DOCUMENTATION

Insightful In-services September 2023

Clinical Supervisors

Electronic Charting

- The **Visit Note Portal** is the required method for clinical charting and submission of all clinical documentation (i.e., "visit notes").

- Visit Documentation should be submitted within 48 hours of the visit.
- No BATCH submitting (i.e., submitting multiple visits over several days old on Saturday night prior to payroll deadline on Monday)
- Visit confirmation via Teams (from the Care Coordination staff) will include the foundational instructions including the importance of whether it is a SOC or not and if additional/supplemental documents are required. It will also include a link with more detailed step-by-step instructions.
    - If not sent this information, please ask.
    - Compensation for each visit is dependent upon accurate and timely submission of documentation per these instructions.
- Admission visits should be no less than 1 hour of visit time.
- Follow-up visits should be no less than 30 minutes of visit time.

PAPER CHARTING

While electronic charting is the **required** method for charting, paper documentation is accepted ONLY when circumstances prevent / limit the use of technology.

Paper documentation must be submitted (uploaded) via the portal following the **guidelines & requirements** set forth in the documentation instructions sent with your visit confirmation.

*It is important to **maintain *paper copies of visit note forms in your Supply Kit*** to use in emergency situations where electronic charting is not accessible. Request paper documentation copies on the online request form.*

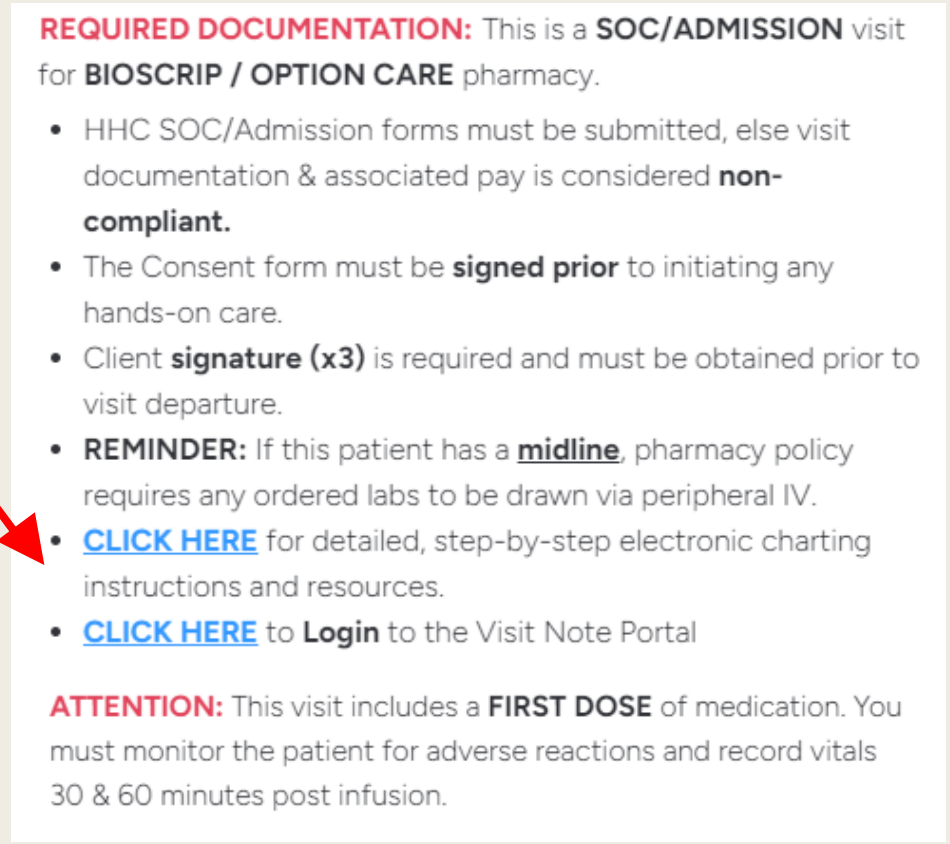
PAPER CHARTING GUIDELINES

WARNING: Charting on paper is only accepted for the following conditions:

- You are a legacy HHC nurse (hired 2021 & prior) with grandfathered approval to continue paper charting under strict guidelines - with the understanding that repeated failure to comply with these guidelines will result in loss of paper charting privileges.
- Device failure and/or unavailability of cellular service. In the event the charting device loses cellular signal, battery or fails to operate for the purposes of charting in the home, paper copies of HHC standard documentation should be available in the car kit at all times. This should be a backup option for **rare** occasions only.
- The requirements for paper charting are listed on the HHC Resources website. In case of a situation where paper charting is used, review the guidelines to avoid corrections or non-compliant pay. Paper charting must be thorough, accurate, legible and without shadows.

CREATING PATIENT

- When the CC confirms the patient visit, the confirmation will include instructions and an additional link if further details are needed.
- Create the patient, making sure **DOB** and **VISIT DATE** are entered correctly.
- It is **VERY** important to carefully read the Confirmation blurb as it includes any special instructions (i.e., first dose, pharmacy forms that must be signed, etc.)



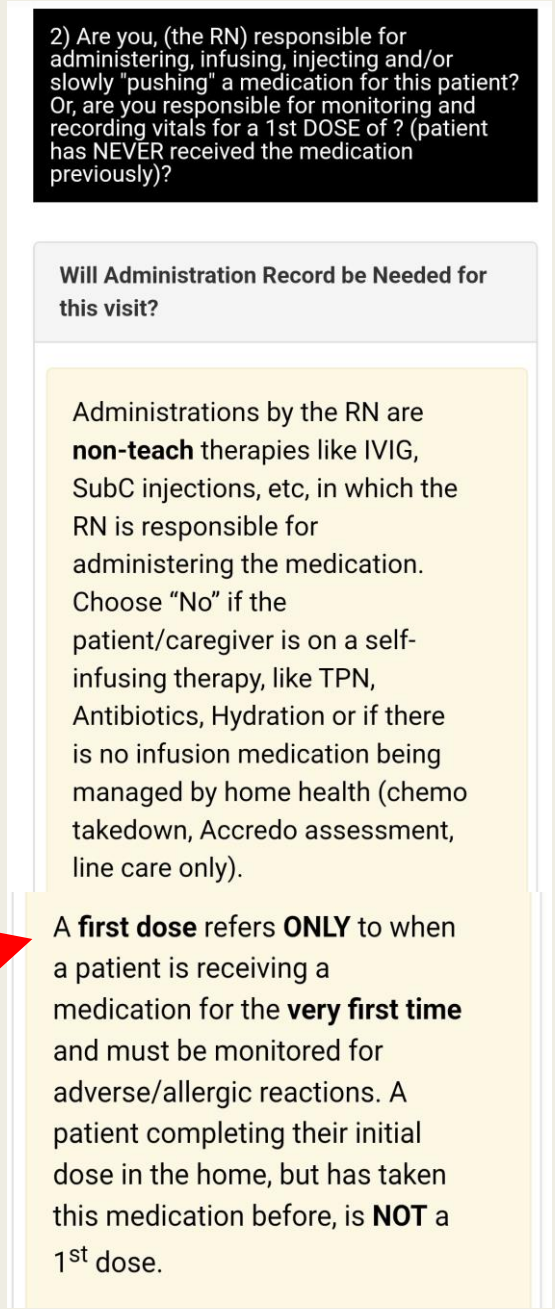
REQUIRED DOCUMENTATION: This is a **SOC/ADMISSION** visit for **BIOSCRIP / OPTION CARE** pharmacy.

- HHC SOC/Admission forms must be submitted, else visit documentation & associated pay is considered **non-compliant.**
- The Consent form must be **signed prior** to initiating any hands-on care.
- Client **signature (x3)** is required and must be obtained prior to visit departure.
- **REMINDER:** If this patient has a **midline**, pharmacy policy requires any ordered labs to be drawn via peripheral IV.
- CLICK HERE for detailed, step-by-step electronic charting instructions and resources.
- CLICK HERE to **Login** to the Visit Note Portal

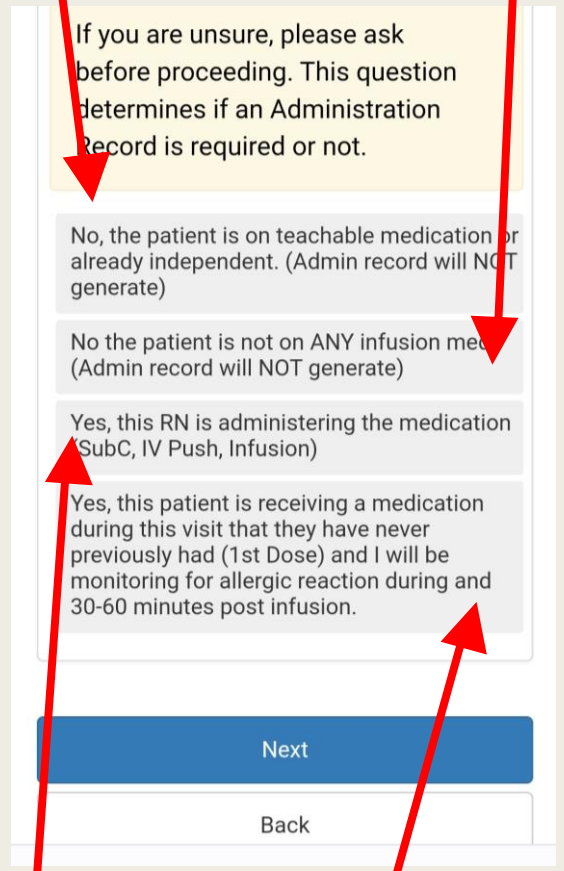
ATTENTION: This visit includes a **FIRST DOSE** of medication. You must monitor the patient for adverse reactions and record vitals 30 & 60 minutes post infusion.

