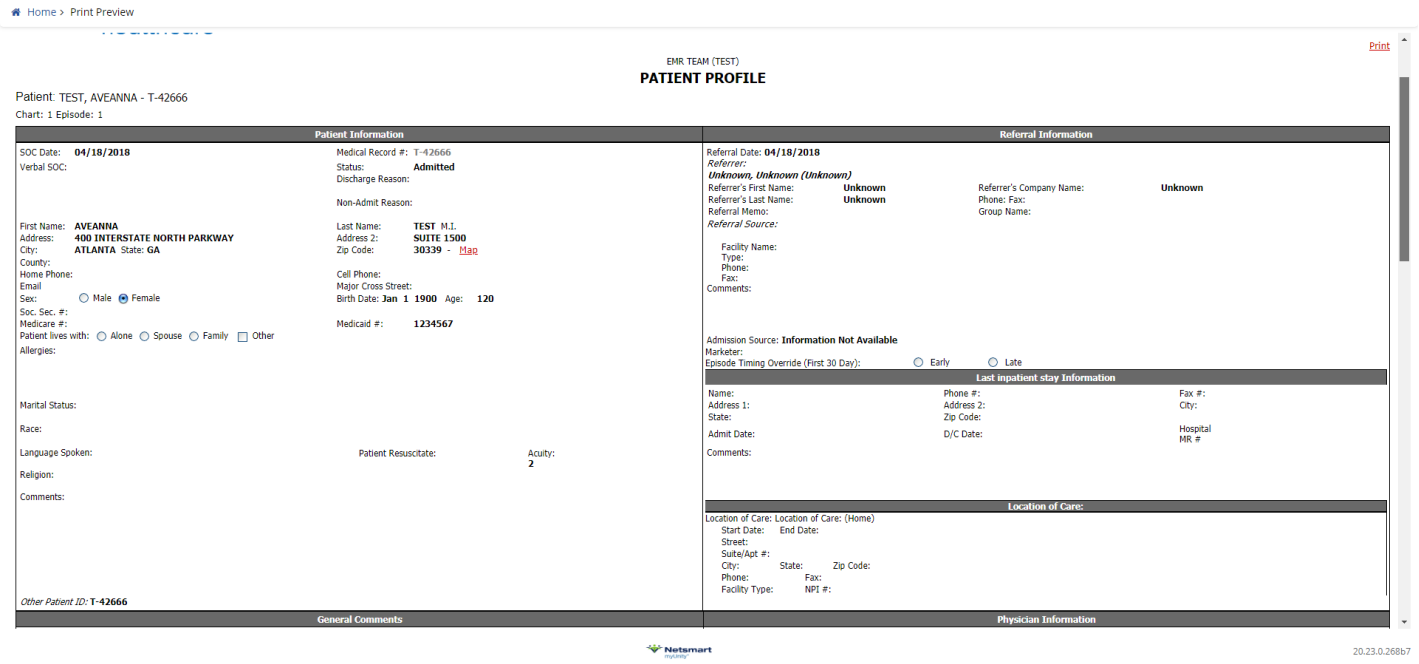
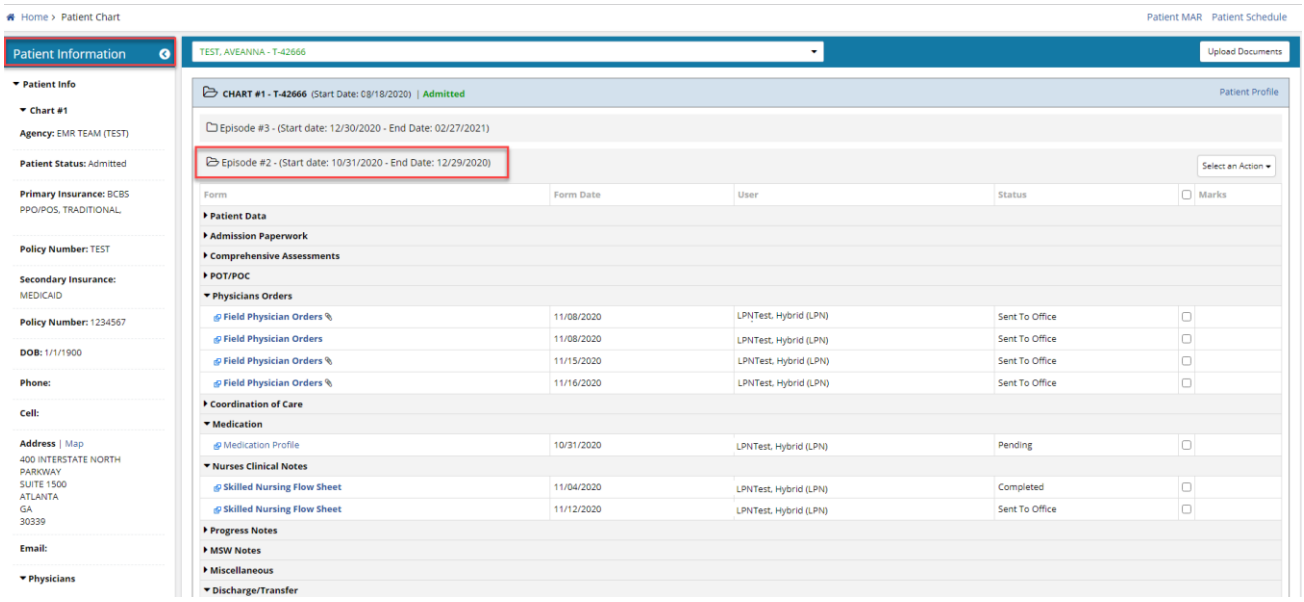


Navigating myUnity Clinical Bedside - Patient Chart

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 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.

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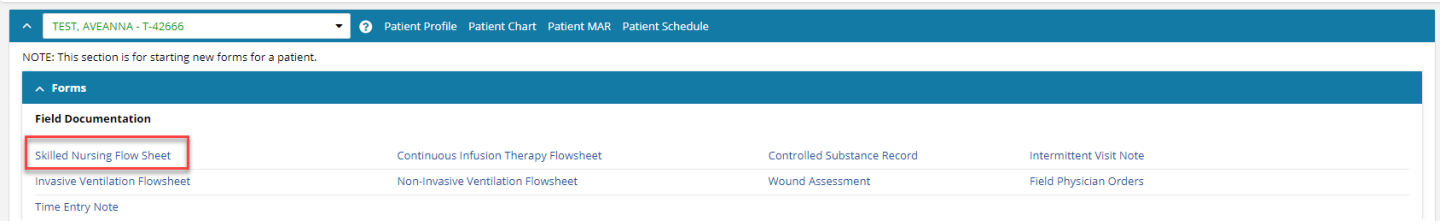
Navigating myUnity Clinical Bedside - Forms

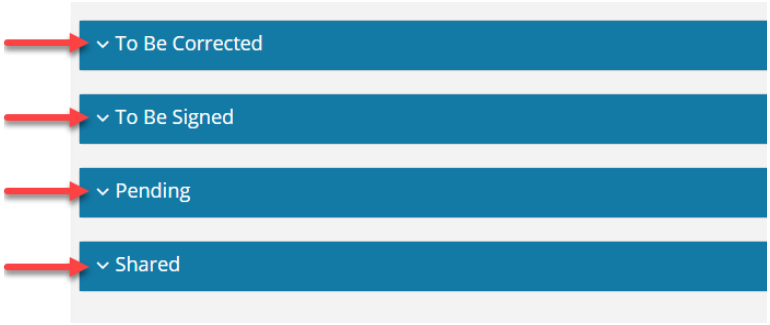
The Forms are divided into different sections and user role drives what sections and forms a user has access to.

- 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.

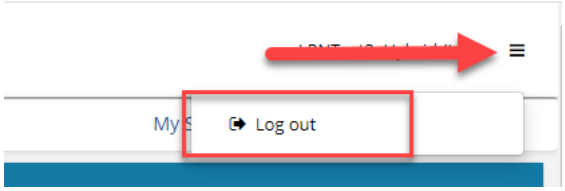


- **To Be Corrected Forms** have been returned to the field caregiver by the agency for correction. Field caregivers can update the form to correct errors and send the form back to the office for review.
- **Pending** forms have been opened/started and can be freely updated by the creator. Forms will 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**.



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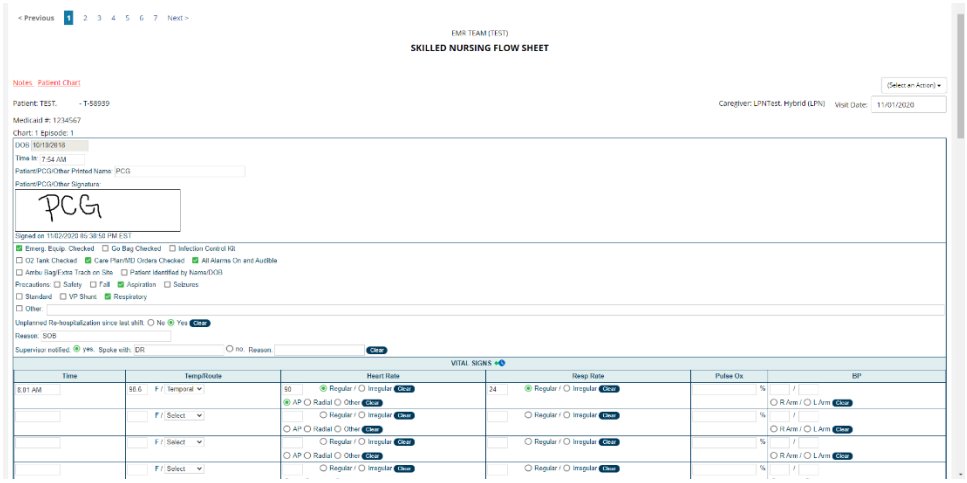
Skilled Nursing Flow Sheet - Documentation

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

Tips for Documenting

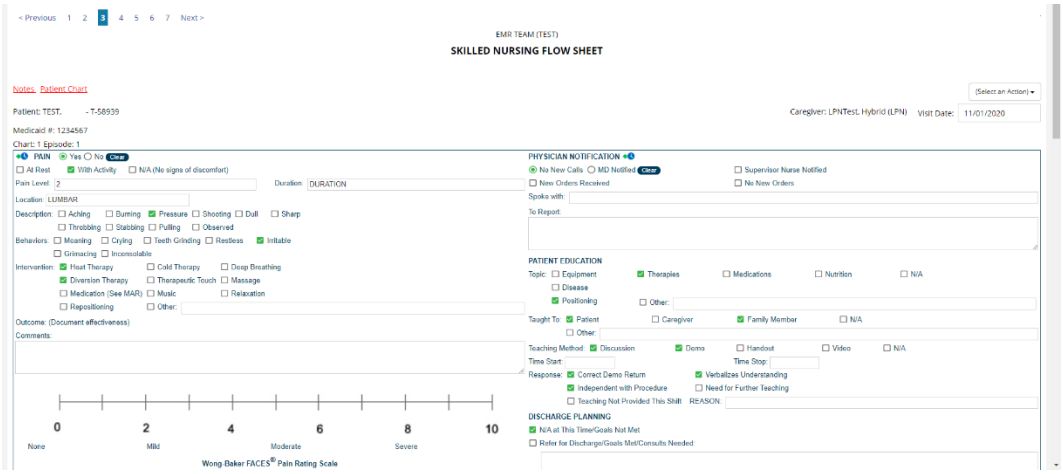
Pages 1-2

- 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.

