Documentation Education for Private Duty Nurses

February 2020

Objectives

BE FAMILIAR WITH CONSEQUENCES OF INACCURATE DOCUMENTATION

LEARN MORE ABOUT ELECTRONIC VISIT VERIFICATION (EVV)

UNDERSTAND DOCUMENTATION EXPECTATIONS

KNOW WHEN TO CONTACT A PATIENT'S CASE MANAGER

GAIN INSIGHT FROM PEER TIPS RELATED TO DOCUMENTATION

Documentation: What is it?

A record of care provided

A communication tool

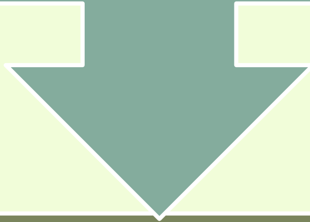
Part of a record keeping system that supports the continuity, quality, and safety of patient care

A financial billing document

Your timecard

A legal requirement

Documentation is vital to patient care, payor reimbursements, individual clinician licenses, the agency's license, and state and federal rules and regulations.



Accurate and complete documentation:

Demonstrates continuity and coordination of care	Provides important information for other TCPS staff, physicians, and other external healthcare providers	Is used to make healthcare related decisions	Demonstrates necessity for continuation of services	Protects against allegations of fraud or neglect	Can protect your license if called to court	Demonstrates compliance with agency policy

Documentation – Why is it important?

Late and inaccurate documentation contributes to subpar patient care:

- Compromises patient safety, leads to medication and other errors
- Negatively affects care coordination and continuity of care
- Causes inaccurate reporting to patients' physicians
- Misinforms healthcare professionals and patients/families
- Results in a delay in the provision of a patient’s care
- Contributes to a denial for services from Medicaid (lack of medical necessity)

- Incomplete records:
  - Demonstrate that care was incomplete
  - Create gaps that reflect poor clinical care
  - Demonstrate noncompliance with agency policies
  - Can be used to support allegations of negligence
  - Used to support allegations of fraud
  - Result in inappropriate billing and lead to chargers of fraud against the agency

Inaccurate/Missing (late) Documentation – Why does it matter?

Falsification of Documentation

Documenting prescribed medications as being given but not giving them

Documenting care that was not completed

Documenting vital signs but not actually taking them

Inaccurate entries

Covering up poor outcomes

Billing for services that were not completed

IS UNETHICAL

CAN RESULT IN FEDERAL / STATE CRIMINAL CHARGES

CAN END YOUR CAREER

CAN RESULT IN JAIL TIME

Consequences for Deliberate Falsification of Documentation

Documentation Trouble

Major consequences can result from inadequate documentation. Check out the links below to read more.

- "Falsification of Patient Care Record Can Lead to Criminal Convictions: Avoiding Liability Bulletin, Ethics, Nursing, Patient Care" by Nancy Brent RN, MS, JD, CPH & Associates https://www.cphins.com/falsification-of-patient-care-record-can-lead-to-criminal-convictions/
- "Inadequate Nurse's Notes Lead to Lawsuit" by William C. Wilson, Caring for the Ages https://www.caringfortheages.com/article/S1526-4114(18)30071-4/fulltext

Electronic visit verification (EVV)

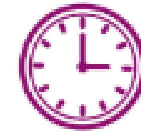
EVV is coming to Colorado. State legislators are still working on finalizing the specific requirements that we will have to abide by. The next several slides review the general requirements thus far. We will continue to keep you informed as we know more.

Electronic Visit Verification Overview

What is EVV?

- Electronic Visit Verification (EVV) is a technology solution which verifies information through mobile application, telephony, or web-based portal.
- EVV is used to ensure that home or community-based services are delivered to people needing those services by documenting the precise time service begins and ends.
- Section 12006 of the 21st Century Cures Act requires all state Medicaid agencies implement an EVV solution.
- States that do not implement EVV will incur a reduction of Federal funding.
- EVV is available for current use in Colorado and will be required beginning late summer 2020.
- Video - What is EVV?
- Video - A Day in the Life of Using EVV
- EVV FAQs

What must EVV capture?

Type of Service Performed	Individual Receiving the Service	Date of the Service
Location of Service Delivery	Individual Providing the Service	 Time the Service Begins and Ends

What Types of Services Require EVV for Colorado?

- Behavioral Therapies (provided in home or community)
- Consumer Directed Attendant Support Services (CDASS)
- Durable Medical Equipment (requiring in-home setup) **- DELAYED**
- Home Health
- Homemaker
- Hospice
- Independent Living Skills Training (ILST)
- In-Home Support Services (IHSS)
- Life Skills Training
- Occupational Therapy (provided in the home)
- Pediatric Behavioral Health
- Pediatric Personal Care
- Personal Care
- Physical Therapy (provided in the home)
- Private Duty Nursing
- Respite (provided in the home or community)
- Speech Therapy (provided in the home)
- Youth Day

For additional details regarding Colorado's implementation of EVV, please visit the state website at

https://www.colorado.gov/pacific/hcpf/evv

Skilled Nursing and Progress (SNAP) Note Protocol

Revised expectations as of February 2020

SNAP Note: Prior to Charting . . .