VERY IMPORTANT

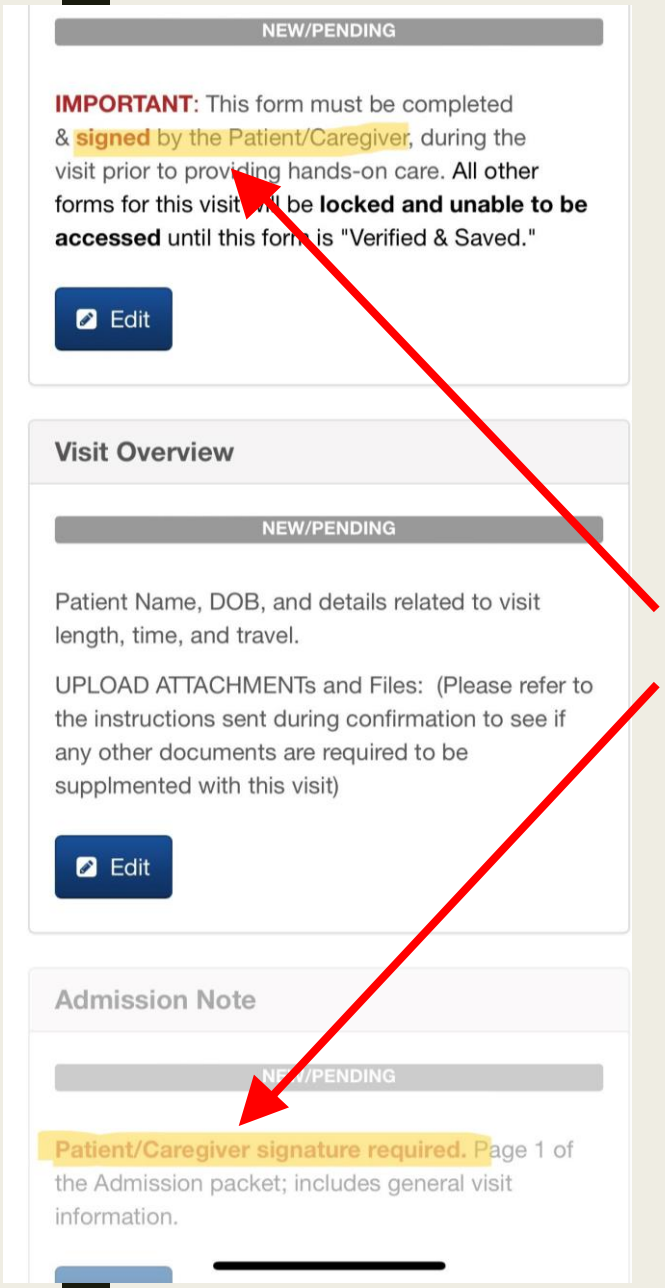
- When creating patient, after choosing whether the visit is a SOC or Not, Question 2 asks whether the visit is a teach, patient is not on any infusion, RN Administration or 1st dose.
- What is chosen here will determine what is populated in Logiforms to fill out.
- VERY IMPORTANT to make the right choice.
- FIRST DOSE is clarified.



Administration Record will NOT generate.



Administration record will generate.



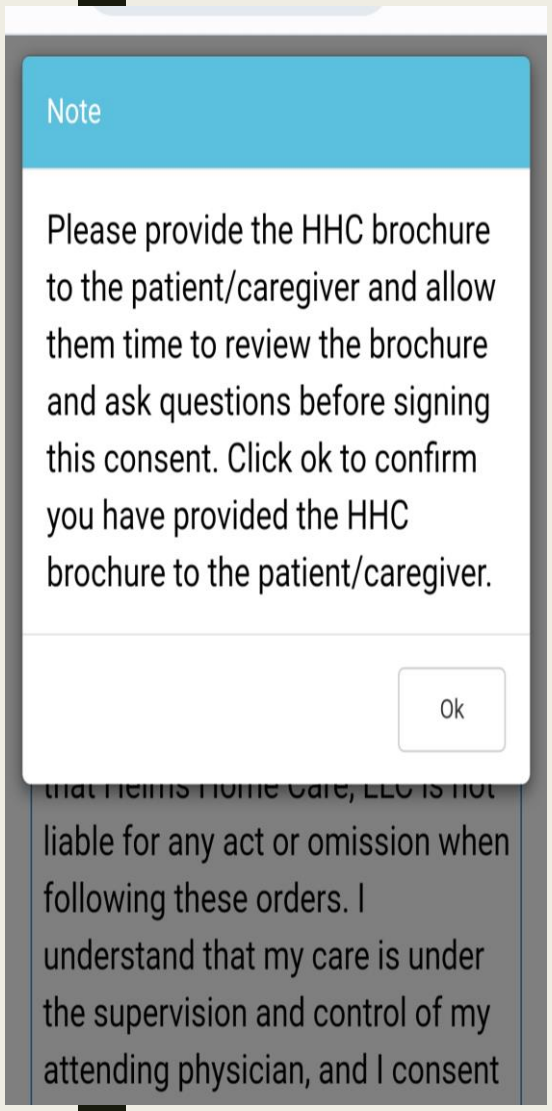
SOC (START OF CARE)

Important:

3 signatures are needed BEFORE leaving the patient's home, (this must be the patient or caregiver's signature)

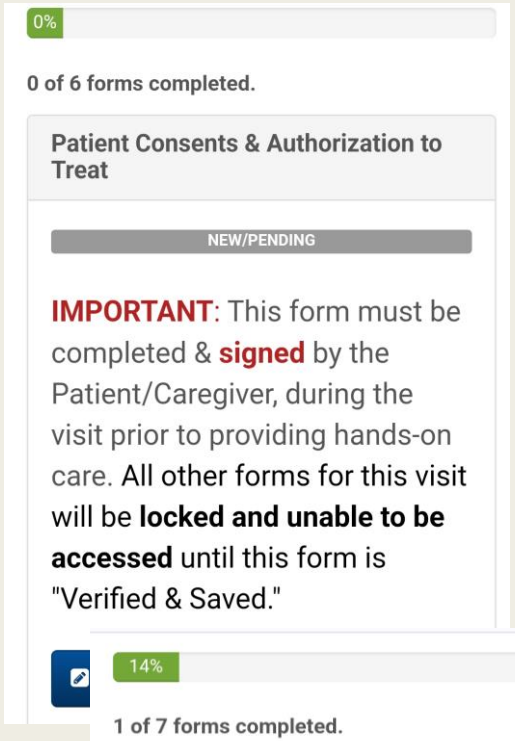
- each section that requires a signature is identified in bold/red in the description of each section
- If for any reason a patient cannot sign, the reason must be documented in the narrative
- If a caregiver signs they must sign **their** name – **NOT** the patient's name
- A nurse signing a patient's name is considered a forgery and can lead to loss of nursing license

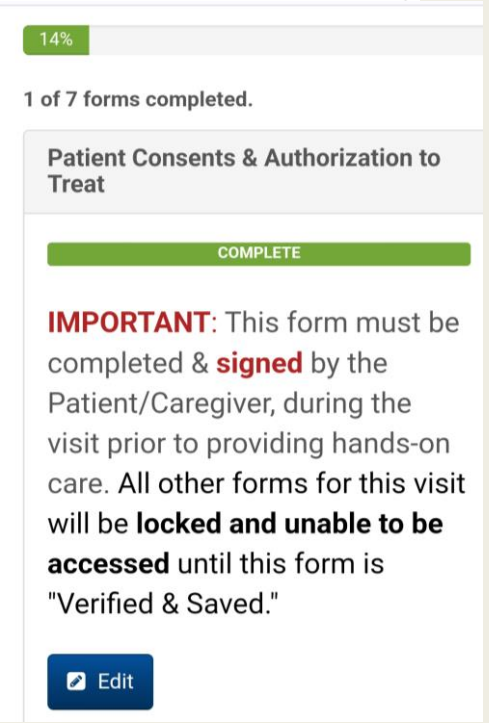
CONSENT FORM



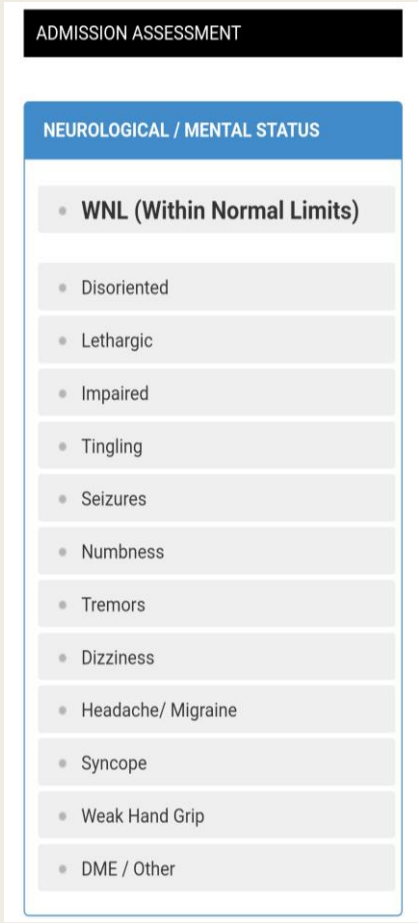
- Consent form is the **FIRST** thing to be done after introducing yourself to the patient and washing your hands.
- Remainder of SOC paperwork is locked, and CAN NOT be accessed until Consent is filled out.
- DO NOT TOUCH patient or supplies until the Consent is signed.
- If patient does not have an Advanced Directive, fill out an emergency contact name and phone number
- If the visit is not completed for any reason, the SOC paperwork, including the Consent **MUST** be filled out and signed.
- PROVIDE the HHC brochure to patient and allow them time to review and ask questions before signing the consent.