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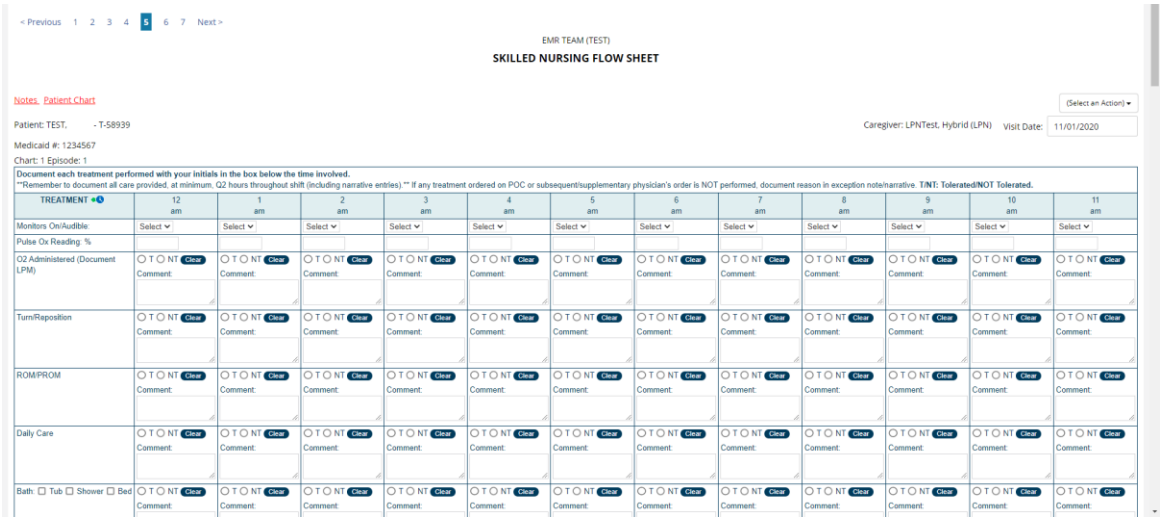
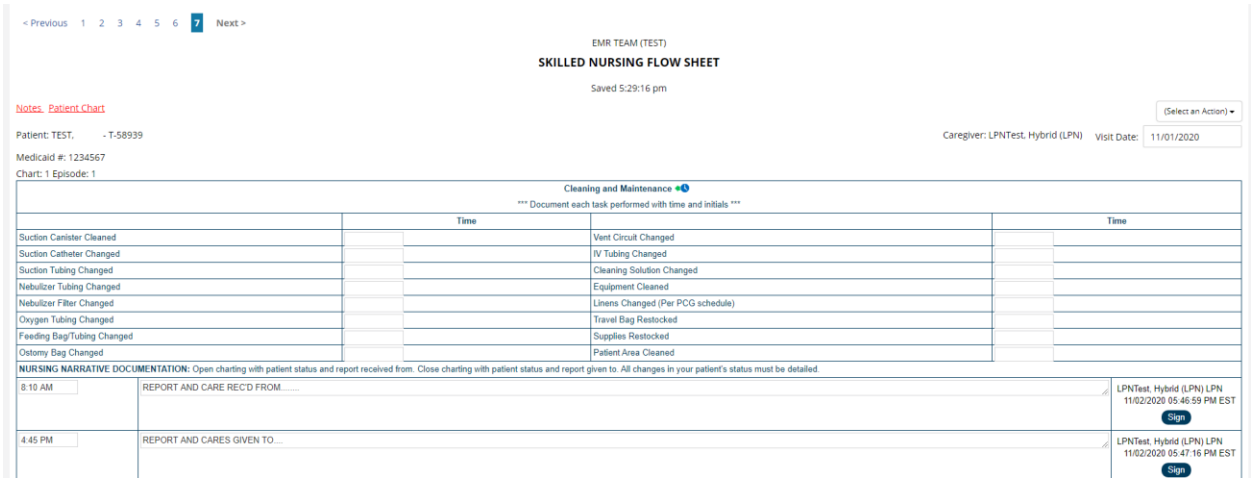
Pages 5-6

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



Page 7

- 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.



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).

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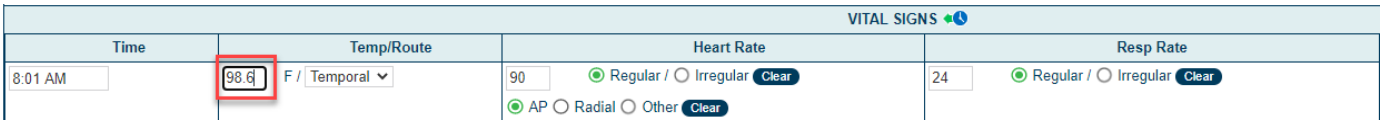
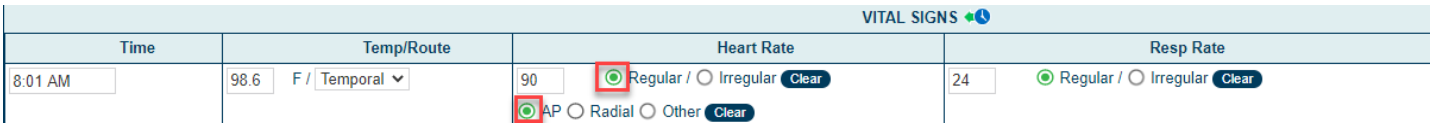
Text Box

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



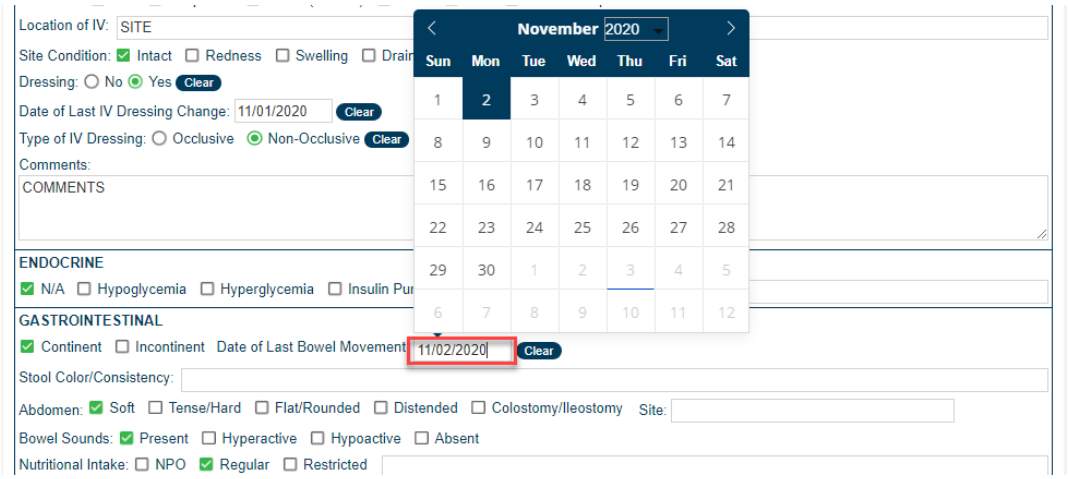
Radio Button

- 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.



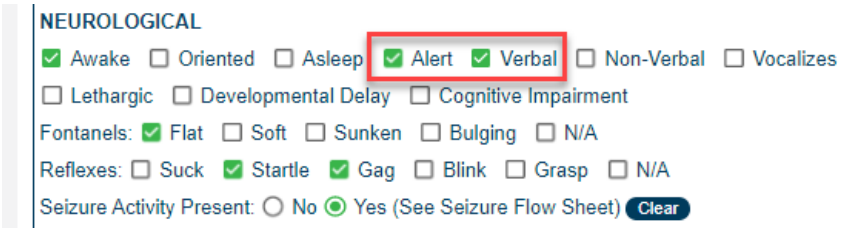
Date Box

- 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.



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.



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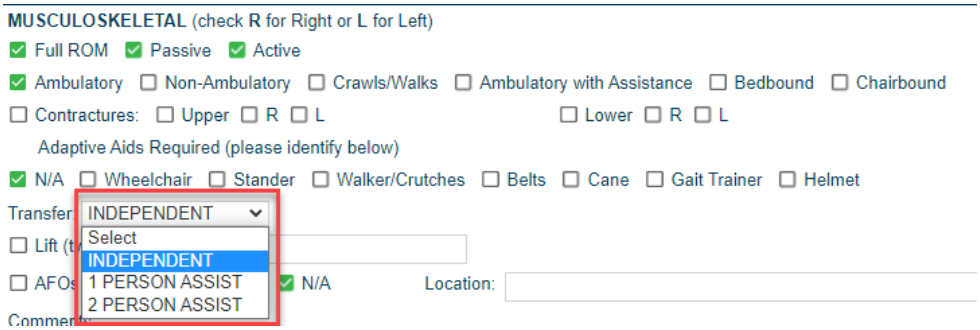
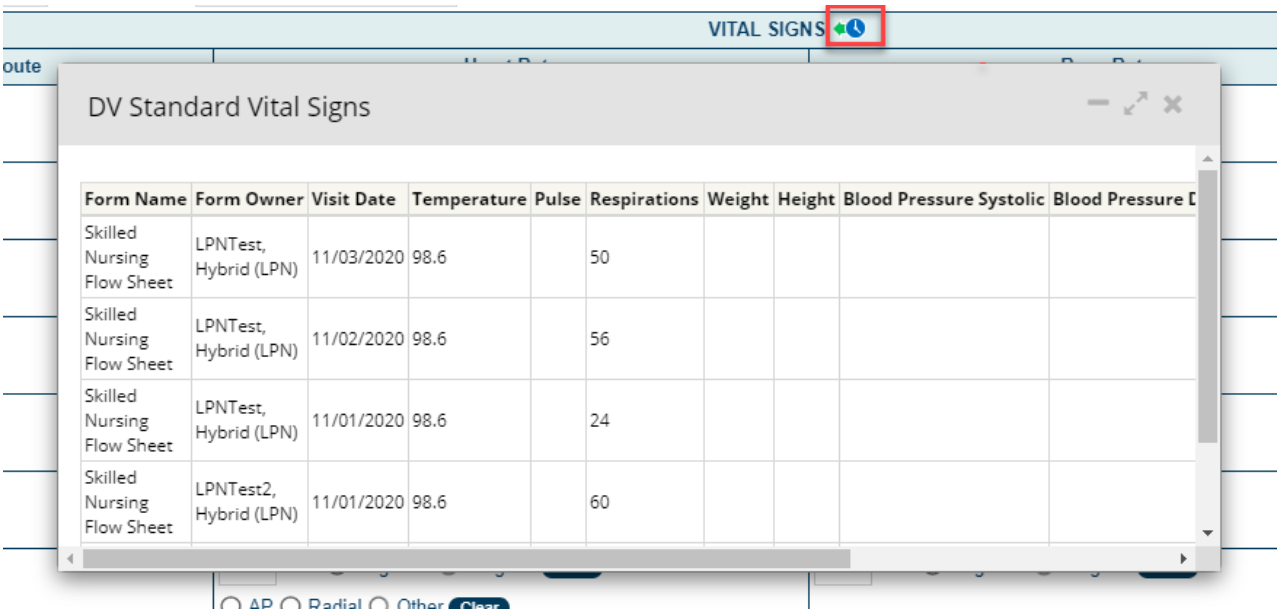
Dropdown

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



Blue Clock "Inline Reporting"

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



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.