SPIG & Goals	Review the SPIG (Specific Patient Information and Guidance) and SMART Goals PDFs located in the patient's chart
BPSR	Review the BPSR (Bullet Point Shift Report) form previous shifts
Tiger Connect	Check Tiger Connect/Devero messages to make sure you are caught up with the latest updates
MAR	Review the MAR for ordered medications, feedings, treatments, and cleaning that is assigned on your shift

SKILLED NURSING ASSESSMENT AND PROGRESS NOTE Quick Start

Visit Date: 01/24/2020

Billing Code: LPNSC - LPN Single Care

(Select a Billing Code)
LPNSC - LPN Single Care
RNSC - RN Single Care
LPNDC - LPN Double Care
RNDC - RN Double Care
LPNTC - LPN Triple Care
RNTC - RN Triple Care
NBLPNDC - Non-billable LPN Double Care
NBLPNSC - Non-billable LPN Single Care
NBLPNTC - Non-billable LPN Triple Care
NBRNDC - Non-billable RN Double Care

Episode Analytics
Patient Activity
Custom Reports
Recertification Audit
Referrals
Restraint Report
OASIS Tra
Skilled Nu
CNA CARE
CNA Visit
Pediatric
Pediatric

SNAP Note - Quick Start Menu

- ❑ Select the visit date
  - For shifts that span two days, select the date the shift started on
- ❑ Select the appropriate Billing Code
  - If single, double, triple care changes throughout your shift; select the code that applies to the majority of your shift for each patient
  - E.g., working a 9-hour shift; 5 hours as single care (with client A) & 4 hours double care (with client A and B), pick single care for “A” and double care for “B”

SKILLED NURSING ASSESSMENT AND PROGRESS NOTE

Patient Chart Notes

(Select an Action)

Patient: Test Patient, Orientation - 000000101

Chart: 1 Episode: 15

Billing Code: RNSC - RN Single Care

Caregiver: Best, Nurse Ever (RN) Visit Date: 01/24/2020

Travel Time: minutes Chart Time: minutes Mileage: Time In: Time Out:

- Safety Check complete
- Goals reviewed
- MAR reviewed
- Prev shift bullet points reviewed
- Trach size verified
- Vent humidity system verified
- Vent settings verified
- G/JB size verified

SNAP Note – Top portion (page 1)

- ❑Verify that you have selected the correct patient
- ❑Document time in; you can document time out at the end of your shift
- ❑Complete review tasks (safety check, goals, MAR, BPSR) and check off
- ❑Verify trach, vent and humidity system settings, G/JB size and check off (as applicable to your patient)

Remember, checking a box without performing the actual task = falsifying documentation

VITAL SIGNS					
Time	Temp/route	Pulse	Resp rate	BP	O2sat/O2 set
0815	98.6 F touchless	93	20	115/78	97% 2L inline bedside
1315	97.7 F touchless	105	22	101/68	100% 2L inline beside
1615	98.1 F touchless	103	21	100/69	100% 2L inline

SNAP Note – Vital Signs (page 1)

- ❑Complete at the start of shift during your initial assessment
- ❑During shift: refer to the SPIG form for the frequency of vital assessments for your patient; many patients require vital assessments every five (5) hours but some patients require vital assessments more frequently
- ❑End of shift: best practice is to take a set of vitals (at least a partial set) sometime within the last hour of your shift

Initial Total Body Assessment

- Complete a total body assessment at the start of your shift
- Refer to the SPIG form for guidance
- Document concerns/details and history of concerns under each body system on page 1
- **Areas of concern/abnormalities** are based on an assessment of a *normal pediatric patient*
- We EXPECT areas of concern
- This helps set the foundation for **why** there is skilled nursing for this patient

NEUROLOGICAL LOC: ○ Alert ○ Sleepy ○ Asleep ○ Lethargic ○ Restless

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☐ History of concerns:

☐ Disorientation: ☐ person ☐ place ☐ time ☐ situation
☐ Hx of sleep disturbance ☐ Hx of seizures ☐ May need to use restraints (per TCPS protocol)
☐ Pain or hx of pain ☐ Chronic, Managed ☐ Chronic, Unmanaged ☐ Acute, Managed ☐ Acute, Unmanaged
☐ Routine pain meds ☐ PRN pain meds available
☐ Pain scale used: ☐ FLACC ☐ FACES ☐ Numeric scale ☐ Can self-report ☐ Pain behaviors
☐ Behaviors or hx of behaviors ☐ Potential to harm self or others ☐ Rejects cares ☐ Hyperactive
☐ Unable to pay attention
☐ Other:

RESPIRATORY ○ N/A ○ Oxygen – PRN or routine (see MAR)

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☐ History of concerns:

☐ Breathing effort ☐ Tachypnea ☐ Rales ☐ Rhonchi ☐ Inspiratory wheezes
☐ Expiratory wheezes ☐ Diminished ☐ Cough: ☐ Productive ☐ Non-Productive
☐ Secretions: ☐ Oral: Consistency Color Amount
☐ Nasal: Consistency Color Amount
☐ Trach: Consistency Color Amount
☐ Increased frequency of suctioning reported ☐ Other

CARDIOVASCULAR

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☐ History of concerns:

☐ Irregular heart tones ☐ Tachycardia ☐ Capillary refill sluggish ☐ Abnormal peripheral pulses ☐ murmurs ☐ bradycardia
☐ Edema: Site: ☐ Other

GASTROINTESTINAL Last BM:

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☐ History of concerns:

☐ Constipation ☐ Diarrhea ☐ Abdominal distention ☐ Hypoactive bowel sounds ☐ Nausea
☐ Vomiting ☐ Poor appetite ☐ Feeding intolerance
☐ ostomy/cecostomy ☐ incontinence
☐ Symptoms of dehydration
☐ Other

GENITO-URINARY

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☐ History of concerns:

☐ Odor ☐ Color ☐ Output amount ☐ incontinence ☐ catheter: ☐ CIC ☐ indwelling ☐ vesicostomy ☐ menses (current)
☐ Other

MUSCULOSKELETAL Repositioning required: ○ Yes ○ No

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☐ History of concerns:

☐ Weakness ☐ Tremors ☐ braces/splints/AFOs ☐ contractures
☐ Other

Chart: 1 Episode:

INTEGUMENTARY

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☐ History of concerns:

☐ Temp ☐ Color ☐ Skin breakdown re: incontinence
☐ Trach Site
☐ G/J Site ☐ Vesicostomy site
☐ Wound/Lesion: (site/description)
☐ pressure areas: ☐ IV/CVAD site
☐ Other

Initial Assessment– System Header Rows

(page1)

NEUROLOGICAL LOC: Alert Sleepy Asleep Lethargic Restless Clear

RESPIRATORY N/A Oxygen – PRN or routine (see MAR) Clear

System header rows with radio buttons/date field must be completed

Select the option/date that applies

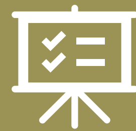
GASTROINTESTINAL Last BM: 01/21/2020

MUSCULOSKELETAL Repositioning required: Yes No Clear

Applies to all body systems (pgs. 1-2)

Initial Assessment: No Concerns

You do NOT have to chart assessment findings that are within normal limits for a pediatric skilled nursing assessment (e.g., clear lungs, regular heart rate, etc.)