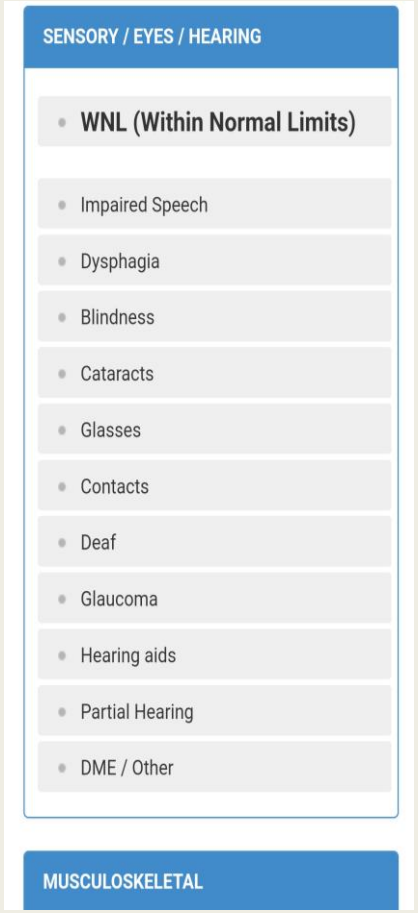
DO NOT leave the home until the SOC paperwork is completed.

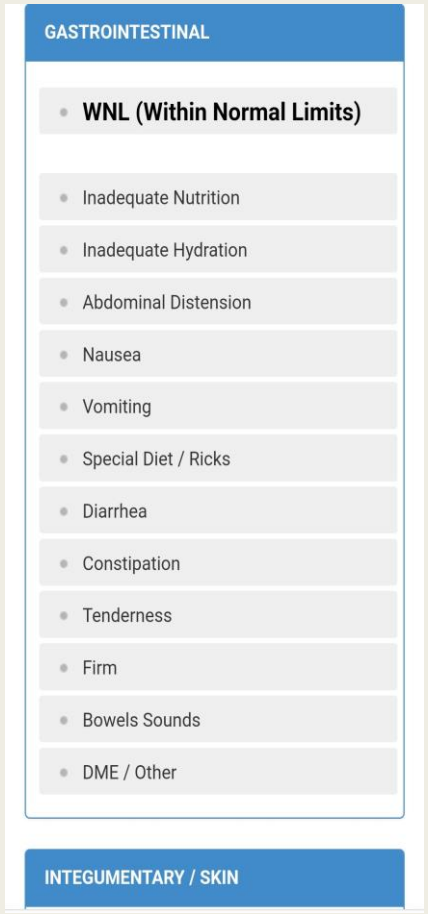


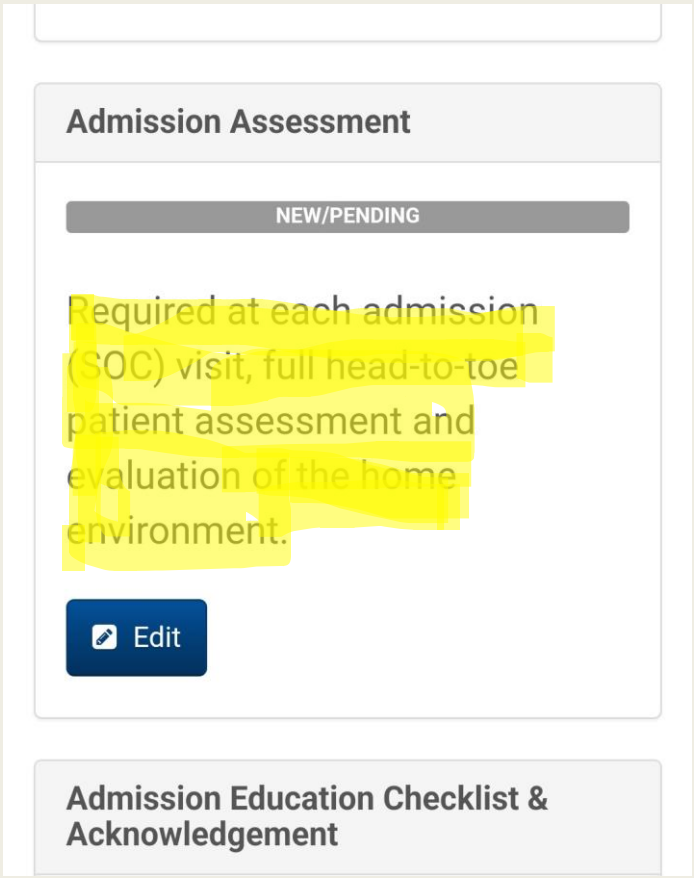


ADMISSION ASSESSMENT



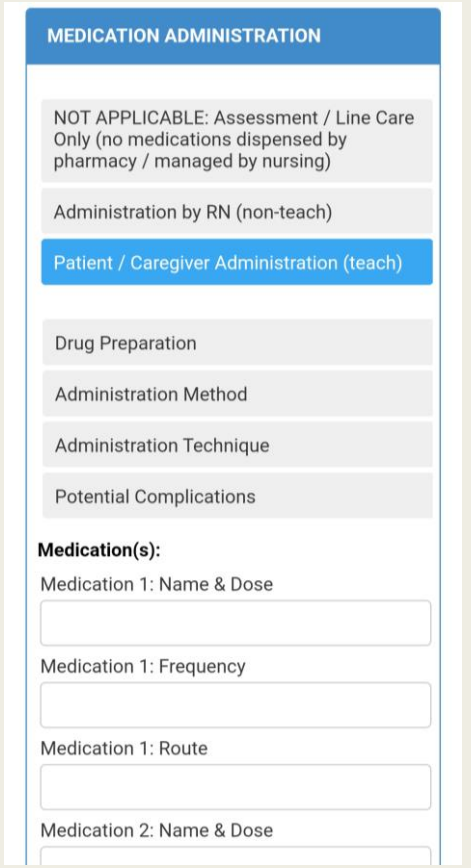


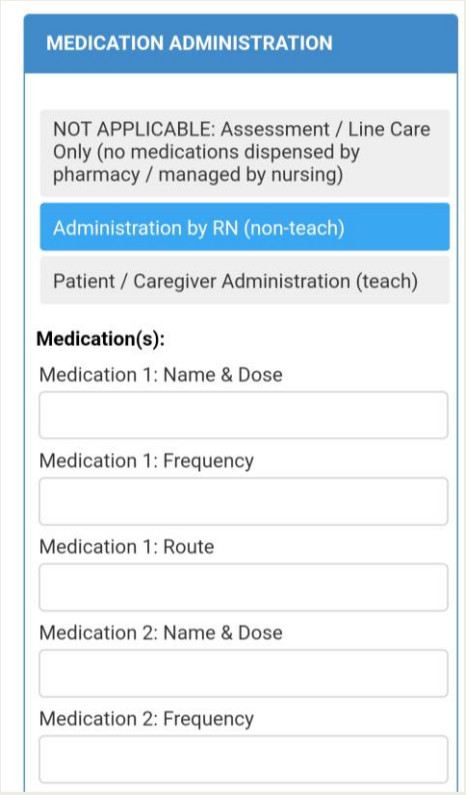




Admission Education Checklist & Acknowledgement

- This is one of the three sections that REQUIRES a patient signature.
- If visit is a patient teach the Release of Direct Supervision must be checked.
- Depending on what is chosen in this field, will determine what is populated.
- NOT APPLICABLE should ONLY be selected if patient is not prescribed infusion medications (i.e., TPN, Abx, Hydration, IVIG etc.) Accredo assessment visits, chemo takedowns and monthly port flushes are the only visits in which medications are not ordered.
- The narrative note should have something that states, *"Patient education elements provided as detailed on Education Checklist"* and note SASH or SAS (as applicable) was taught and the teaching method (i.e., IVP, gravity, CADD pump etc.)