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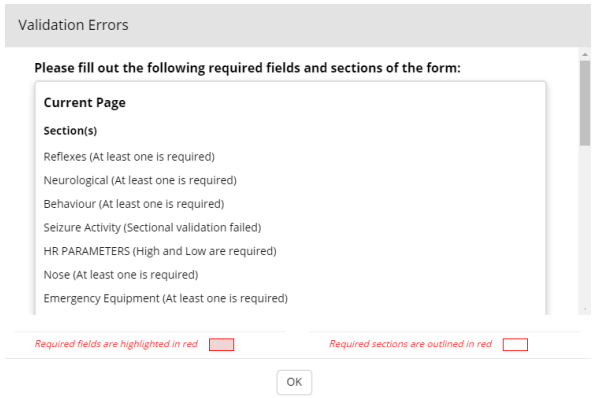
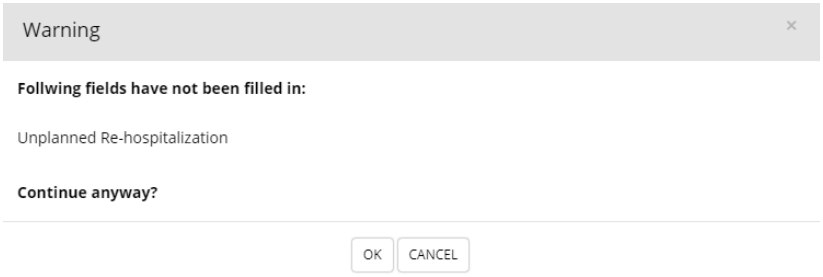


Warnings

- **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?

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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)

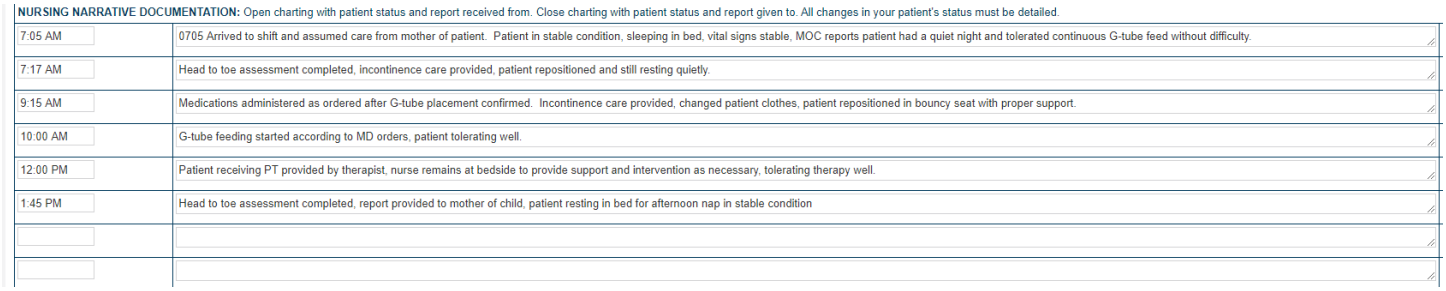
- Log each patient seizure in a horizontal row. Select all boxes in the row that describe the seizure activity. Best practice is to always complete: Time, Duration, all dropdowns that apply, O2 if used, Post-Ictal response, V/S During and After and any pertinent comments.

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.

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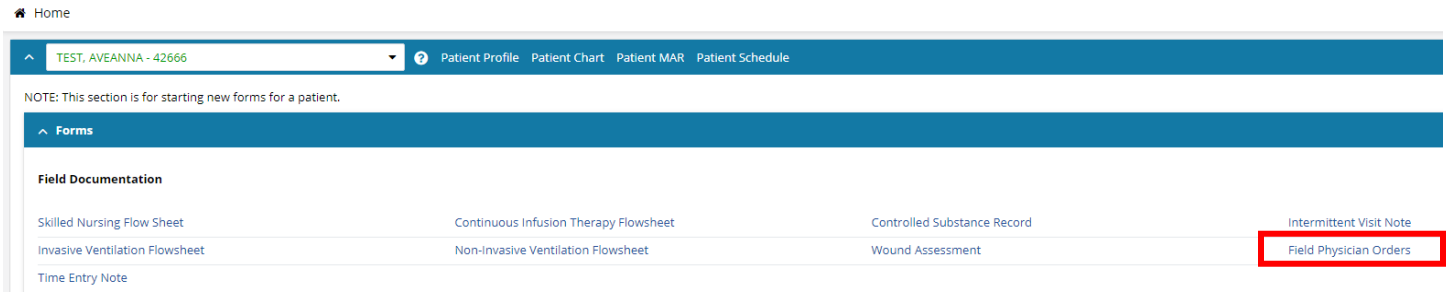
myUnity Clinical Bedside – Updating the Medication Profile and Physician Orders

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.

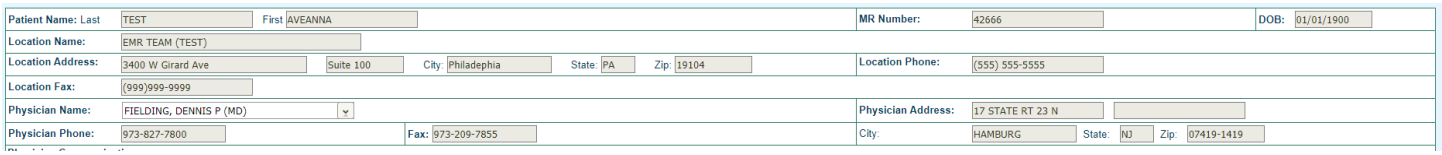
Accessing Field Physician Orders

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

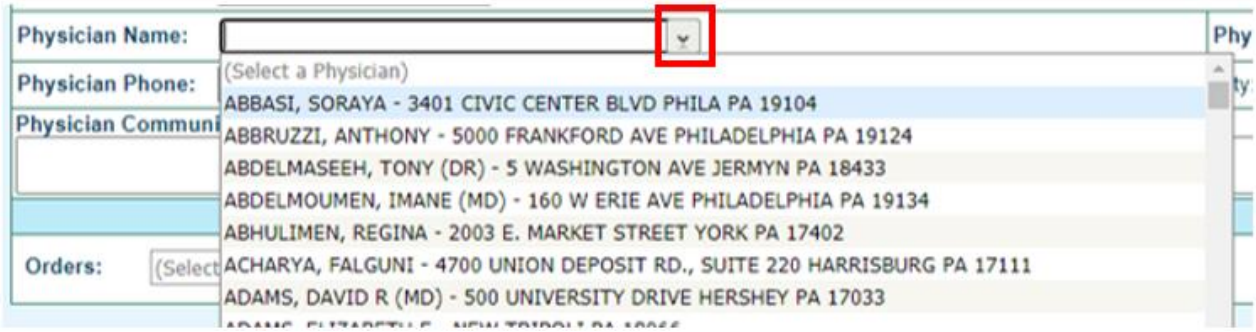


The top portion of the order should auto-populate with the current date and information from the patient profile:

- 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)



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



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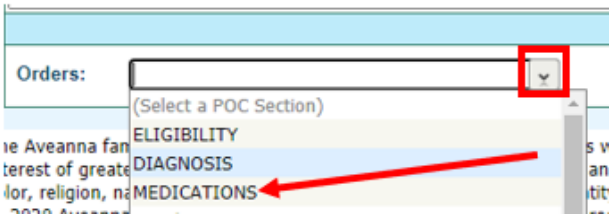
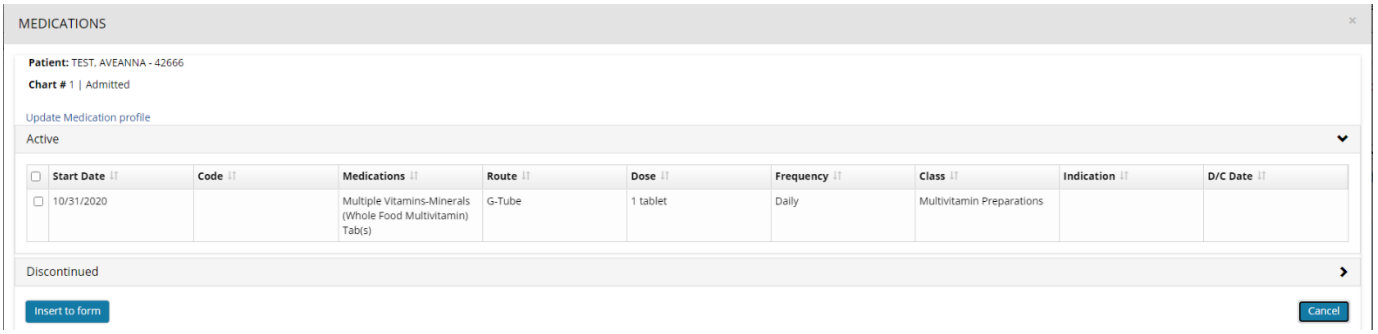
2. If the physician you are searching for cannot be located:
    a. **Remove** the incorrect physician.
    b. In the **Physician Communication** field, document the name, phone and fax information for the correct, ordering physician along with any non-medication orders you may have received.
        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.