If there are no concerns after you have completed your assessment, check the box “no areas of concern identified after assessment.” This is the only time you would check this box.

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment

If you checked boxes to indicate current concerns or history of concerns in a body system, do not also check the no concerns box in the same area

Conduct a skilled head-to-toe nursing assessment and document findings in the appropriate body section

Initial Assessment: Concerns Identified

Check concern boxes provided for common areas of concerns

Document abnormal findings/concerns that you have identified that are not in the common areas of concern in the "Other" text box field

GASTROINTESTINAL Last BM: 01/23/2020

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☑ History of concerns: Constipation. Increasing rate of bolus feeds to goal of 30 minutes per feeding.

☐ Constipation ☐ Diarrhea ☐ Abdominal distention ☐ Hypoactive bowel sounds ☐ Nausea

☐ Vomiting ☐ Poor appetite ☐ Feeding intolerance

☐ ostomy/cecostomy ☑ incontinence

☐ Symptoms of dehydration

☑ Other

Tolerating bolus feed over 45 minutes.

If you check any areas of concern or any history of concern, your nursing process to address these areas should be evidenced in your narrative

1100: GB feeding complete - bolus feeding given over 45 minutes, tolerated AEB no gagging, abdominal distention and client stating via Tobii that she had no discomfort.

History of concerns differs from patient to patient dependent on what the case manager is looking for; refer to SPIG form or contact the case manager if you are unsure what applies to your patient

If there is a history of concerns, but the patient is not exhibiting them at the time of your initial assessment, check the "History of concerns" and complete the text box to the right.

For instance, if the patient has occasional bradycardia or tachycardia, but it is not occurring on your shift, you should add it to the History of Concerns section in Cardiovascular.

CARDIOVASCULAR

Concerns: (if yes, check those that apply): ☐ no concerns identified after assessment ☑ History of concerns: History of intermittent bradycardia

☐ Irregular heart tones ☐ Tachycardia ☐ Capillary refill sluggish ☐ Abnormal peripheral pulses ☐ murmurs ☐ bradycardia

☐ Edema: Site: ☐ Other

Initial Assessment - History of Concerns (page 1-2)

This area is reviewed by the next nursing shift as well as the case manager

It should be complete, concise, and to the point

The BPSR is the best place to see previous shift summaries, reports, and PRN meds

The BPSR may not be left blank

The Bullet Point Shift Report (BPSR)

BPSR – New/Ongoing Infection Concerns

Example of an 'ongoing infection' concern:
"day 6 of 14 of antibiotics for a UTI"

- If concerns have been identified, choose new or ongoing from the dropdown box
- Relay only current concerns. For instance, a trach/vented child will always be at increased risk of upper respiratory infections but that does not need to be noted as ongoing concern.
- If there are no concerns identified, choose N/A from the drop-down box

BPSR – New/Ongoing Safety Concerns

- If concerns have been identified, choose new or ongoing from the dropdown box
- Relay only current concerns. For instance, “at risk for falls” is an ongoing safety concern that will probably always exist for many patients; there is no need to document this in the BPSR every shift

  However, you would want to document a new concern related to fall risk (patient is on a new medication that could contribute to balance issues, etc.)
- If there are no concerns identified, choose N/A from the drop-down box

BPSR – New/Ongoing Other Concerns

Example:

1) L ear drainage 2) pain/fever 3) no BM x 3 days

- List new/ongoing concerns in bulleted or numbered fashion
- One or two words is fine
- The goal is to document concerns so we can communicate issues and don’t lose concerns from shift to shift
- This will change based on the client’s condition
- Refer to SPIG form to find what info case manager is looking for

BPSR – PRN Interventions and Meds

Example:

1) ear drops at 1400, 2) acetaminophen at 1400, 3) bisacodyl suppository at 1000 (**PRN meds**)

- Check and complete if you provided any pertinent PRN intervention or PRN med during your shift
- This area is reviewed by the next nursing shift as well as the case manager
- A brief word or two for your PRN interventions, meds, and outcomes will suffice
- For ease of following concerns, PRNs, and outcomes, please arrange or number them so that we can see the relationship between them clearly
- Indicate the time you gave the PRN meds as well as the dose if there is a range available

BPSR – OUTCOMES

Example (based on the PRN meds example from the previous slide):

1) decreased drainage/cont to monitor, 2) afebrile, 3) large BM

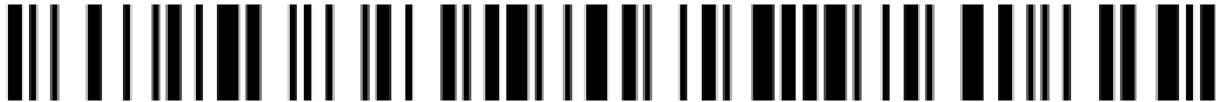
- Check and complete if you provided any pertinent PRN intervention or PRN med during your shift
- Indicate outcomes for all PRN interventions and meds, plus outcomes to SMART goals
- Goals - you do NOT have to write a positive or negative outcome to ALL goals but do note some
- For example, skin remains intact; lungs clear, O2 Sats greater than 93%
- The goal is to communicate issues and outcomes from shift to shift to help provide continuity of care
- This area is reviewed by the next nursing shift as well as the case manager
- *Note: You will document your on-going assessment, intervention, and outcomes in your narrative note, so we do not want you to duplicate your charting here*