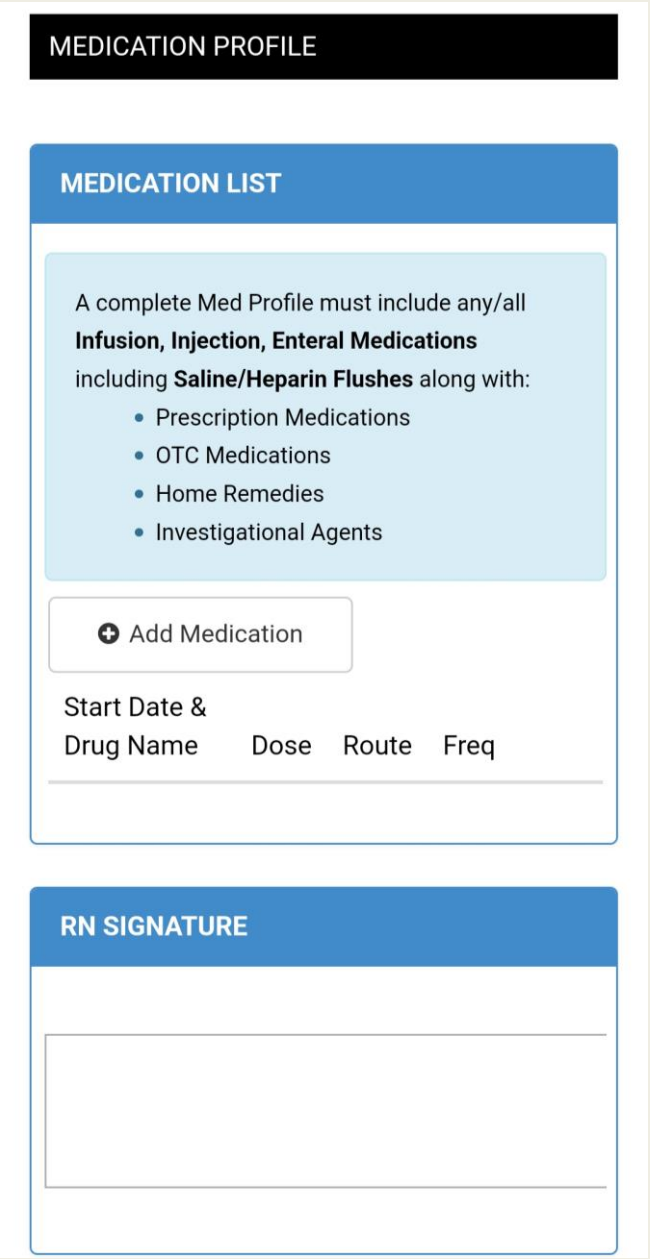




MEDICATION PROFILE

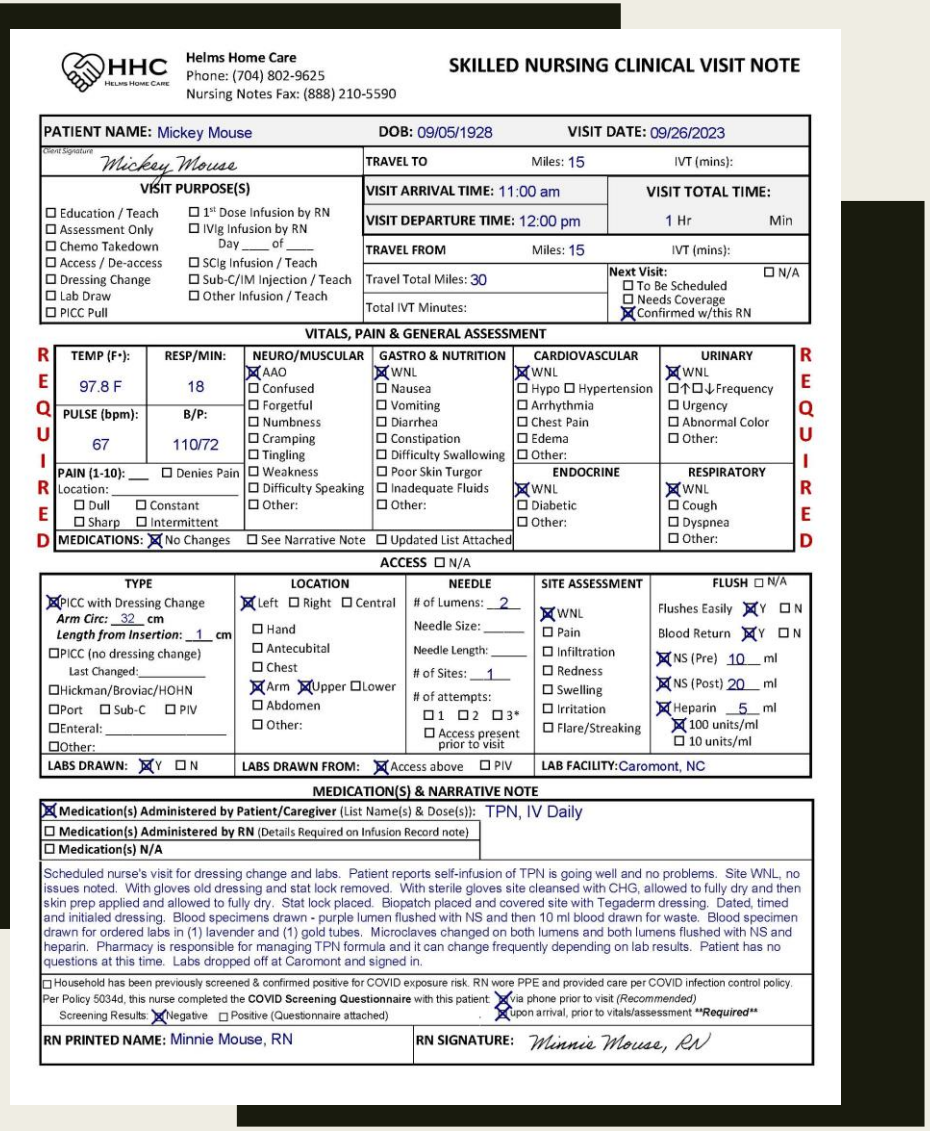
- Include all current medications, prescription medications, OTC medications, home remedies and Investigational Agents.
- Include the therapy that agency is seeing patient for, including Saline/Heparin flushes.
- If patient does not know start date, obtain the approximate year.

DO NOT upload pictures of medication bottles, hospital discharge medication lists or lists from patient.



REMAINING SECTIONS of SOC

- The Clinical Admission Note and the Administration record (if the RN is infusing the medication) are the remaining sections
- The Clinical Admission note is another section that will require the patient's signature.
- The Admission note is very similar to the Visit note. This and the Administration record will be gone over in further detail under the Visit Note section.



Helms Home Care
Phone: (704) 802-9625
Nursing Notes Fax: (888) 210-5590

SKILLED NURSING CLINICAL VISIT NOTE

PATIENT NAME: Mickey Mouse **DOB:** 09/05/1928 **VISIT DATE:** 09/26/2023

Client Signature: Mickey Mouse

TRAVEL TO Miles: 15 IVT (mins):

VISIT ARRIVAL TIME: 11:00 am **VISIT TOTAL TIME:** 1 Hr Min

VISIT DEPARTURE TIME: 12:00 pm

TRAVEL FROM Miles: 15 IVT (mins):

Travel Total Miles: 30

Total IVT Minutes:

Next Visit: ☐ N/A
☐ To Be Scheduled
☐ Needs Coverage
☒ Confirmed w/this RN

VISIT PURPOSE(S)

☐ Education / Teach
☐ Assessment Only
☐ Chemo Takedown
☐ Access / De-access
☐ Dressing Change
☐ Lab Draw
☐ PICC Pull
☐ 1st Dose Infusion by RN
☐ IVIg Infusion by RN Day ____ of ____
☐ SCIg Infusion / Teach
☐ Sub-C/IM Injection / Teach
☐ Other Infusion / Teach

VITALS, PAIN & GENERAL ASSESSMENT

REQUIRED

TEMP (F°):	RESP/MIN:	NEURO/MUSCULAR	GASTRO & NUTRITION	CARDIOVASCULAR	URINARY
97.8 F	18	☒ AAO ☐ Confused ☐ Forgetful ☐ Numbness ☐ Cramping ☐ Tingling ☐ Weakness ☐ Difficulty Speaking ☐ Other:	☒ WNL ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Difficulty Swallowing ☐ Poor Skin Turgor ☐ Inadequate Fluids ☐ Other:	☒ WNL ☐ Hypo ☐ Hypertension ☐ Arrhythmia ☐ Chest Pain ☐ Edema ☐ Other:	☒ WNL ☐↑ ☐↓ Frequency ☐ Urgency ☐ Abnormal Color ☐ Other:
PULSE (bpm):	**B/P:**			**ENDOCRINE**	**RESPIRATORY**
67	110/72			☒ WNL ☐ Diabetic ☐ Other:	☒ WNL ☐ Cough ☐ Dyspnea ☐ Other:

PAIN (1-10): ___ ☐ Denies Pain
Location: _____
☐ Dull ☐ Constant
☐ Sharp ☐ Intermittent

