CHARTING

Examples for Better Charting

1. Infection control completed, wiped equipment, wiped bed and floor with antibacterial/antiviral agent, patient currently stable with no s/s infection.
2. Incontinence Care administered. Dermal assessment completed. No s/s of infection or dermal irritation.
3. Patient has decreased attention span. Patient watching age appropriate developmental stimulation for approximately 15 minutes. This is approximately 5 minutes more than observed on 5/5/19.
4. Respiratory assessment completed. POX reading. POX probe rotated to left great toe. Vitals stable. No s/s of respiratory distress.

Examples for Better Charting

5. GB feeding administered. No abdominal distention. Feeding tolerated well.
6. Scheduled medication administered via GB. Patient tolerated well.
7. PRN Nebulizer treatment administered as ordered for increased congestion and course rhonchi. CPT performed for approximately 5 minutes. Trach and oral suction performed and pt. tolerated well. Patient's breath sounds improved in all lobes. Remain improved when reevaluated 30 minutes post treatment.

Examples for Better Charting

8. Patient at risk for safety secondary to medical condition. Evaluated patient's environment and no changes needed at this time.
9. Patient unable to reposition. Repositioned from left side to right side and utilized pillow between knees and low lumbar to facilitate comfortable positioning. Dermal assessment of potential pressure areas completed. No s/s of irritation or dermal complications.

More details about charting

- Each entry must have a line drawn to the end of the space and your initials as well as your credentials written at the end of your entry. There may not be any “open” spaces in your note where someone could document/change your note after you have finished.
- Indicate who you gave report to at the end of your shift as well as the condition of the child after you completed your last full assessment and vitals.
- Your entire first and last name plus credentials must be written at the very end of you documentation to close out your note.
- Do not document incorrect times to try to gain an extra few minutes. If you are not working, you are not charting. If caught, this can be considered Medicaid fraud and may be grounds for disciplinary action.

Suction, Seizure and Vent Logs

I know…we don't like them either, but guess what?…. The state does…

- **Suction logs** are crucial for hour approval. Be clear, accurate and thorough. Many of you do a great job with this. KEEP IT UP! ☺
- **Seizure logs**. Icon nurses are not so great at this one. They are a pain, but they are important. Please complete them and send them in with your notes each week.
- **Vent logs**. There is a date section at the top of the page. COMPLETE IT PLEASE. Overall, Icon nurses do a great job with these logs. Please keep it up!
- Nurses often voice that they do not have time to properly document. You have only one patient. Garry's popular saying is, *"If you cannot do it in the hospital, then you cannot do it for me."* ICU nurses, Life Flight Nurses and Floor Nurses with multiple patients, get their jobs done and chart properly. You can too. If you do not, there is a really good chance that the patient's lost hours will come back on you.

Medication Administration Records (MARS)

- On the first signature page, make sure that your shift times are the exact times that you clocked in and out on your nurses' note. They must match!
- Medications must be administered within the hour (30 minutes before and 30 minutes after) they are scheduled. If they are consistently not given on time, we need to revisit the timing of the medications with the parents.
- Every box must have the time that you administered the medication, the units that you gave (ml, tabs, caps, ampules etc) as well as your initials. YOU ARE RESPONSIBLE for every medication, feeding, treatment, etc ordered by the physician during your shift. IF YOU DO NOT ADMINISTER, then who did? This section cannot be left blank. "Mom" and your initial if the mother administered is a good example of what should be in there if you did not give the medication.

Weekly Updates and Communication Book

- Coordination of care is mandatory per DADS requirements.
- Weekly updates are mandatory. One Weekly update per patient is required and multiple nurses can document and sign on the same form. Changes in condition, MD appointments, future MD appointments, etc. must be documented. It is just as important to check “no change” and sign. A reduction in hours is not supposed to be allowed without a change in patient condition. Your documentation of “no change” makes it more difficult for them to reduce hours on a stable child. If this is not done during the course of the week, the nurse working the last shift of the week is responsible for completion. This should be a team effort and the more nurses utilizing this form, the better.

Weekly Updates and Communication Book

- The Communication book in the home is important as well. This is how nurses coordinate and communicate with each other. PLEASE INITIAL THE ENTRY/ENTRIES of the other nurses. This simple act goes a long way in confirmation of communication while ensuring coordination and continuity of care.
- It is a great way to reference status of the patient during previous shifts without referencing the previous nurse's notes and trying to remember every single detail you received in your report.

Assuring We Keep Working

- If the hours are cut, your hours will be reduced or eliminated. You may be out of a job.
- Be the professional nurse that you are and document well.
- NO EXCUSES, take responsibility for your actions.
- As an agency, we are only as good as each and every one of you. Be the best you can be!!
- We are withholding a great reputation in the industry. Let's keep it going team!!

Assuring We Keep Working

- Lastly, the managed care agencies are requiring that we submit the latest AVS (After Visit Summaries) from each of their MD visits (PCP as well as Specialists) with each PDN renewal process. Please get a copy of those to the office ASAP. (You may also send in the original with a note to copy one for the home and we will send it back to the home with the following week's MAR).
- If we do not submit one of the requested items that the Managed Care agencies ask for within the 12 to 24 hour window they provide us, the hours will immediately be denied forcing the Fair Hearing Request and Appeal by the Parents.

Assuring You Get Paid On Time

- You must have your notes completed and ready for pickup by Monday morning each week. THIS HAS BEEN A MAJOR ISSUE.
- If you are mailing them in, get them in the mail Monday please.
- For those mailing them in, please email a photo of the 1st page of the nurse note as well as the first and last page of your progress notes. This helps us to verify that the time you charted in and out are correct.
- If your notes are received in the office after 4:00 on Tuesday, you will not be paid for those hours until the following paycheck.

WARNING!!

- DO NOT PRE-CHART any part of your nursing assessment, your narrative, your MAR or your logs.
- If for any reason, you must leave your shift abruptly, you gave proper report and assured adequate care for the child then had to leave without finishing your charting, it must not be noted that you completed your documentation ahead of time. If so, this will be considered MEDICAID FRAUD and will be grounds for disciplinary action.