BULLET POINT SHIFT REPORT

- New/Ongoing concerns Infection concerns **N/A** Safety concerns **N/A**

  ☑ Other
  1) yeast rash at vesicostomy
  2) redness on elbows, blanchable

Page 1 of 7



SKILLED NURSING ASSESSMENT AND PROGRESS NOTE

Patient: Test Patient, Orientation-MR#000000101 Caregiver: Best, Nurse Ever (RN) Visit Date: 01/24/2020

- ☑ PRN Interventions:
  2) WC padded under elbows

  ☑ PRN Meds:
  1) Nystatin to vesicostomy- 1000
- Outcomes of PRN Interventions/Meds and progress toward SMART goals:
  1) no change in yeast rash. 2) redness gone by 1000, remain without redness. Client tolerated bolus feed over 45 minutes
- Report given to: **Parent** ☑ Notified of changes in Condition: **no change in yeast rash.** ☑ parent ☐ case manager

Example of an ideal BPSR

Report given to:

Document who you gave report to

For example: on-coming nurse, family, MOC, etc.

You do not need to document the person's name

Make sure a nurse is taking over if you write "report given to on-coming nurse"

Report Reminders

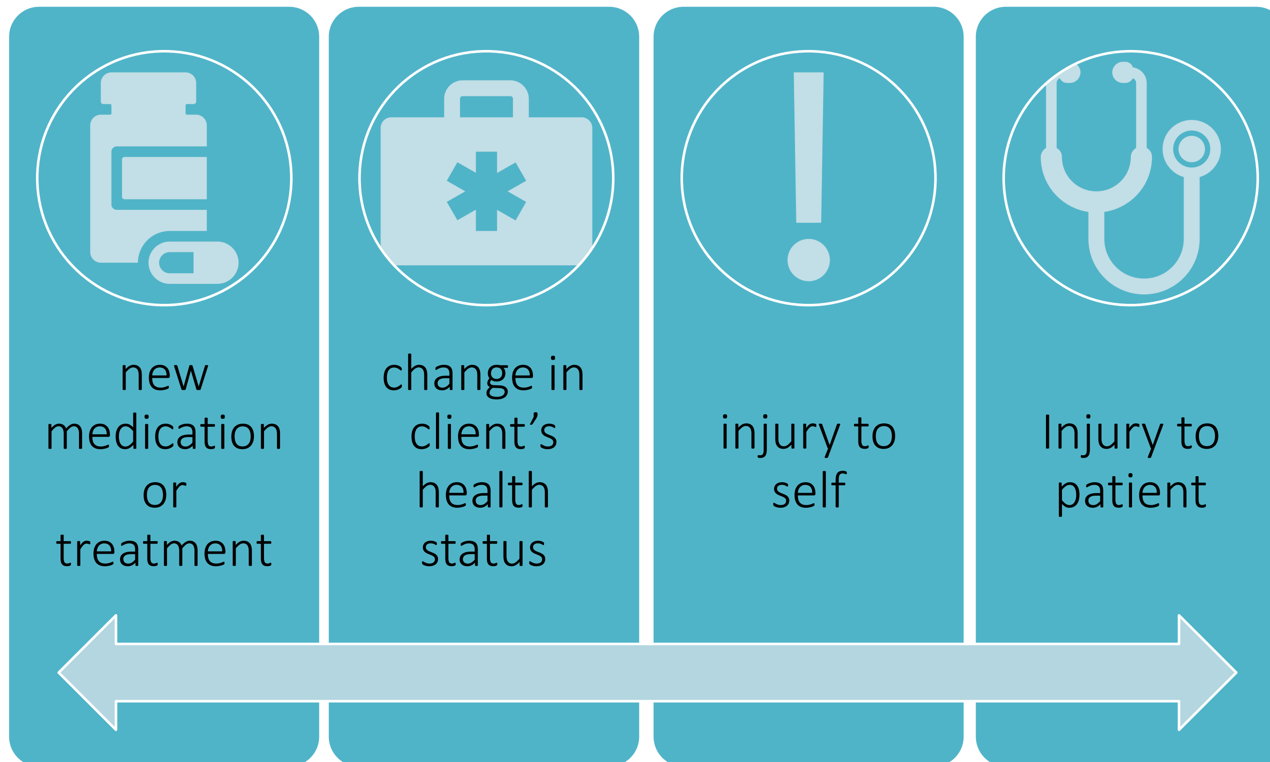
Always handoff the patient to another person (nurse, parent, other caregiver) . . . even if it is the "middle of the night"

Nurses cannot handoff a patient to a CNA (but can to a parent)

When to Notify the Patient's Case Manager or On-call Case Manager (after hours)

Important for LPNs:

In accordance with the Scope of Practice for LPNs, when you identify any new concerns, you should contact the main number (970-686-5437) to speak with an RN who will provide direction to you.



Complete the text box and indicate the case manager you notified for (located at the bottom of the BPSR).

Notified of changes in Condition: RN CASE MANAGER NAME

PROGRESS NOTES: ENTRY REQUIRED AT LEAST EVERY 2 HOURS (chart identified concerns, on-going assessments, skilled nursing interventions/outco
readings if applicable

- [ ] Report received from [ ] Select ▾
- [ ] Initial assessment completed (see pg 1 and top of pg 2)
- [ ] Second Total Body Assessment (time and any changes noted) [ ] Select ▾
- [ ] I have reviewed my entries on the MAR for completeness and accuracy
- [ ] End of shift safety check completed at what time [ ]
- [ ] Completed therapy exercises per TCPS home exercise program
- [ ] Communication device in use (comment below as needed)

Progress Notes- Top portion (pg. 2)

Just above the narrative notes section, there are check boxes for report received from, verification that initial assessment was completed, TIME and whether or not changes were noted for second total body assessment, verification that you have accurately completed your MAR for your shift, and when your end of shift safety check occurred

These checkboxes and text areas are here so you do not have to re-write these details in your narrative notes.