MEDICATIONS: ☒ No Changes ☐ See Narrative Note ☐ Updated List Attached

REQUIRED

ACCESS ☐ N/A

TYPE	LOCATION	NEEDLE	SITE ASSESSMENT	FLUSH ☐ N/A
☒ PICC with Dressing Change *Arm Circ:* 32 cm *Length from Insertion:* 1 cm ☐ PICC (no dressing change) Last Changed: _____ ☐ Hickman/Broviac/HOHN ☐ Port ☐ Sub-C ☐ PIV ☐ Enteral: _____ ☐ Other:	☒ Left ☐ Right ☐ Central ☐ Hand ☐ Antecubital ☐ Chest ☒ Arm ☒ Upper ☐ Lower ☐ Abdomen ☐ Other:	# of Lumens: 2 Needle Size: _____ Needle Length: _____ # of Sites: 1 # of attempts: ☐ 1 ☐ 2 ☐ 3* ☐ Access present prior to visit	☒ WNL ☐ Pain ☐ Infiltration ☐ Redness ☐ Swelling ☐ Irritation ☐ Flare/Streaking	Flushes Easily ☒ Y ☐ N Blood Return ☒ Y ☐ N ☒ NS (Pre) 10 ml ☒ NS (Post) 20 ml ☒ Heparin 5 ml ☒ 100 units/ml ☐ 10 units/ml

LABS DRAWN: ☒ Y ☐ N **LABS DRAWN FROM:** ☒ Access above ☐ PIV **LAB FACILITY:** Caromont, NC

MEDICATION(S) & NARRATIVE NOTE

☒ **Medication(s) Administered by Patient/Caregiver** (List Name(s) & Dose(s)): TPN, IV Daily
☐ **Medication(s) Administered by RN** (Details Required on Infusion Record note)
☐ **Medication(s) N/A**

Scheduled nurse's visit for dressing change and labs. Patient reports self-infusion of TPN is going well and no problems. Site WNL, no issues noted. With gloves old dressing and stat lock removed. With sterile gloves site cleansed with CHG, allowed to fully dry and then skin prep applied and allowed to fully dry. Stat lock placed. Biopatch placed and covered site with Tegaderm dressing. Dated, timed and initialed dressing. Blood specimens drawn - purple lumen flushed with NS and then 10 ml blood drawn for waste. Blood specimen drawn for ordered labs in (1) lavender and (1) gold tubes. Microclaves changed on both lumens and both lumens flushed with NS and heparin. Pharmacy is responsible for managing TPN formula and it can change frequently depending on lab results. Patient has no questions at this time. Labs dropped off at Caromont and signed in.

☐ Household has been previously screened & confirmed positive for COVID exposure risk. RN wore PPE and provided care per COVID infection control policy.
Per Policy 5034d, this nurse completed the **COVID Screening Questionnaire** with this patient: ☒ Via phone prior to visit *(Recommended)*
Screening Results: ☒ Negative ☐ Positive (Questionnaire attached) ☒ Upon arrival, prior to vitals/assessment ***Required***

RN PRINTED NAME: Minnie Mouse, RN **RN SIGNATURE:** Minnie Mouse, RN

VISIT NOTE

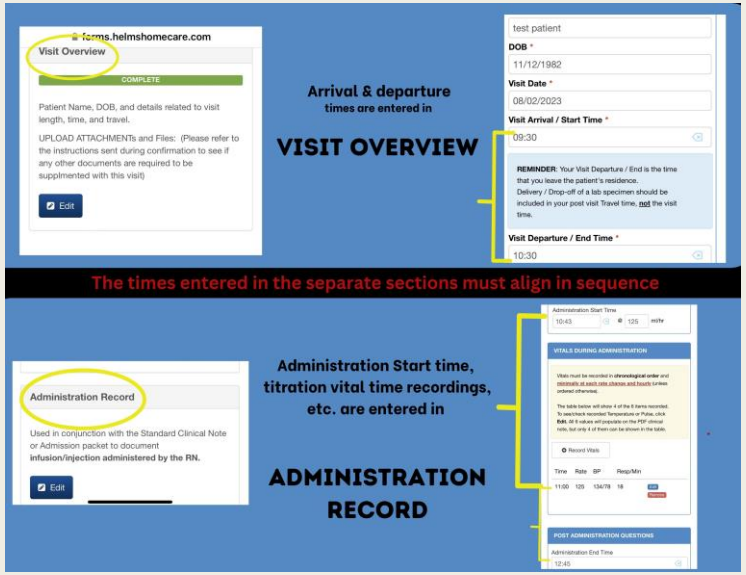
This is a copy of what the pdf will look like once completed on Logiforms.

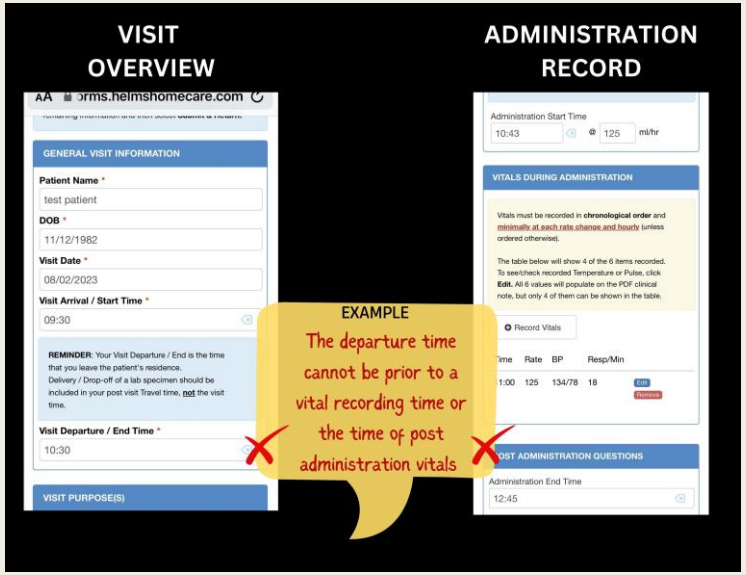
Overview Section

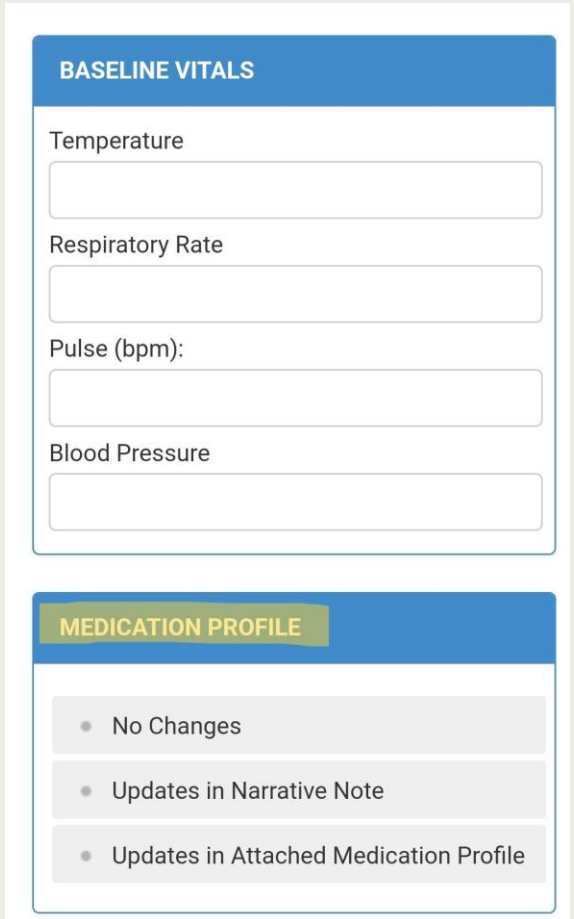
- Arrival and departure times are charted in the Visit Overview section.
- Administration start time, vital sign times and administration end time are charted in the Administration record.
- It is very important to ensure that the ARRIVAL time is BEFORE the start of the infusion and that the DEPARTURE time is AFTER the completion of the infusion.

The times entered in the separate sections MUST align in sequence.

- **Next scheduled visit is charted here -** If the next visit is not scheduled with the patient, the agency MUST be alerted that the patient will need coverage for future visits once visit is completed
- Time and mileage will be recorded here





