FAX: 703-263-3119 Email: admin@primahomehealth.com

SKILLED RESPITE RECORD – DMAS-90A

Recipient's Name: _____ Medicaid ID: _____

Provider Name: PRIMA HOME HEALTH, INC. Provider ID: 1164545240

Reason for Skilled Respite: _____

DAY:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
DATE (Month/Day/Year):	/ /	/ /	/ /	/ /	/ /	/ /	/ /
NEUROLOGICAL							
LOC A/O x3, Asleep, Awake							
CARDIAC							
Rhythm NSR, No Murmur							
Pulse / Quality Palpable in Extremities							
Edema / Cap Refill							
Invasive Lines None/CVL/PIV							
RESPIRATORY							
Rate							
Breath Sounds							
Secretions							
Chest PT							
Trach Care / Change							
Suction / Times per shift							
MONITORS							
Cardiac/Apnea – Settings							
Type / Oxygen Amt							
Vent – Settings							
C-Pap / Bi-Pap							
Blood Sugar Levels							
GASTROINTESTINAL							
Abdomen Assessment							
Bowel Sounds							
GT/NGT / Tube Patient							
TPN							
Feeds Tolerated							
GENTIOURINARY							
Spon. Voids/Diaper/Cath							
Catheter Care							
Intermittent Cath							
OTHER							
Complete/Partial Bath							
Oral Care							
Skin Care							
Skin Tugor							
Wound Care							
Turn & Position							
Medication							
Need for POC changes							
New MD Orders							
TIME IN							
TIME OUT							
NUMBER OF HOURS							

Comments:

Weekly Signatures:

Recipient/Family's Signature Date

RN/LPN's Signature Date

RN Supervisor's Signature (not mandatory) Date

Print RN/LPN Name

DMAS-90A
0705

This form contains patient-identifiable information and is intended for review and use of no one except authorized parties. Misuse or disclosure of this information is prohibited by State and Federal Laws. If you have obtained this form by mistake, please send it to: DMAS, 600 East Broad Street, Suite 1300, Richmond, VA 23219

Attachment to DMAS-90A (This form combines the DMAS-90A) rev. 03/04

INSTRUCTIONS FOR COMPLETION OF THE DMAS-90A

Agency-directed services must use this form for all RN/LPN Respite Care services. The instructions for filling out the DMAS-90A follow. Detailed instructions for filling out the DMAS-90A for agency-directed and consumer-directed Respite services are provided below. If you have further questions, please call the Waiver Services Unit for assistance at (804) 786-1465.

It must include: the recipient's name, address, phone number, and the reason for skilled Respite.

Date: Must be a complete date, including the month, day and year.

Neurological: Level of Consciousness-is the recipient alert and oriented x3, asleep, awake, disoriented, semi-comatose or comatose. Assess the level of consciousness and document for each day Respite Care is provided.

Cardiac: The RN/LPN should auscultate the apical pulse and document the regularity of the rhythm, if there is any murmur or irregularity heard. Pulses in all extremities should be palpated and documented. Edema and capillary refill should be checked and documented. The RN/LPN should document if there are invasive lines such as Central Venous or Peripheral Intravenous.

Respiratory: The RN/LPN should note the rate of the respirations, if breath sounds are present or absent in any lobes, if the recipient has secretions, if Chest P.T. has been ordered and if so what is the order, If the recipient has a trach and if it was changed during this shift. Does the recipient require tracheal suctioning and if so how many times per shift was the recipient suctioned.

Monitors: Does the recipient utilize monitors-Cardiac or apnea monitor-what are the settings. Type of monitor and oxygen amount. Ventilator used and settings. C-Pap/Bi-Pap machine settings. Blood sugar levels.

Gastrointestinal: The RN/LPN should assess the abdomen to include distention, firm, soft as appropriate. The nurse should auscultate the bowel sounds and document presence or absence in the four quadrants. The presence of a G-tube, or NG-tube should be documented, as well as if the tube is changed during this shift. Does the recipient receive TPN feedings-what is the formula. Document if the feeding was tolerated and if not what symptoms were presented.

Genitourinary: Does the recipient spontaneously void, wear a diaper or incontinent pad, have a texas catheter, foley catheter or supra-pubic tube. Document if catheter care was provided during each shift. If intermittent catheterization is provided, document how often for each shift.

Other: Was a bath given to the recipient- document the type provided-sponge bath, partial bath, shower, tub-bath.

Oral care-does the recipient wear dentures, or were the teeth brushed. Skin care should be provided every shift or more often if required. Note any reddened areas and dry or cracked areas. Skin turgor should be checked every shift and documented. Wound care must be documented and there must be a doctors order for all wound care-what type of wound care, how often is wound care provided, describe the wound, include measurements, odor, color-wound descriptions may need to be documented under Comments. Turn and Position-this should be done at least every two hours or as often as needed.

Medication: Did the recipient receive medication during this shift. Was the medication tolerated.

Need for POC Changes: Is the Plan of Care appropriate or do changes need to be made?

New MD Orders: There must be a doctors order for all skilled services. Is there any new doctor orders-the orders may be discussed in the Comments section.

Time In: Document the arrival time to the recipient's home

Time Out: Document your departure time from the recipient's home

Number of Hours: Document the total number of hours respite care was provided to the recipient.

Comments: Include any new doctor orders, description of wounds, anything out of the ordinary that the RN supervisor or doctor should be aware of. Include any conversations/concerns of the primary caregiver, conversations with the doctor, note any issues with the environment or changes with the recipient.

Weekly Signatures: The recipient/family or primary caregiver must sign the DMAS-90A weekly to confirm services were rendered as documented.

RN's Signature: This is the RN supervisor's signature for the agency / LPN/RN Signature: Is the signature of the nurse that actually provided the respite care

Print LPN/RN Name: The name of the RN/LPN must be printed here.