Your narrative note does not have to be long to demonstrate that your skills were necessary, just filled with skilled nursing data that is based on each client's goals and plan of care

Document your skilled nursing process (at least every two hours)

Narrative/Progress Notes

Examples of Good Narrative Charting

0815: Oral care complete. Client tolerated well AEB no increased wob, no crying. Trach, nares and mouth sxn, secretions as charted on page 1. Client tolerated well AEB no increased wob. 0840: Transferred to WC via lift. Positioned in chair, states she is comfortable via eye gaze. Client on portable vent, battery full, alarms active and appropriate, Vent readings: AVAPS: 5; RR 12; TV 450; IPAP Max/Min: 33/28; EPAP:8; I Time: 1.5; Temp 37 C; O2 tank full. Tobii in place. Encouraged client to voice all wants/needs via tobii.

Pt tol pm cares well. No signs of skin breakdown with peri care. LG BM. Feeding infusing at 75ml/hr cont via GB, venting via farrell bag. Pt tol infusion well, abd soft and no distention, 10 ml formula colored residual with small amt of air removed. Pt tol meds well. No signs of adverse effects. Pt asleep at 2030.

0300-0500: Pt. asleep. Lungs CTA, no need for sxn. No S/S respiratory distress/increased WOB noted. Pt. repositioned on right side with wedges. Diaper changed with moderate amount urine output. Peri area cleansed, pink and intact. Pt. asleep.

Narrative/Progress Notes – No Concerns

If your patient is relatively stable, and there are no concerns or PRNs, document to goals

If you consider what the patient's goals are, and all the critical thinking you do while you are with the patient, there are many skilled nursing items to note

Examples:

"1200 – no airway concerns, lungs clear to auscultation bilaterally, no feeding intolerance noted as evidenced by (aeb or AEB) no residuals or bloating."

Or "2300 – client sleeping restfully, respirations even and non- labored, oxygen at 2 Lpm via nasal canula."

Narrative/Progress Notes – Variable Vent Readings

EXAMPLE:

Client on portable vent, battery full, alarms active and appropriate, Vent readings: AVAPS: 5; RR 12; TV 450; IPAP Max/Min: 33/28; EPAP:8; I Time: 1.5; Temp 37 C; O2 tank full.

Document current ventilator readings for a client on a ventilator, at least every 4 hours

If your client is exhibiting signs/symptoms of respiratory distress or has a significant change in condition, vent readings will be required at least every 2 hours.

Note the current (actual):1) respiratory rate, 2) tidal volume, 3) minute ventilation (RR*Vt), 4) PIP/IPAP, 5) PEEP/EPAP, 6) I:E ratio, 7) SpO2 on current FiO2, 8) humidifier temp. 9) If on the Trilogy vent: the leak

Note: This is different than verifying the vent settings per orders that you mark on the MAR. These are the actual numbers you read on the ventilator at that time – variables

Narrative/Progress Notes – Additional Items to Document

Skin Condition

- Note condition in diaper area with every diaper change
- Condition at all sites (GB/trach/cecostomy/NG..) every time you check the site

Transfers

- How a child is "transferred"- single person transfer, hand hold assist, mechanical lift
- Do not just say, "transferred" or "safely transferred"
- Please contact your Case manager if you are unsure if your client requires a mechanical lift

Routine medications

- It is great to note "scheduled meds and flush given per MAR, client tolerated aeb….." (no gastric distress, no discomfort, remained asleep…)
- You do <u>not</u> need to list the specific details (route, concentration, dose, etc. of routine medications; this is already documented in the MAR

MAR

- Checking a box indicates: given, complete, or verified
- Indicate time for every PRN
- Start at the left in the appropriate time slot and make subsequent entries to the right. Night shift nurses may need to ‘circle back’ to the left side
- Indicate DBF if an item was given or completed by a family member during your shift
- Do not mark the MAR for medications administered prior to or after your shift; you may include details that family reported to you in your narrative or Bullet Point Shift Report as applies
- Click here to review additional instructions for the MAR – LINK TO UPDATED PROTOCOL HERE

SNAP Note Send to office

Review your note; remember to document your time out on page 1

Click send to office

Notes need to be sent to the office at the end of your shift

Extensions will be granted for unforeseen circumstances if you have a qualifying event and CALL the office by the end of your shift

Keep reading to learn more . . .

Date Filters

- Form Date
- Date Created
- Date Sent To Office
- Date Modified

Form Statuses

- To Be Corrected
- Pushed Forms To Sign
- Pending
- Shared
- Completed

Go

To Be Signed

Pending

Patient	MR#	Form	Form Date	User	Date Created	Date Sent to Office	Date Modified	Agency
Test Patient, Orientation	000000101	SKILLED NURSING ASSESSMENT AND PROGRESS NOTE	01/24/2020	Best, Nurse Ever (RN)	01/24/2020 11:40 AM MST		02/04/2020 09:11 AM MST	TCPS

Showing 1 to 1 of 1 results

Shared

Completed

Patient	MR#	Form	Form Date	User	Date Created	Date Sent to Office	Date Modified	Agency
Test Patient, Orientation	000000101	SKILLED NURSING ASSESSMENT AND PROGRESS NOTE	01/22/2020	Best, Nurse Ever (RN)	01/22/2020 03:42 PM MST		02/04/2020 09:25 AM MST	TCPS

Showing 1 to 1 of 1 results

Use the Activity Log on the DeVero home screen to verify that your note was successfully sent to the office

After you send your note to the office, your note will move to the completed section. Check completed and click Go to view.

Patient Schedule

Home

(Select a Patient) Patient Profile Patient Chart Patient MAR Patient Schedule

NOTE: This section is for starting new forms for a patient.