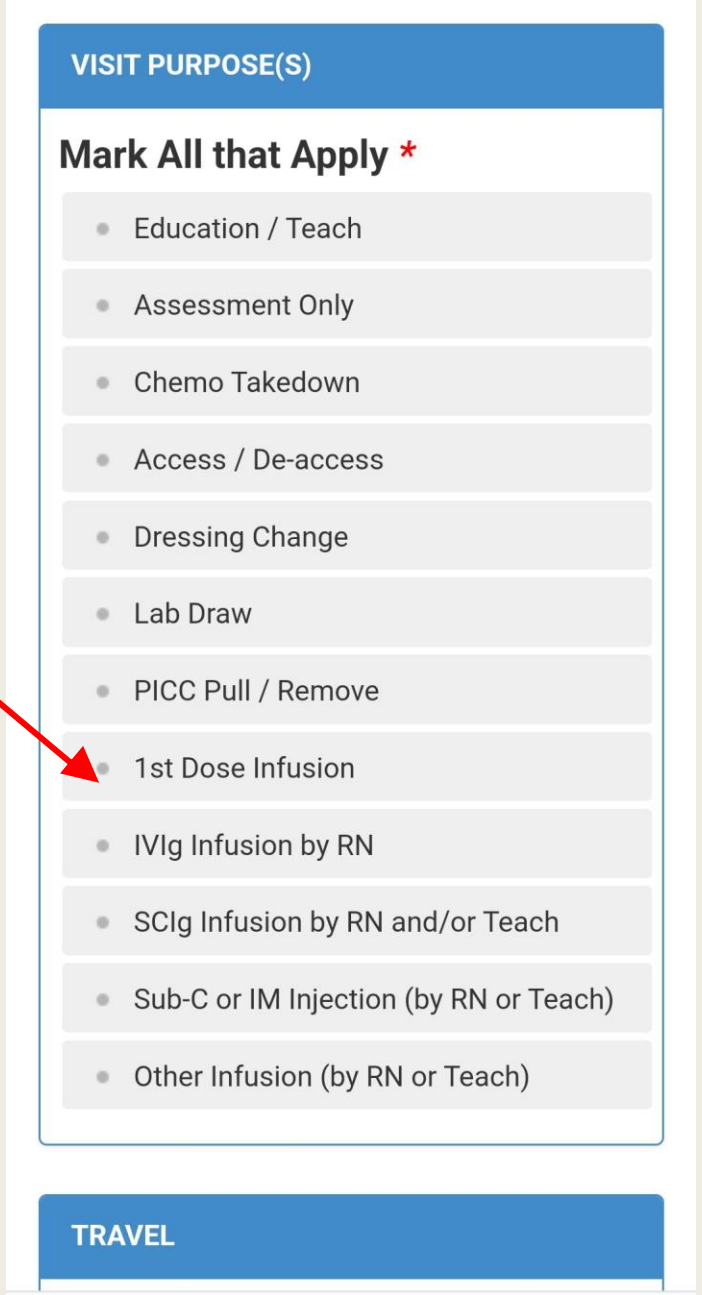


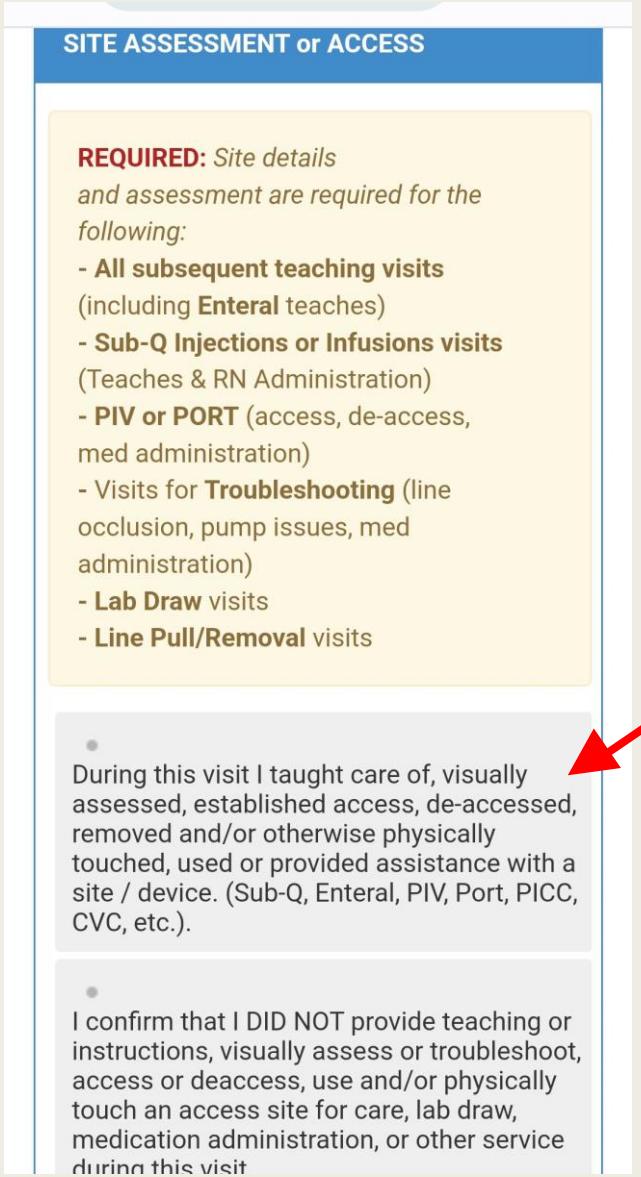
MEDICATION CHANGES

- Ask **at every** visit if patient's medications have changed.
- If there has been a change, it must be noted in the narrative, or an updated medication profile attached.

Visit Purpose(s) - 1st Dose

- This box should ONLY be checked when the patient is receiving the medication for the first time (ever).
- RN must monitor the patient for adverse reactions for 30 minutes (unless pharmacy specifies differently), and obtain and record a set of vitals at the end of the observation period post-infusion
- Document in the narrative that the patient verbalized understanding of adverse reactions, education and procedures.



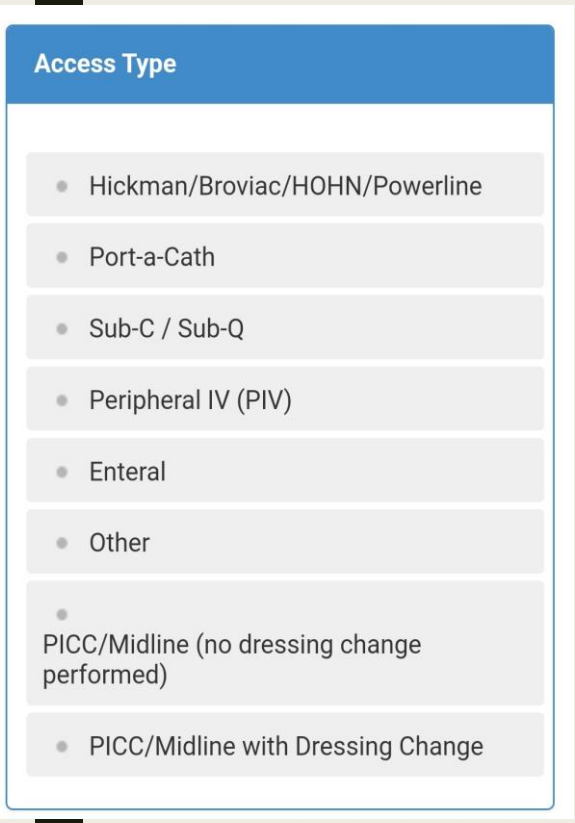


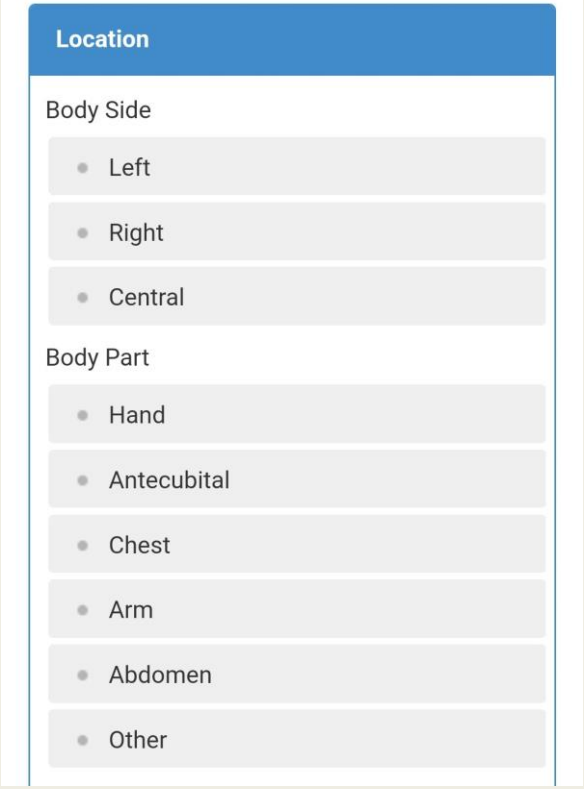
Site Assessment or Access

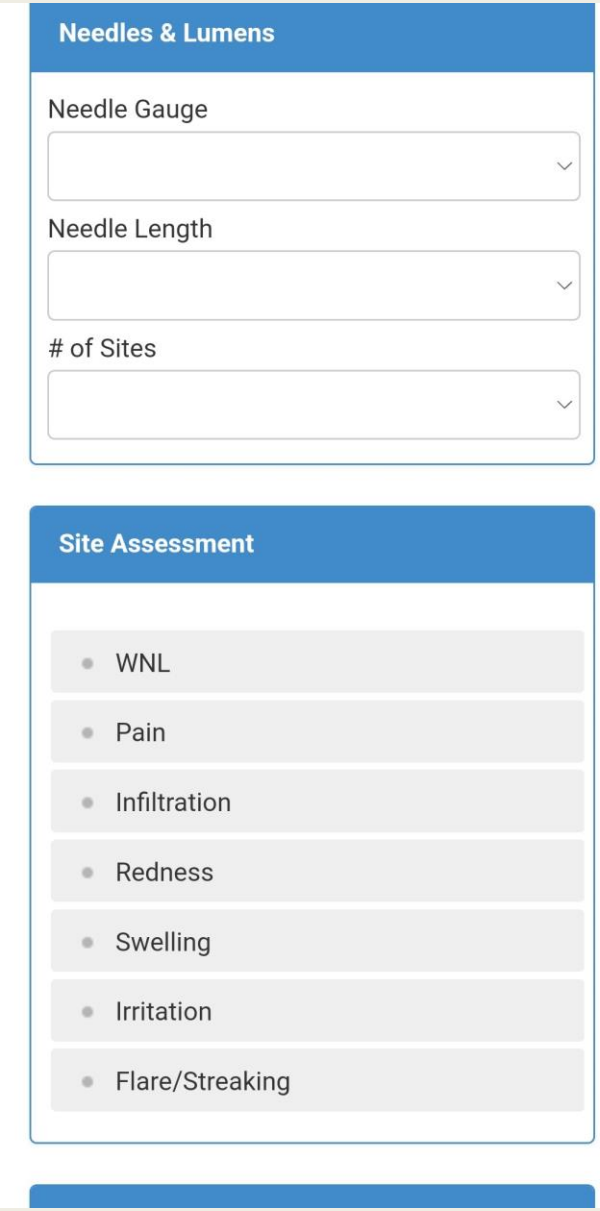
- If patient has a line, regardless if it is “USED” or not during the nurse’s visit, the first option needs to be selected. This way the general information about the line, including type, location, and general assessment, will generate and can be filled out.