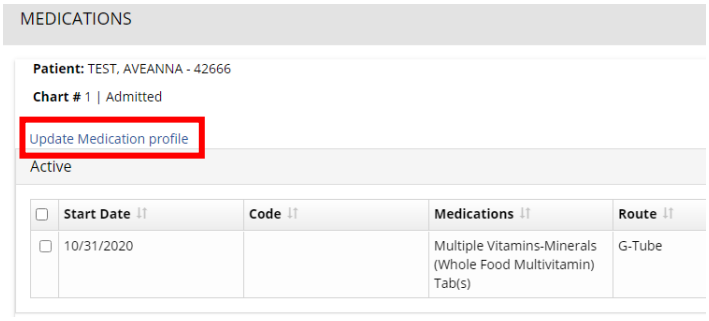
3. If the order is for a medication or a new patient allergy, proceed to the **Orders** dropdown and select **MEDICATIONS.**



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



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



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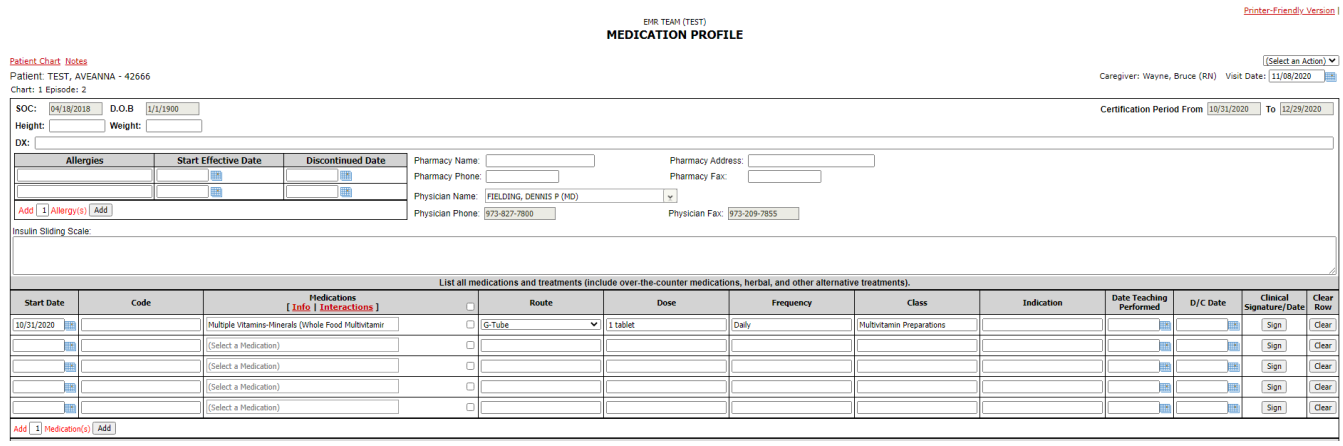
a. This action will open the active **Medication Profile** in a new browser tab.



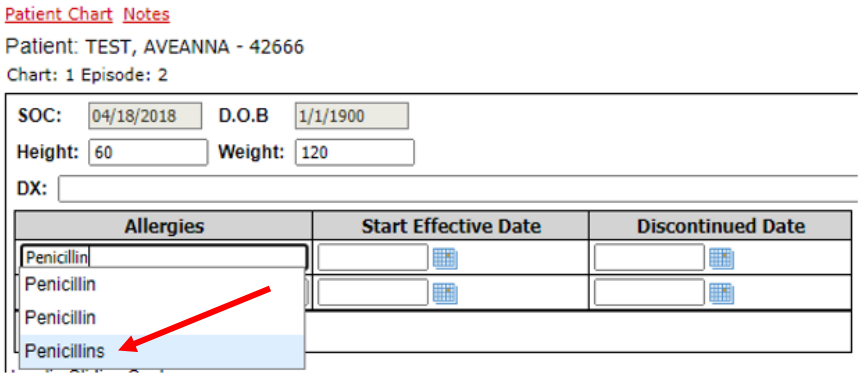
Please note:

- 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.



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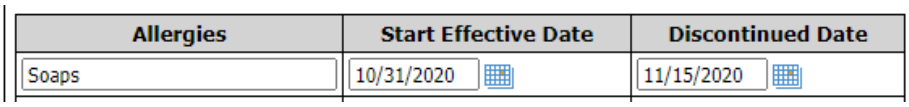
b. Once a selection is made, the allergy and today's date will populate.

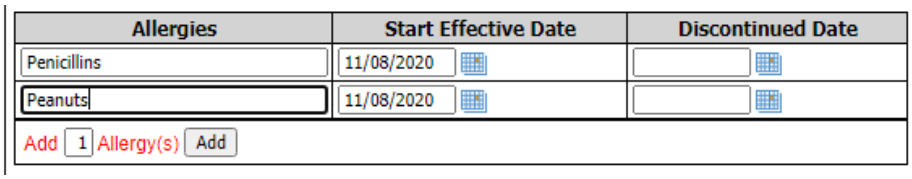
c. If you are not able to locate the correct allergen, ***as a last resort***, you may free text the allergy.

i. **FREE TEXT ALLERGIES WILL BE EXCLUDED FROM DRUG INTERACTION RESULTS.**

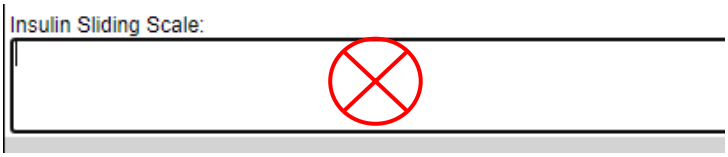
d. To discontinue an existing allergy, enter a Discontinued Date.



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

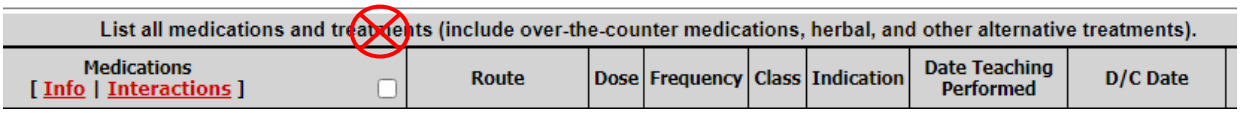


- **Insulin Sliding Scale** field: Do Not Use.
  - It will not write them to the physician's order or the Patient MAR.
  - All Sliding Scale information must be included in the Medication section.



6. MEDICATIONS

a. NOTE:



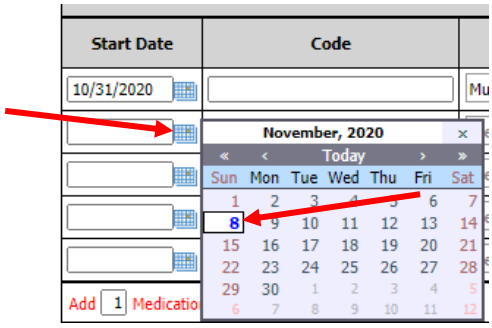
i. The statement above medications says to 'List all medications and treatments', but Aveanna only includes medications in the Med Profile.
   - Example: Oxygen, Pedialyte, medicated topicals, OTC medications, Rx medications

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.



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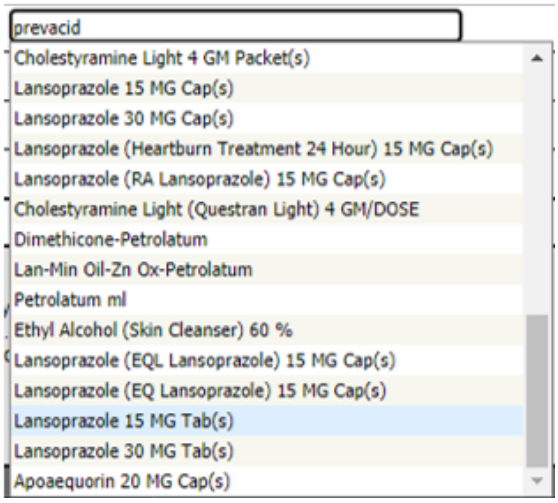
c. Leave the **Code** field blank.

i. Optional: You may use the Code field to flag a medication as **OTC, Existing** or **Hold o**nly 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.

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i. **DOSE:**

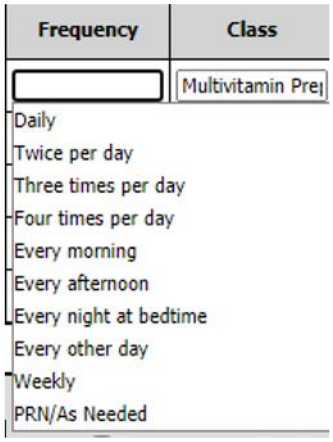
i. Should be written in MG when possible. You may add the amount to administer in parenthesis and include a delivery method such as nebulizer or nasal cannula if applicable.

- Dose Example:

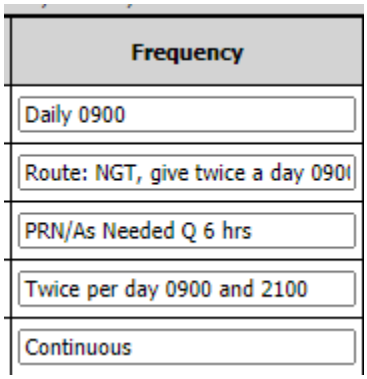
Dose
1 tablet
15 mg (1 tablet)
650 mg (1 suppository)
125 mg (5 ml)
1 LPM via N/C

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.



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



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.*

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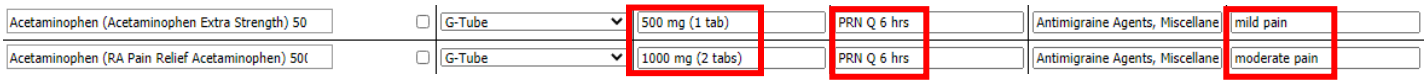
k. PRN MEDICATIONS:

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:



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.

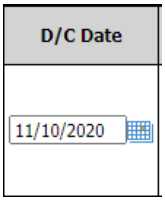
vi. Doses cannot be written as MG/KG, they must specify the current dose. When the dose changes, the physician should be contacted for a new order.

l. DATE TEACHING PERFORMED – leave blank

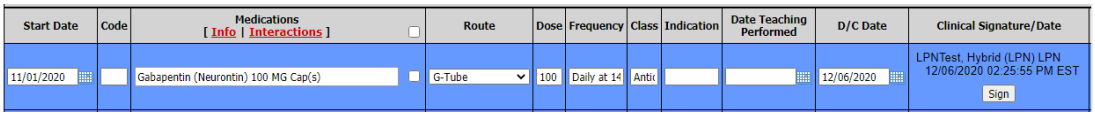
i. Do not use. Teaching is addressed on Supervisor's assessments and the Skilled Nursing Flowsheet.

m. D/C DATE

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



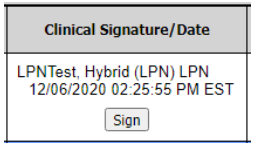
n. Once the med profile is saved, discontinued meds will be highlighted in blue.



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.



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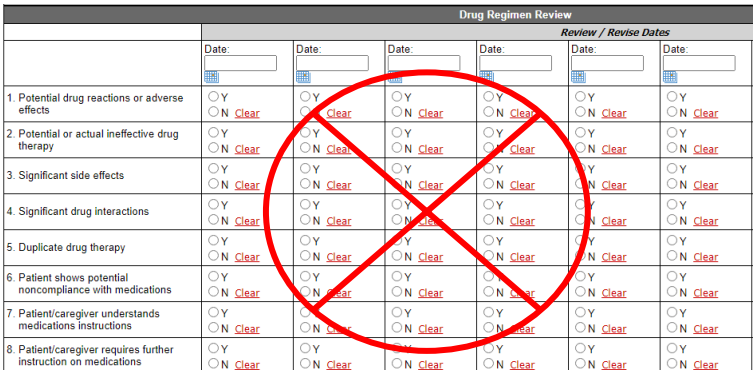
p. DRUG REGIMEN REVIEW

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.