The patient schedule option can be found on the home page. You can easily see all opened forms by date and time. It is a good idea to check the patient schedule view to ensure that in/out times have been documented as intended, and there are no overlaps with other visits (including other disciplines).

			05/01
VP	7:00 AM	-	8:00 AM
VP	6:00 PM	-	7:30 PM
VP	8:30 PM	-	9:30 PM

If you hover over the visit box you will be able to see if your form is in the correct status (if you see a form in pending or in to be corrected statuses that means that the form has not been submitted for processing). Form status can also be seen from your home screen.

Filters

Agency

(Select an Agency)

From To

11/14/2016 - 12/12/2016

Date Filters

- Form Date
- Date Created
- Date Sent To Office
- Date Modified

Form Statuses

- [x] To Be Corrected
- [x] Pushed Forms To Sign
- [x] Pending
- [x] Shared

To Be Corrected

Patient	MR#	Form	Form Date	User	Date Created	Date Sent to Office	Date Modified	Agency
No matching records found								

Showing 0 to 0 of 0 results

To Be Signed

Patient	MR#	Form	Form Date	User	Date Created	Date Sent to Office	Date Modified	Agency
No matching records found								

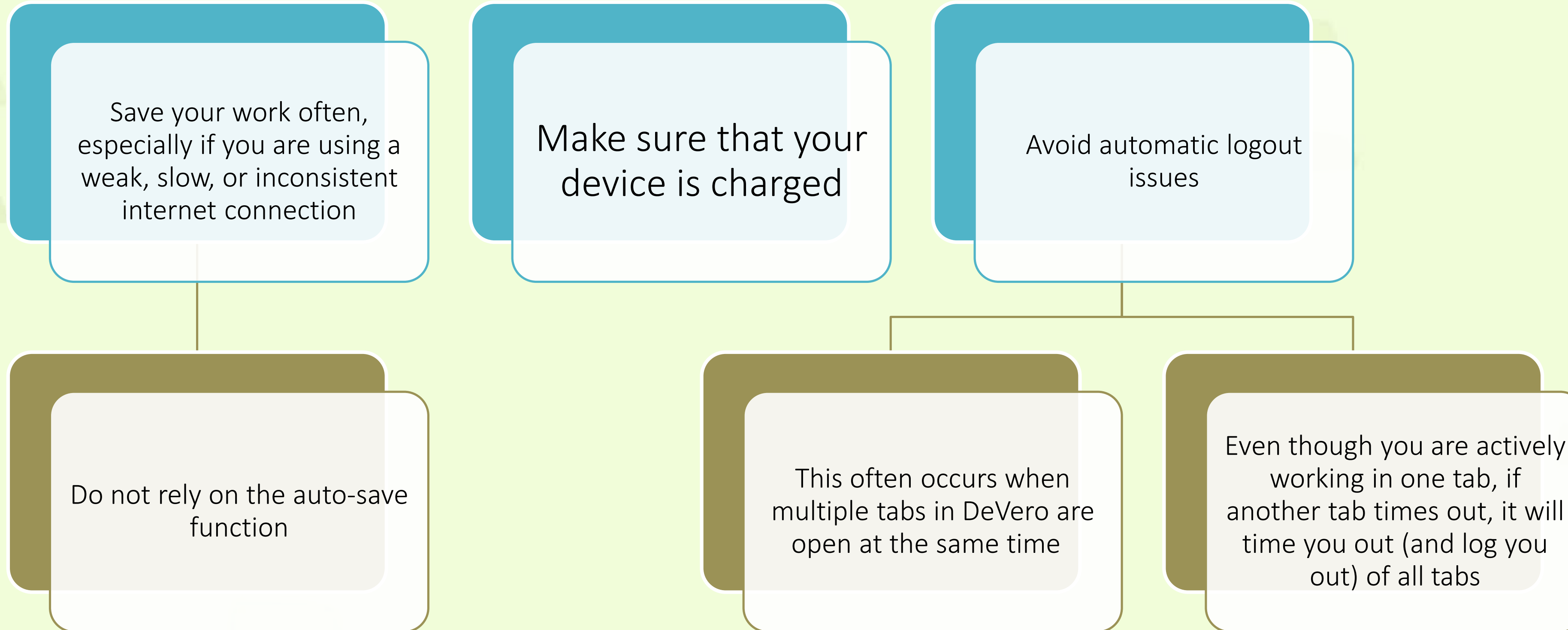
Showing 0 to 0 of 0 results

Pending

Patient	MR#	Form	Form Date	User	Date Created	Date Sent to Office	Date Modified	Agency
Patient, Test	000000003	HHA Patient Missed Visit	10/18/2016	Huner, Amanda (CNA)	10/18/2016 03:27 PM MDT		11/29/2016 11:51 AM MST	TCPS

Corrections

- ✓ Check the to be corrected section on the DeVero home page every day you work
- ✓ Address corrections within 24 hours of notification and send the note back to the office (notifications sent through Tiger Connect).