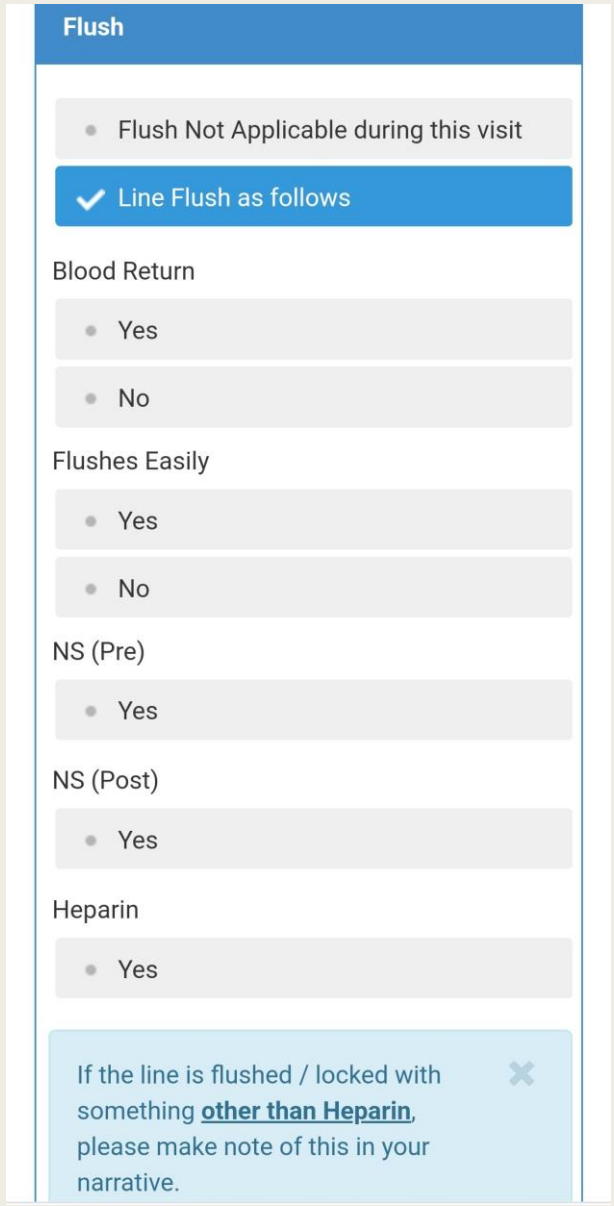
- If the bottom option is chosen, the RN will NOT SEE the required sections that need to be completed. EVEN when there is not a dressing change done, if patient is being taught to administer through a line, SQ or IM injections are given, a lab draw visit, a PRN visit for assessment or troubleshooting a line, line pull/removal, etc., the general assessment of the line needs to be filled out.

Screens that open when the option is chosen “I taught care of, visually assessed, established access, de-accessed, removed and/or otherwise physically touched, used or provided assistance with a site/device. (Sub-Q, Enteral, PIV, Port, PICC, CVC, etc.