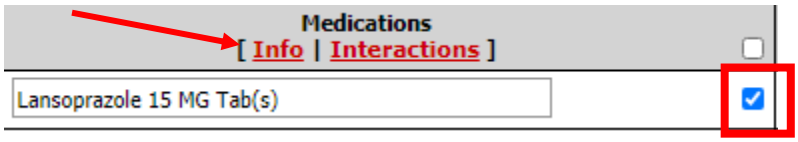


Drug Regimen Review						
	Review / Revise Dates					
	Date:	Date:	Date:	Date:	Date:	Date:
1. Potential drug reactions or adverse effects	○Y ○N Clear	○Y ○N Clear	○Y ○N Clear	○Y ○N Clear	○Y ○N Clear	○Y ○N Clear
2. Potential or actual ineffective drug therapy	○Y ○N Clear	○Y ○N Clear	○Y ○N Clear	○Y ○N Clear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

q. INFO | INTERACTIONS

i. Drug Information is available in the system for many medications.

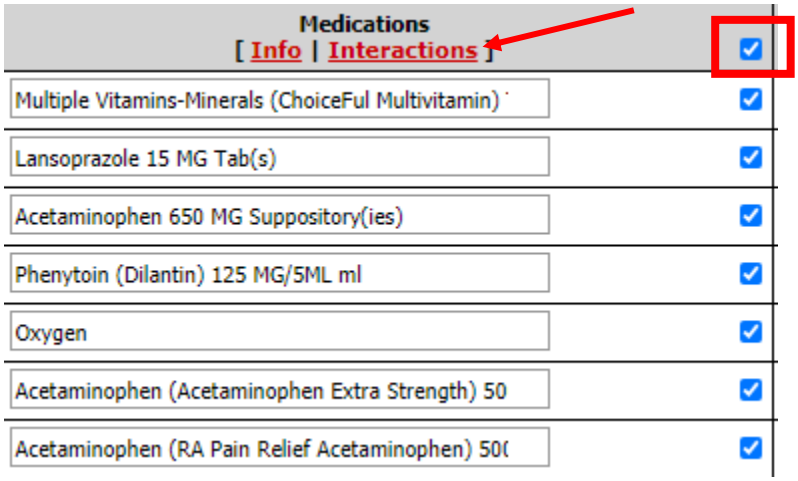
- First, place a check in the box next to the new medication(s) or all medication(s) you wish to see information on.
- Then, select the **Info** hyperlink.



- 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.



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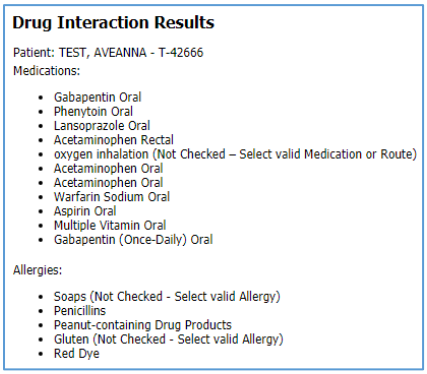
iii. A new browser tab will launch displaying drug interactions
- The top left area will list all meds and notification of any that are not being factored in due to manual entry of the medication. Best practice is to always select medications from the database when available.
- Also listed are the patient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

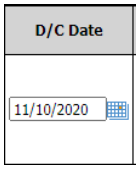
- Soaps (Not Checked - Select valid Allergy)
- Penicillins
- Peanut-containing Drug Products
- Gluten (Not Checked - Select valid Allergy)
- Red Dye

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:

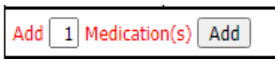
*****REMINDER: ALL SIGNIFICANT (MAJOR) DRUG INTERACTIONS/CONTRAINDICATIONS MUST BE REPORTED TO PHYSICIAN AND NURSING SUPERVISOR.*****

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.



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



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

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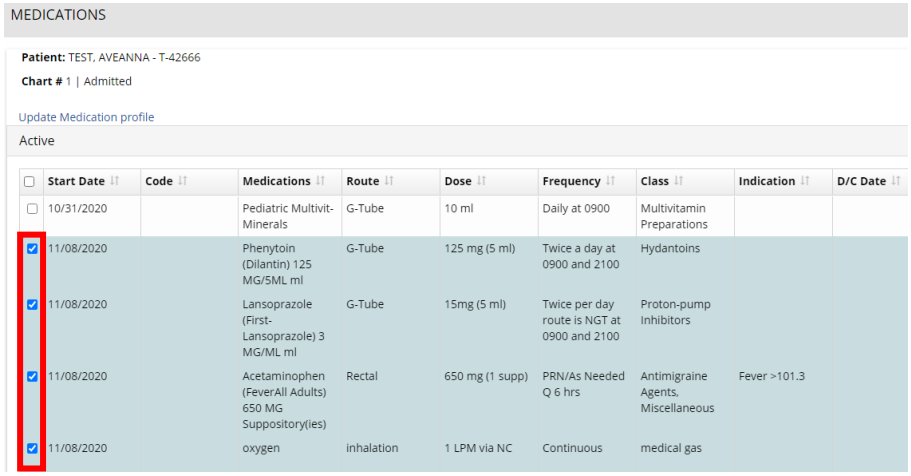
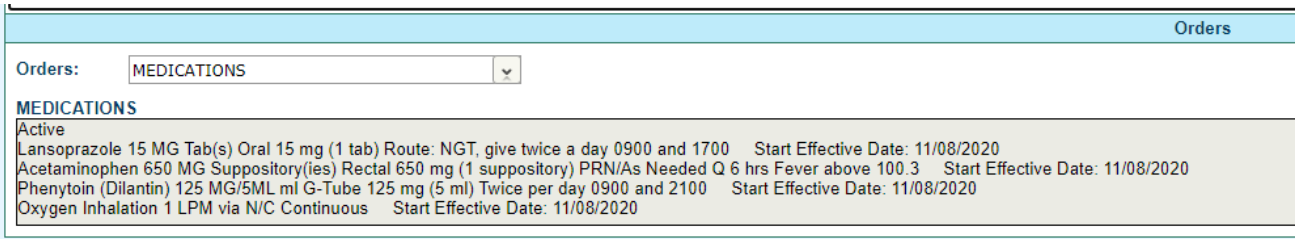
s. Save the Med Profile

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.

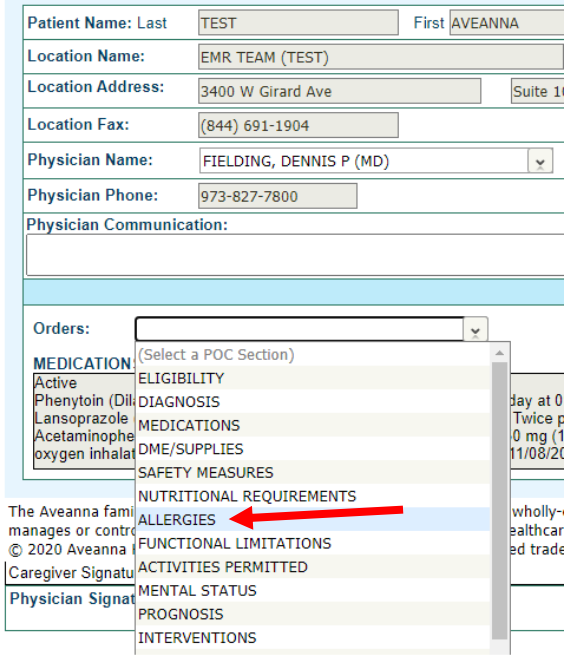
ii. On the Medications page, select the new medications you want to appear on the Order by selecting the check box in the appropriate rows. Then use the 'Insert to form' button.



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



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



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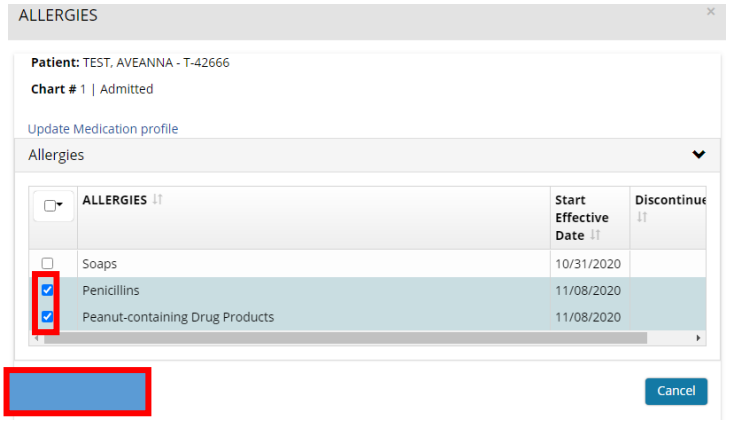
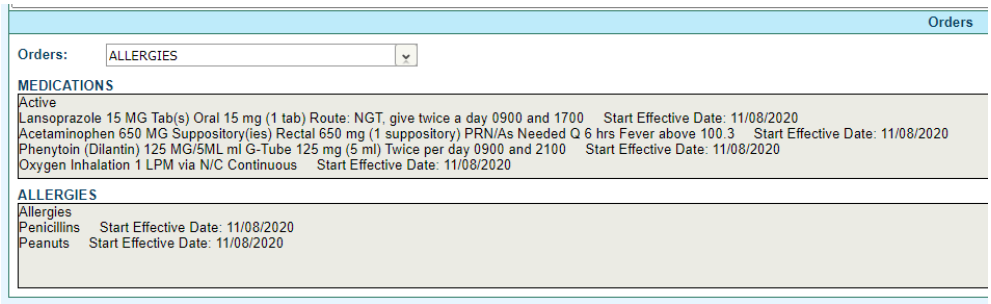
November 2018 (Version 1.0)

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



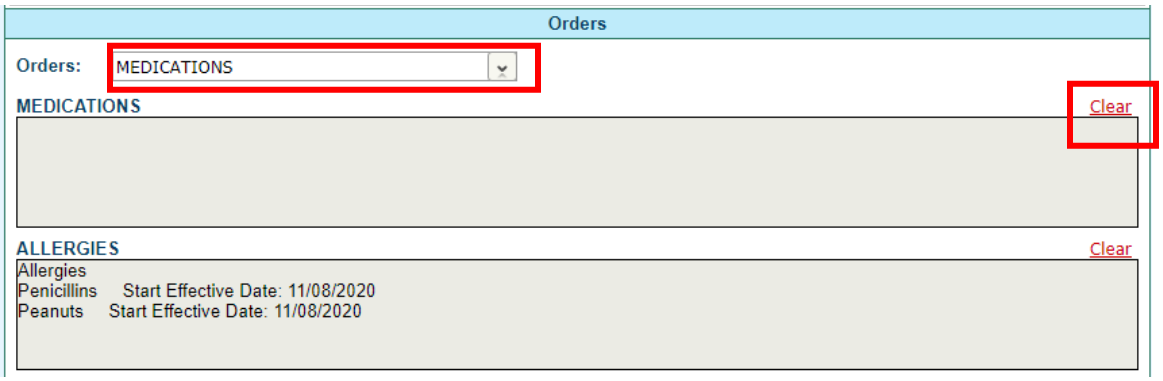
- This action will add an Allergies section to the orders and populate with the allergies that were selected in the previous screen.



t. If you notice an error that needs to be corrected before you submit the order:

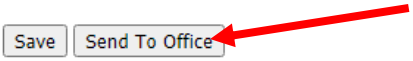
i. Use the **Clear** hyperlink on the right to clear the affected field.

ii. Use the **Orders** dropdown to return to the the appropriate area. In this example, Medications:



iii. Make the correction and re-insert to form.

u. If the order is complete, scroll the the bottom and use the **Send to Office** button to submit the order to the office.