Tech tip: avoid losing your work

#OnTimeEveryTime

Documentation expectations, goals, and tips

#OnTimeEveryTime

The following section will review:

- Documentation deadlines
- When late charting will be allowed
- Agency-wide documentation goals for nurses
- Peer tips – submitted by nurses
- Who to contact if you need help to work through issues

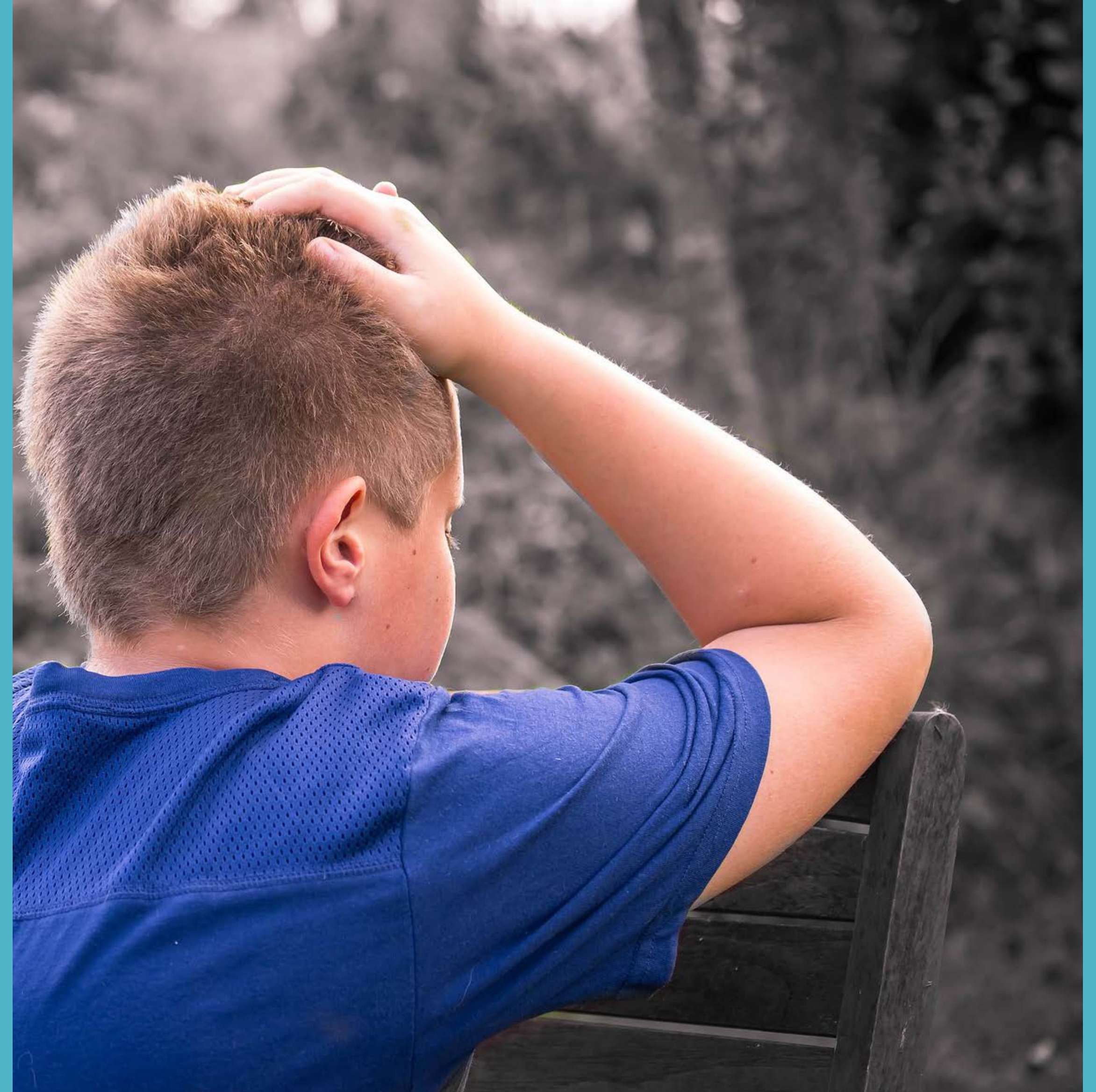
Tender Care is here to **support** you.

Review the following section about documentation deadlines. This includes important policy changes that will go into effect on

March 1, 2020.

Do not wait to contact someone for help if you have any questions or concerns about the requirements listed.

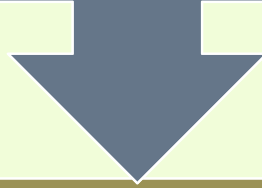
If you have concerns, please understand that you are not alone. We are here to help. Our Mission is to remain a sustainable business for years to come so **WE can all be here to support the very special children we serve.**



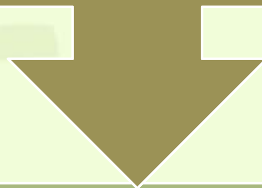
Letter to families

[Click here to learn how we are working with families to support you]

Notes need to be sent to the office at the end of your shift

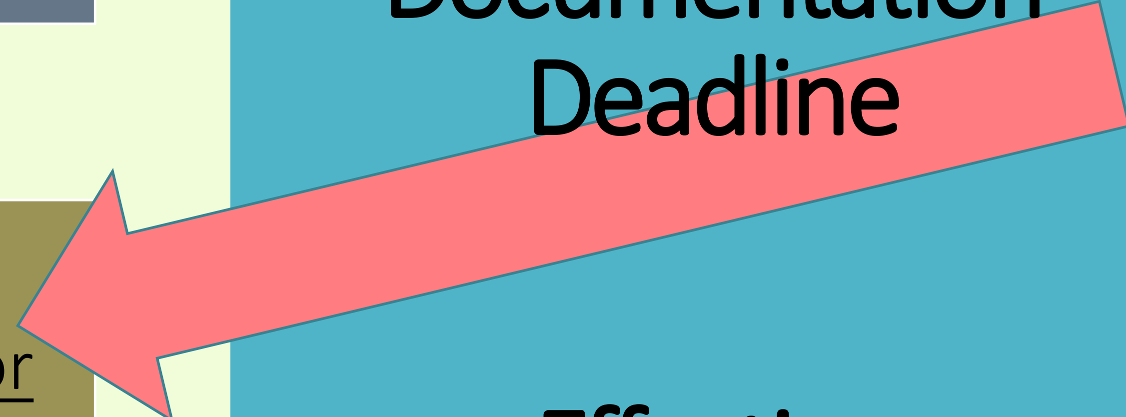


You will not be paid for shifts worked if your visit note is sent in late without prior approval



TCPS will not bill payor sources when documentation is submitted late without prior approval

