Documentation

Approval Process for PDN hours

- The authorizing agencies continue to look for ways to decrease services. Accurate and concise patient specific documentation is the primary focus for PDN authorized hours.
- We must submit 10-14 days of consecutive nurse notes, MARS, suction logs, apnea logs and seizure logs with EVERY PDN renewal. This means that your notes no longer MIGHT be sent, THEY WILL BE SENT.
- Your documentation notes are being looked at by many professionals at the insurance health plans. So make sure your charting is on POINT!!

Your Documentation Requirements

- YOU ARE DOCUMENTING TO KEEP YOUR JOB!!!
- If hours are cut for these children, make sure it was not because you did not do your job!
- It is MANDATORY that you chart fully and completely for your entire shift and do it well. **THIS MUST BE IN BLACK OR BLUE INK ONLY.**
- Write legibly and on one single line at a time. Do not scrunch an extra line into the space to save paper. Remember. We are now having to fax your notes to the state and that can make them very blurry.
- Your name and credentials must be at the top of the first page of the Nurse's note and on the top of each page of your progress note.

Your Documentation Requirements

- Your time in and out and your total time must be completed every single shift and must be the same as your initial time and your final time on the progress notes.
- Your time in and out should also be correct. So many unnecessary phone calls, both to you and the parents, about confirming times every week can be avoided this way.
- The correct date is a must too. I know most of us have cell phones. If you don't know the date, look it up. It is a nightmare putting notes in order when the dates are wrong.
- Caregivers must sign your notes before they are turned into the office. This confirms to the office and ultimately the state that you truly worked the hours you charted.

Vital Signs and Narratives

- Vital signs must be completed within 30 minutes of the start and 30 minutes of the end of your shift with Q4 vitals completed in between.
- The Input and Output section must be totaled at the end of your shift.

YOUR NARRATIVE - PLEASE REMEMBER THE FOLLOWING!

- Document the exact time you took over care.
- All of your times for your entries must be at the left side of the page under the section that says “TIME”. Please do not put times in the body of the narrative. This becomes messy.
- Document who you received a full report from and what condition the child was in when you received him/her.

Vital Signs and Narratives

- At both the beginning and end of your notes, state that you completed a full assessment and hit on some key elements about your assessment that reflect the medical care that the child requires. (Respiratory, GB, Neuro-seizures etc).
- With every treatment, medication, feeding, activity and anything else that you do with your patient, state how he/she tolerated it.
- Give small details about what you do with the child all day. What stimulation you provide, activities you engage in etc.
- Charting must be minimally Q2 hours. You may chart more often, but there should NEVER be longer than a 2 hour span between entries.
- EACH 2 HOUR ENTRY MUST HAVE A MINIMUM OF ONE NURSING ASSESSMENT DETAILED!
- According to the state, the only things that differentiate a nurse from a caregiver are assessments and documentation of those assessments.

Patient Specific Documentation Guidelines

- In an effort to make documentation more patient specific, the Case Managers will be providing specific guidelines for each of your patients that will be sent to each home.
- If the bullet points provided do not cover all of your patient's care needs as your assessments are most current, make the necessary changes on the guideline forms and contact your CM to make the corrections on our paperwork.
- Staff nurses and Case Managers will coordinate together to identify changes and update the patient specific guidelines.