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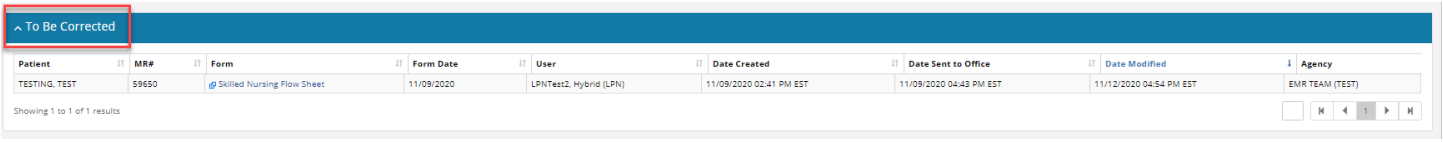
Correcting Documentation- Bedside Caregiver

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

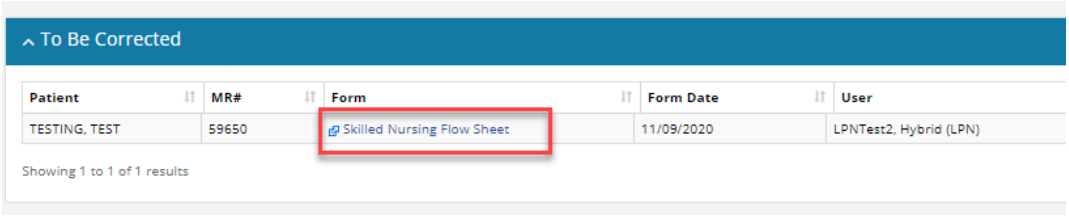
Forms sent back to for correction will be found in the **To Be Corrected area (known as the To Be Corrected queue)** of the myUnity Clinical Bedside Home page.

Correcting Documentation

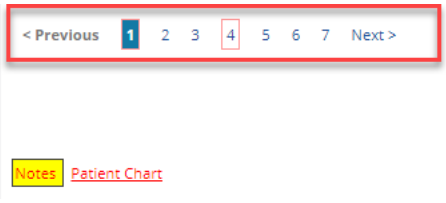
- Locate the Form in the **To Be Corrected** queue.



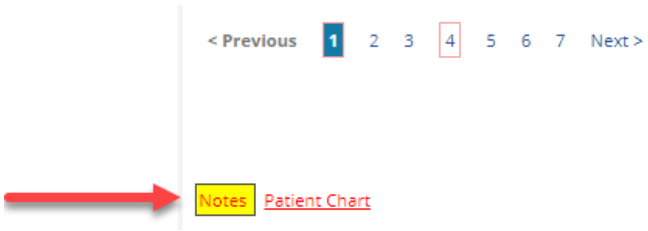
- To open the form, select its blue title.



- 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.



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



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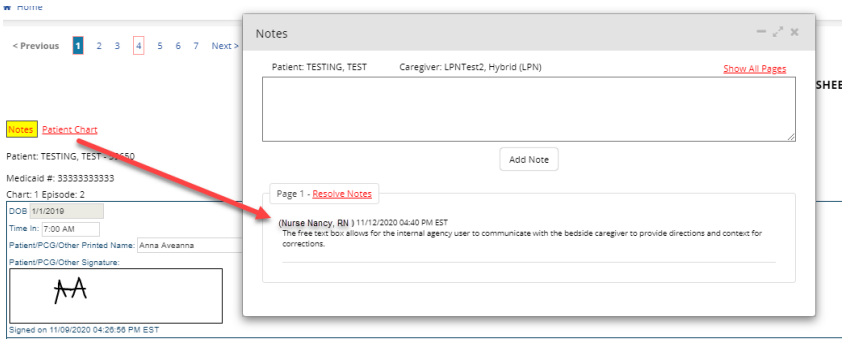
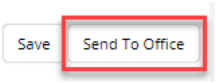
- Correct the documentation as instructed or select Add Note to explain why the requested change is not being made.



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



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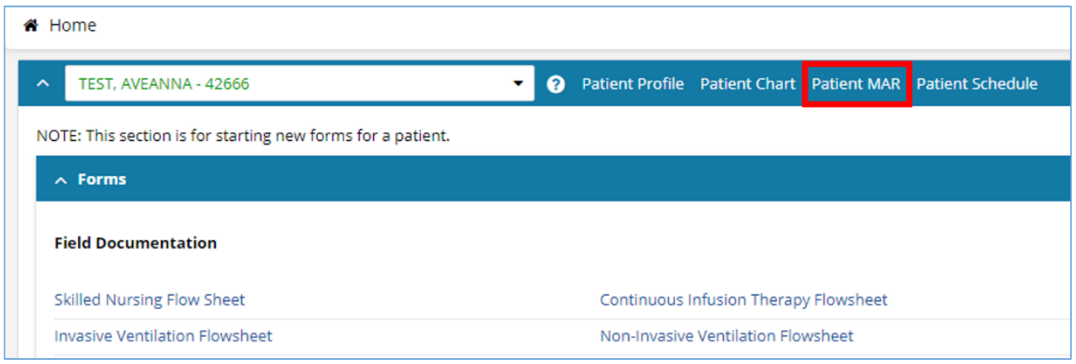
Patient MAR – Guide to Documenting Medication Administration

Medication Administration is documented using the Patient MAR.

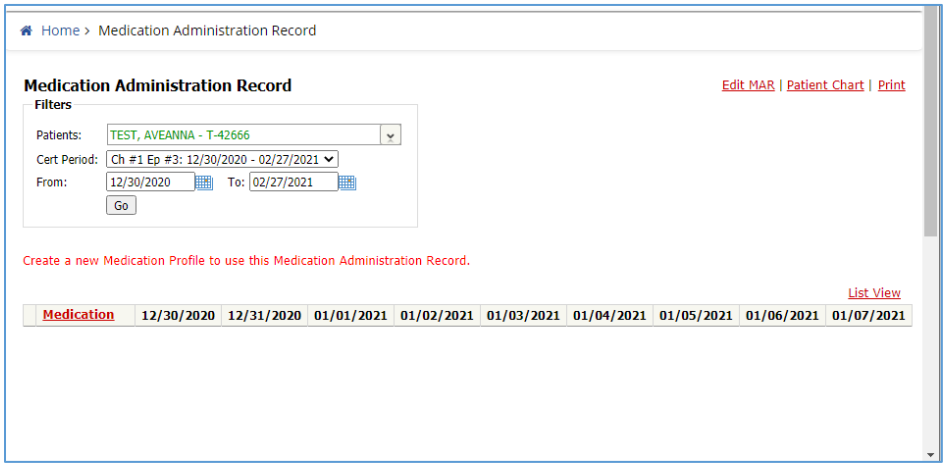
Patient MAR

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

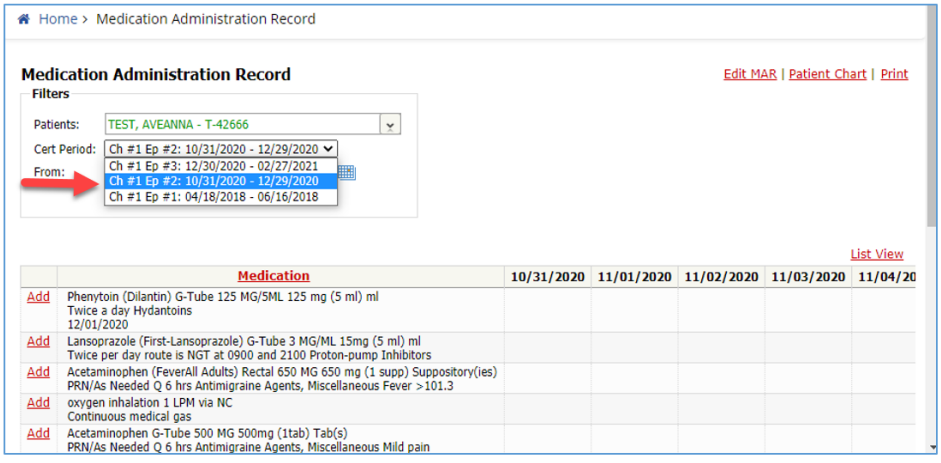


When the Patient MAR opens:

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



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



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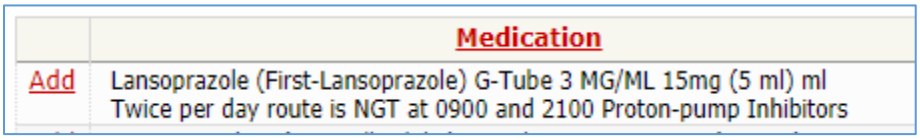
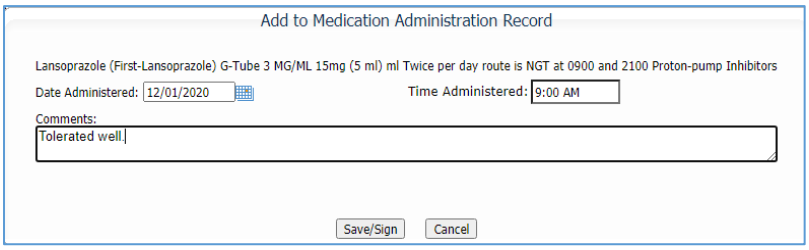
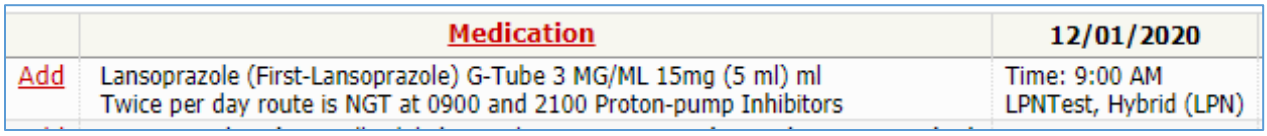
2. To document medication administration, tap the **Add** button
    - **Meds that are given when an Aveanna nurse is not on shift:** Clinical documentation represents care provided while Aveanna is on shift and providing care. Aveanna caregivers should not ever document medications that are given when 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)"



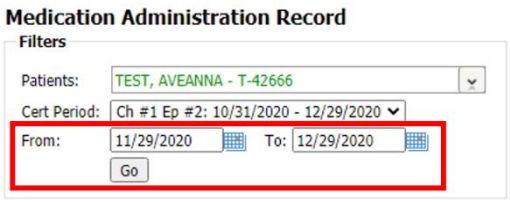
3. A popup window opens with the medication order, administration date, time administered, as well as a comments box.