Documentation Deadline



Effective
March 1, 2020

Extensions

1. You must have a qualifying event

AND

2. <u>Call</u> the office by the end of your shift (970-686-5437)

Note: after hours calls will be received by the on-call RN Case Manager

Emergent patient care needs

Change in patient condition requiring additional interventions and you cannot stay late to finish documentation due to other obligations

Technical issues

internet unavailable, broken device, DeVero is down through the end of shift

<u>documentation should still be completed on a paper note and left in the home</u>

Employee emergency which requires sudden leave

Other unforeseen circumstances

see additional information on next slide

Examples of Unforeseen Circumstances

Acceptable reason to request an extension:	Situations that do not qualify for an extension:
Transportation issue while out with patient (car accident, extended delay in return due to traffic)	I had a busy shift and need to sleep before I finish my documentation
Patient appointment ran late, returned past the end of scheduled shift and impossible for nurse to stay to finish charting (need to pick up his or her own child, etc)	Demanding/active child, extensive time at bedside (not related to emergent patient care needs)
My patient required additional cares due to a change in condition and I cannot stay late to finish charting because I have an appointment to get to	The family wants me to leave right away but I am not finished with my charting
I was injured, had a personal/family emergency and need to leave unexpectedly	I handed off care to another nurse and haven't finished my documentation

I have had a qualifying event and cannot stay to finish my documentation, what do I do?

Call the office 970-686-5437 to relay your qualifying event

You will still need to ensure that the Bullet Point Shift Report and MAR have been completed

You will have an additional 24 hours to complete your documentation and submit the note to the office

What if I must go and cannot complete the BPSR or MAR?

- These areas are vital to patient care and must be completed
- Call the office to report your qualifying event and relay that your documentation will be late
- You will need to report details to another nurse in the office who can complete the BPSR on your behalf
- You will still need to review, complete, and submit your documentation within 24 hours of the end of your shift

Due to the nature of my scheduled visit, I regularly have trouble completing my visit note by the end of my shift, what do I do?

Contact the patient's case manager or a clinical manager right away (before the end of February) to relay the issues that you face.

We will work together to see what solutions are available.

What happens if I do NOT have a qualifying event and I submit my documentation late?

Starting the week of March 1, 2020, **you will not be paid for late documentation** unless you have called the office to report a qualifying event.

This would affect paychecks starting the payday of March 20, 2020.

What if my shift is over and I haven't finished my documentation?

Unless you have gotten an extension, you will still need to submit your documentation before you leave the patients home

If you have reported off to another nurse, the time out on your SNAP Note should reflect the time that you stopped caring for the patient

Submit additional time spent on documentation after the patient handoff as admin time via the Payroll Extra Items form

Admin time is reviewed

TCPS will work with clinicians who frequently submit admin time to review the shift and provide support as needed

Goals

- ✓ 80% of PDNs will submit visit notes at the of end of shift by March 31, 2020 (without the need for an extension).
- ✓ 95% of PDNs will submit visit notes at the end of the shift by May 1, 2020 (without the need for an extension).

Current status:

For the week measured, 77% of nurses submitted notes by the end of their shifts.

Peer tips for success

"I have to make time for it. Sometimes the patient wants attention, but I know that the charting is important and needs to get done. I try to set up activities for the patient then get charting completed while also supervising the activity. I try to complete sections of charting for 10-15 minutes every few hours instead of charting the whole shift [at once]."

Peer tips for success

"Continued commitment on my part."

"I write my vs and bm info at the beginning of the shift and then do the bulk of my charting at 2030 when the [patients] are in bed or during feeding or nap times during the day. I work quickly and efficiently . . "

"I make notes, if needed, then stay a few minutes after to chart what I couldn't. You can even ask the family if they mind taking over for a few minutes while you chart."

"I do my best to chart as often as I can through out the day and when there is a therapy appt I get a lot of it done."

Peer tips for success

"Open note at beginning of shift, start filling in assessment, check routine boxes. I like to chart every 1 to 2 hours if possible, 10-15-minute increments at a time when I get a free moment. Narrative and BPSR takes me the longest to complete. Multiple charting in different areas makes it take longer for me also. I like to have a majority of my narrative complete at least an hour prior to the end of my shift, that way I can just fill in BPSR and remainder of what needs to be noted/checked."

Tender Care is here to **support** you

It is important that you understand the documentation expectations that apply to your job. There are tools and resources available to help you perform your job to the best of your abilities. If you have questions, frustrations, concerns, or challenges you don’t know how to overcome, **call your patient’s case manager or your direct supervisor so that we can work together to navigate the challenges you face.**

Resources

Visit the employee portal to access policies and forms

http://www.tcpskids.com/employee

Password: tendercare

Employee FORMS

Policy and Procedure

Employee Forms

Payroll Extra Items Form

Employee Time Off Request

Policies and Procedures

Includes:

Clinical Records Policies

Client Care Policies

Infection Control & Prevention

Emergency Preparedness

Complete Part 2:

Due February 19, 2020

Please locate a separate email sent from Heidi Dailey <echosign@echosign.com>

Open the link in the email and review the revised policies

Follow the instructions to electronically sign the policy acknowledgment and revised PDN job description

References

Skilled Nursing Assessment and Progress (SNAP) Note Protocol. Tender Care Pediatric Services. Rev. 2/2020.

PDN Documentation Checklist. Tender Care Pediatric Services. Rev. 2/2020

Do Not Use Abbreviations/Symbols. Tender Care Pediatric Services. Rev. 2/2020

Protocol for making Corrections to the Clinical Record. Tender Care Pediatric Services. Rev. 2/2020

Timeliness and Accuracy of Clinical Documentation. Tender Care Pediatric Services. Rev. 2/2020

Colorado Department of Health Care and Policy and Financing. *Electronic Visit Verification.* Accessed on January 30, 2020 https://www.colorado.gov/pacific/hcpf/evv.