- 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.



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



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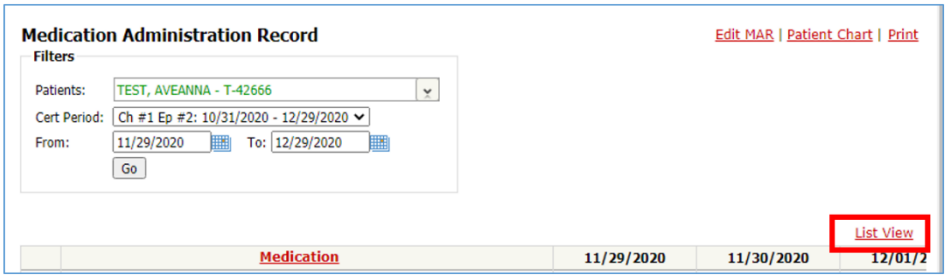
5. To be able to view the Comments for medications that have been administered:
   - Select the date filters as shown above.
   - Tap the List View hyperlink.



   - Review administration Comments

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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 logout.

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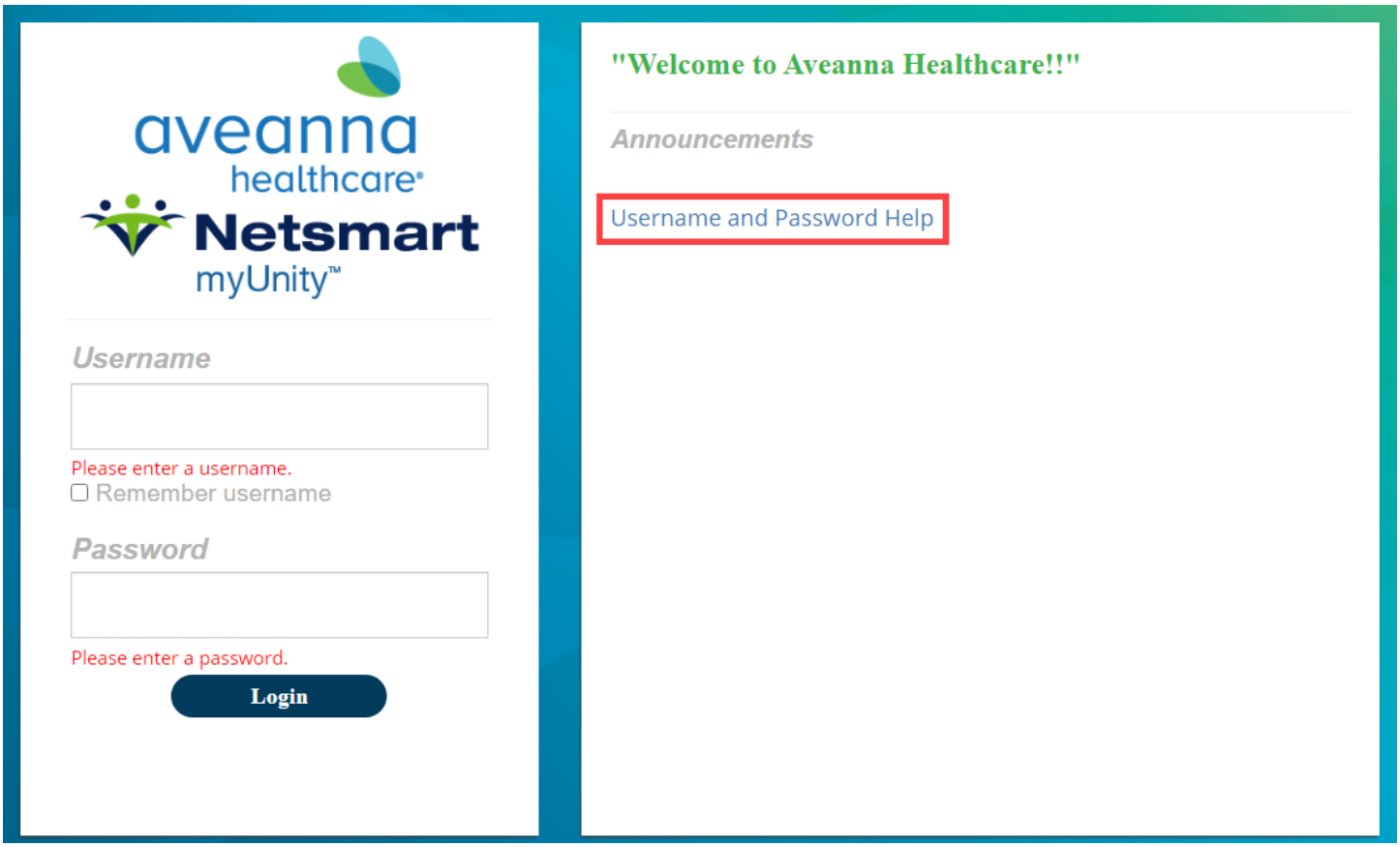
myUnity Clinical – Amelia Login Assistance

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

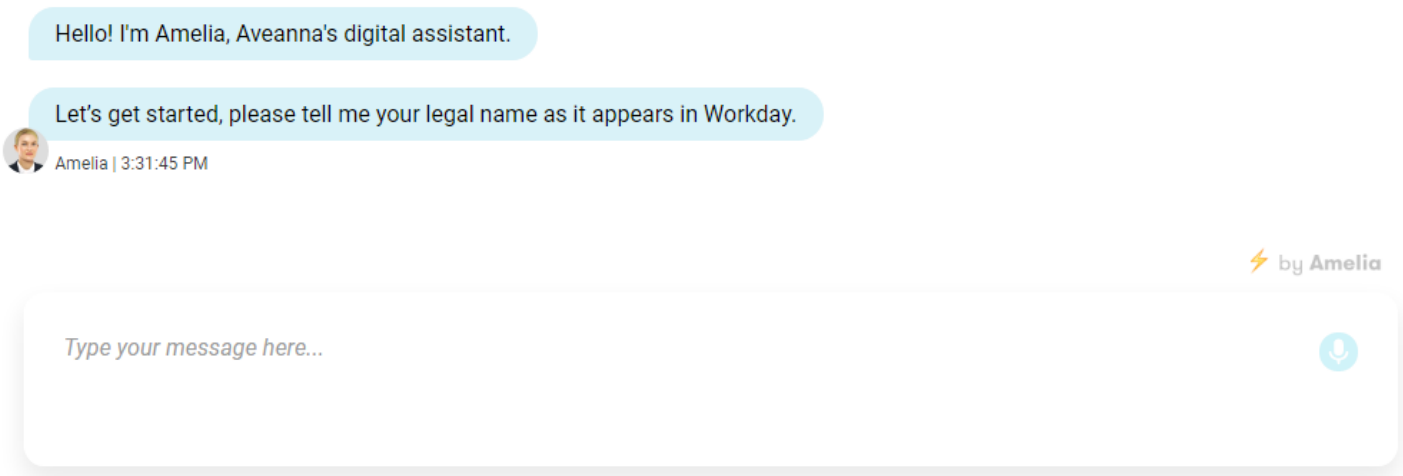
Accessing Amelia

To access Amelia and reset your password:

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



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



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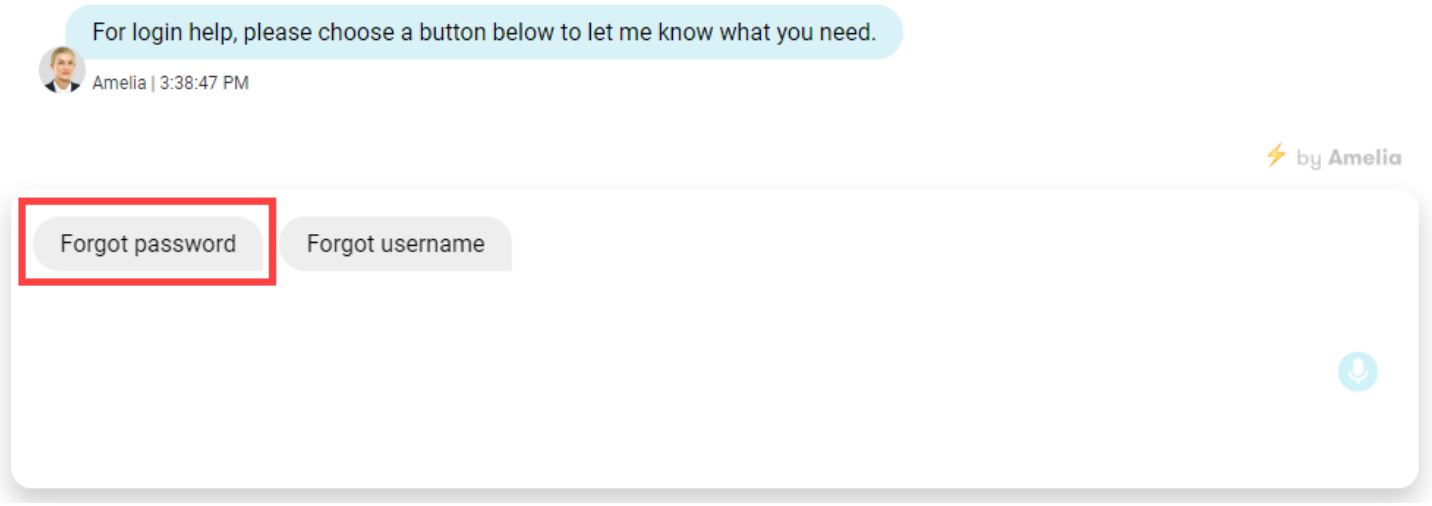
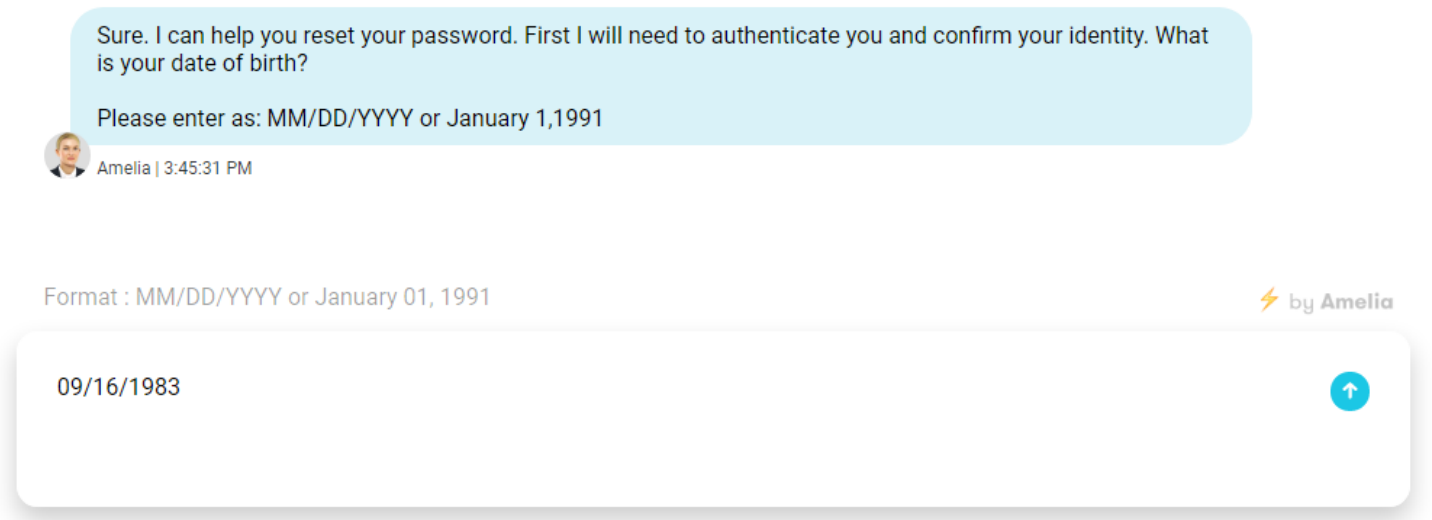
- Type in your name, as it appears in Workday, and hit Enter.
- Amelia will provide two options, **Forgot password** and **Forgot username**. In this case, we will select **Forgot password.**



- Amelia will confirm your identity.



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

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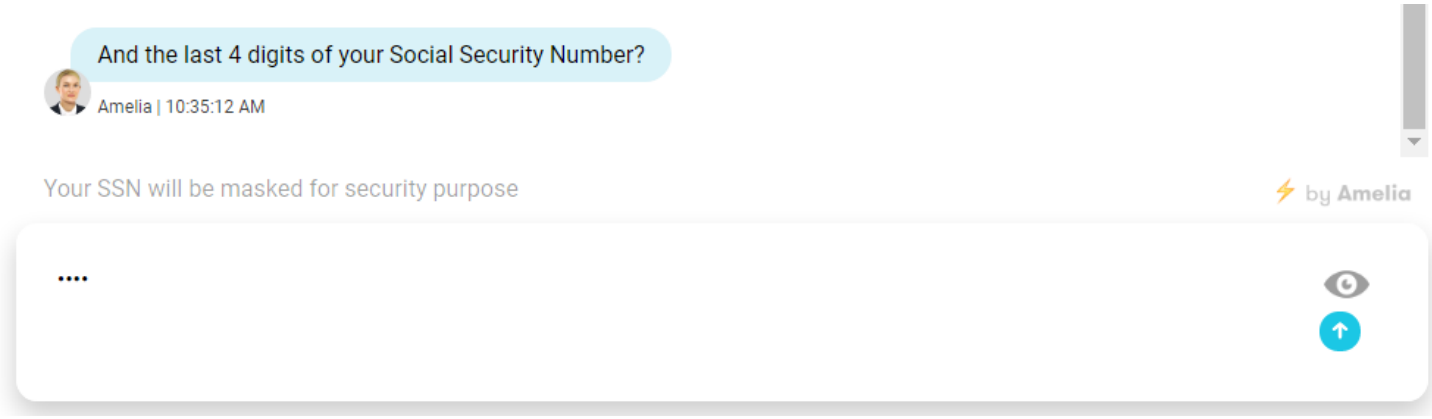
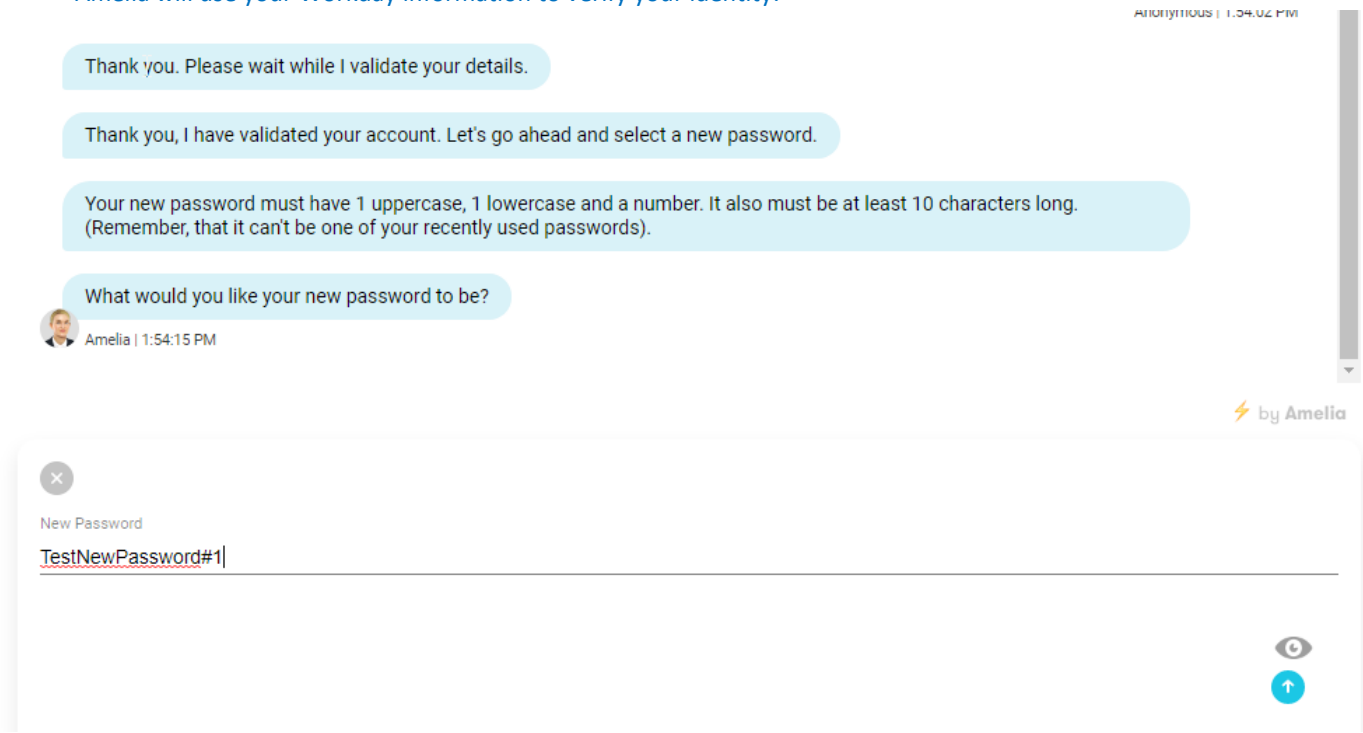
- Next, enter the last four digits of your Social Security Number. As seen below, these digits will be masked as they are entered.



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



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

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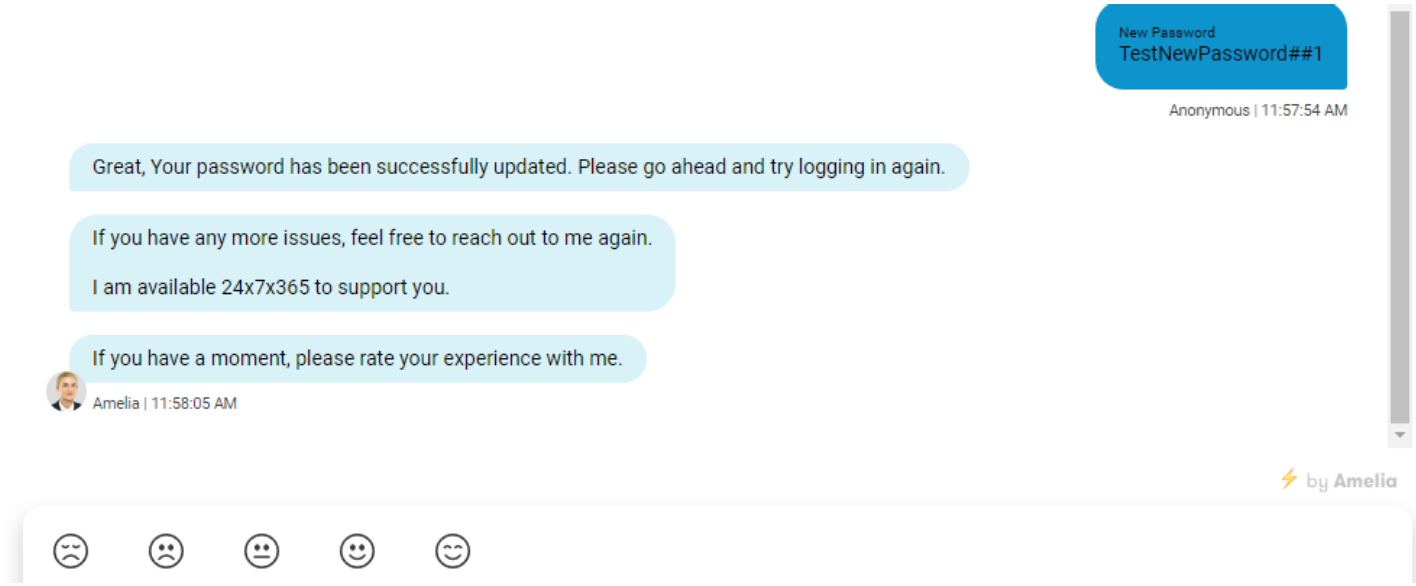
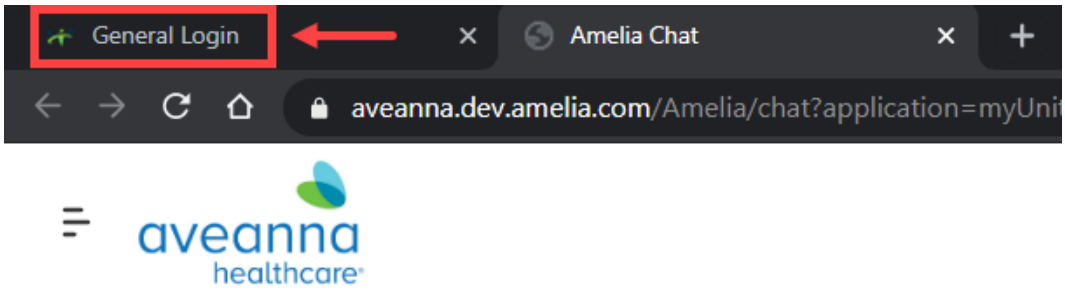
- This completes the password reset process, which Amelia will confirm.



- 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.*****

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