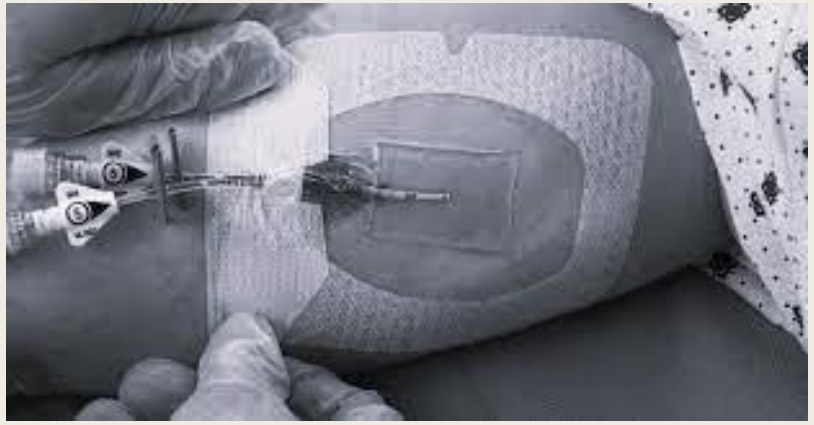








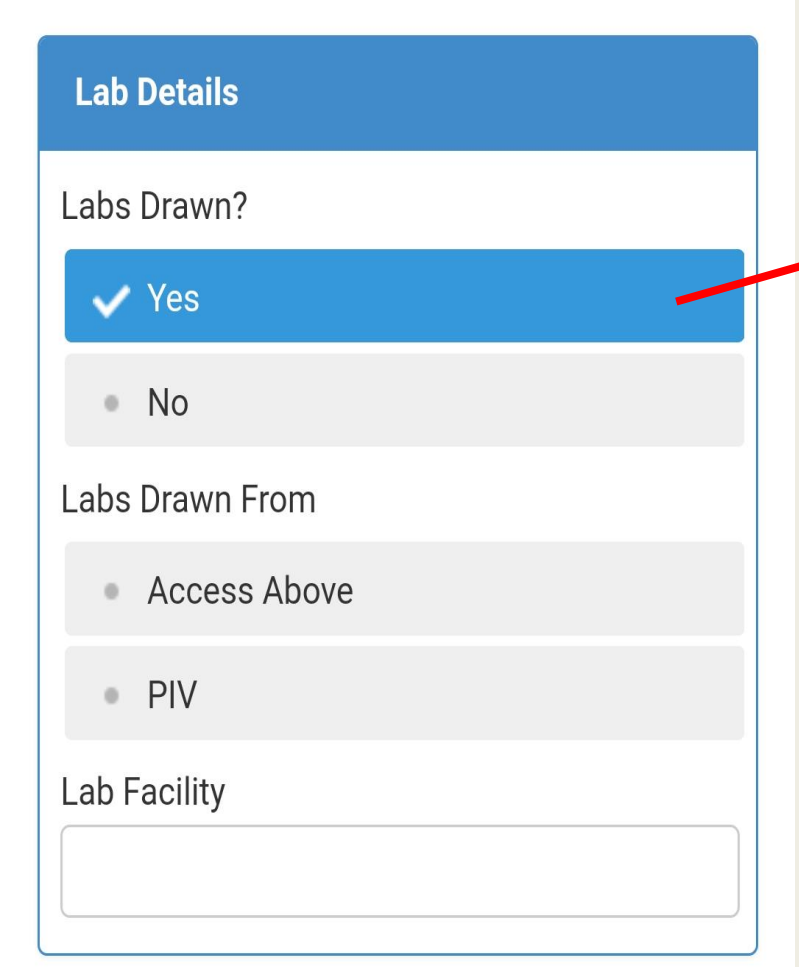
Access and Dressings

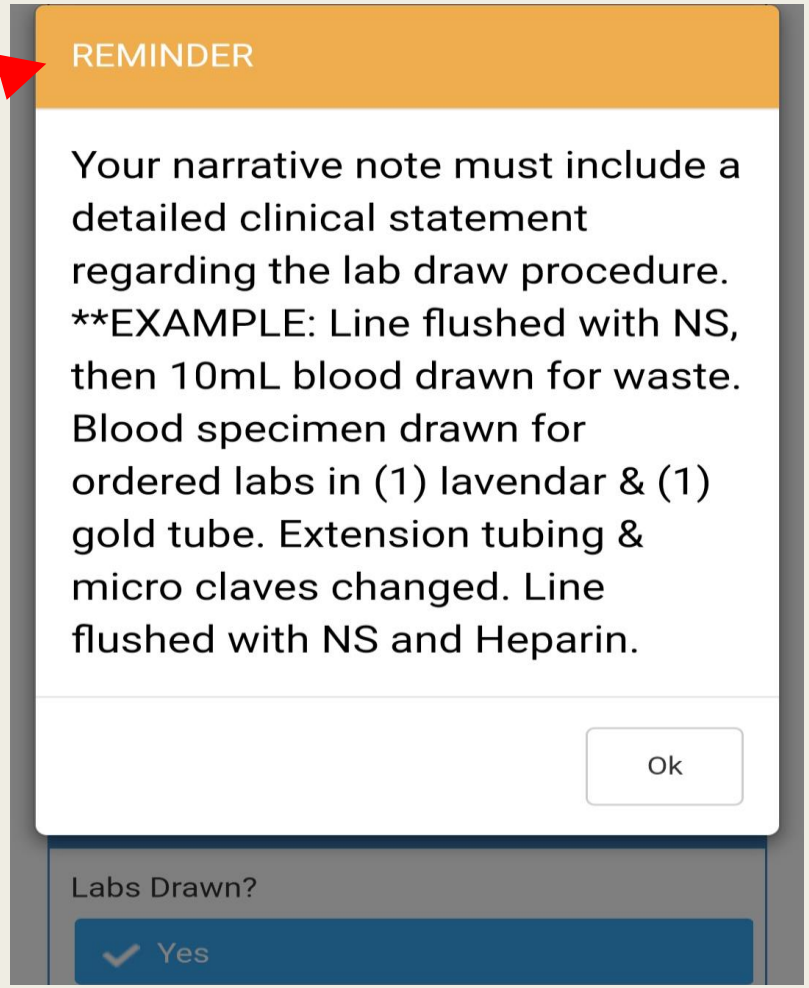


- Reminder – RN must reach out to agency after attempting two sticks without success for approval for a third stick
- For dressing changes the narrative should include detailed aspects of the dressing change as applicable: cleansing agents, securement device, antimicrobial patch (Biopatch or Silveron), skin prep and type of dressing applied (Tegaderm, gauze).
- For PIV starts the narrative should include detailed information of cleansing agent and type of dressing applied and how many attempts.
- For site assessment, if anything besides WNL is checked, a detailed note of the site should be included in the narrative.

Lab Draws

When YES chosen under Lab details, a REMINDER screen will pop up what must be included in the narrative





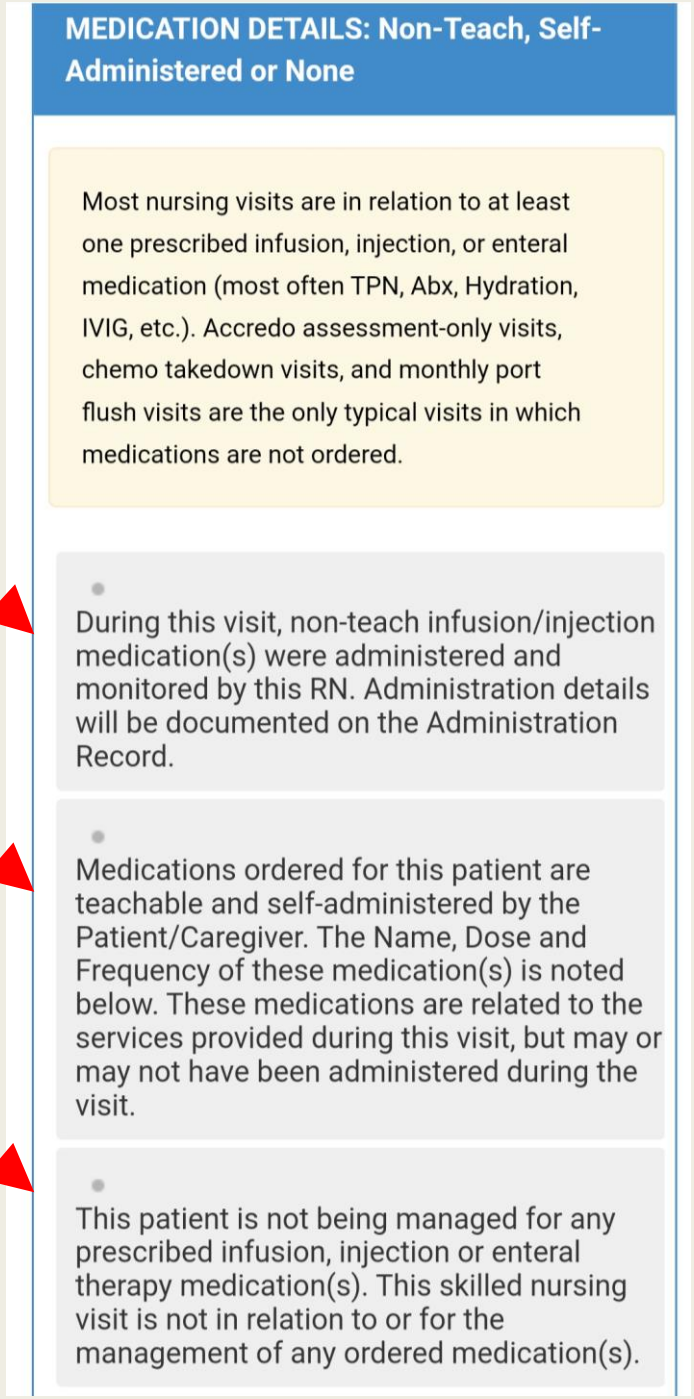
Medication

- When RN is responsible for administering the medication(s) choose “During this visit, non-teach infusion/injection medications were administer and monitored by the RN …” Administration record is populated when the patient was created in Logiforms and the option “Yes, the RN is administering the medication” is chosen.

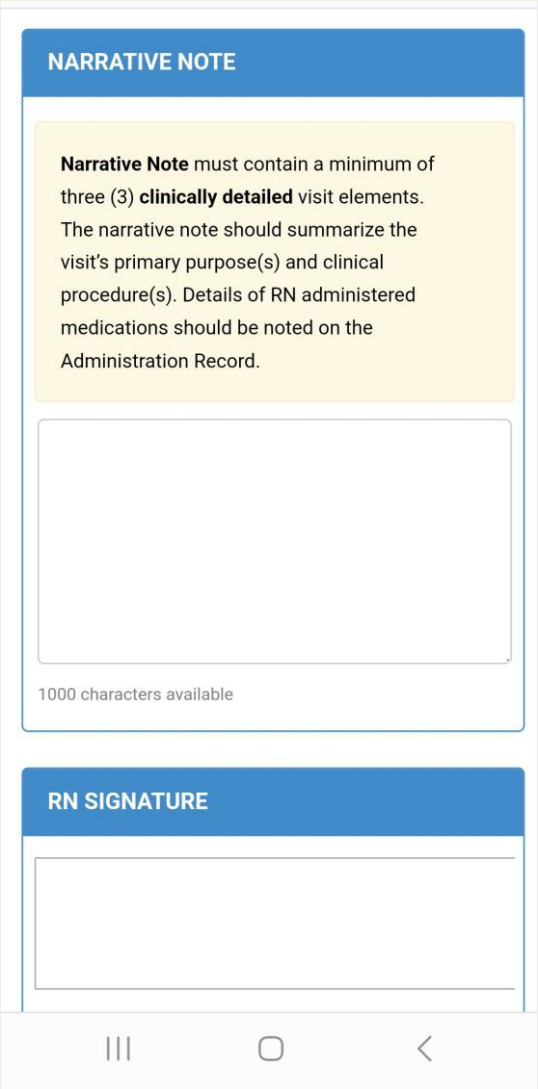
- When teaching a Patient/Caregiver to infuse medication(s) ongoing choose “Medication(s) ordered for this patient are teachable ….” Write the name of the Medication, the Dose and the Route

- The patient is not being managed for any prescribed infusion, injection or enteral therapy medications is only used if patient is NOT being seen by agency for any medications, (i.e., monthly port flushes, Chemo Takedown, Accredo vital sign patients)

- For Sub-Q or IM injections if the RN is drawing up the medication and injecting the drug then this is considered “RN administration” and the Administration record must be filled out. Only if the RN is present to observe/teach/watch the patient/caregiver then this is considered administered by the patient/caregiver.



Narrative Note



- The narrative should contain a minimum of three (3) clinically detailed visit elements. (This does not mean a minimum of 3 sentences!!) The narrative note should summarize the visit's primary purpose(s) and clinical procedure(s) .
- If visit is longer than expected include why (i.e., *Arrived at patient's house and patient was not ready, Waited 45 minutes for patient to shower and dress*.)
- TPN orders change frequently depending on patient's labs. *"TPN IV daily"* is noted under Medication/Administered by Patient/Caregiver and then in the narration something like *"Pharmacy is responsible for managing TPN formula and it can change frequently depending on lab results."*
- PICC Pull – Narrative note must include the measurement of the line (in cm) after removal and the integrity of the line (i.e., tip intact) and application of a pressure dressing. The narrative should also include a statement about the patient/caregiver verbalizing understanding of education related to the therapy conclusion and line removal procedure.

Helms Home Care
Phone: (704) 802-9625
Fax: (888) 502-5390

CLINICAL NOTE: ADMINISTRATION RECORD

*This form is required when the RN is responsible for administering a medication (including SIVP and Sub-Q injections). This form is also required when monitoring a first dose for adverse reactions. This form is not a stand-alone record & must be submitted with a Standard Note or Admission Note.

PATIENT NAME: Mickey Mouse **DOB:** 09/05/1928 **INFUSION DATE:** 09/26/2023

PRE-MEDICATION(S) ☐ None Ordered ☐ Declined by PT/CG

DRUG	DOSE	ROUTE	DRUG	DOSE	ROUTE
Acetaminophen	650 ml	PO			

HYDRATION ☐ Only ☒ None

☐ D5W ☐ 0.9% NS
☐ Other:
☐ Pre: _____ml @ _____ ml/hr
Start: _____ End: _____
☐ Post: _____ml @ _____ ml/hr
Start: _____ End: _____
☐ Concurrent: ____ ml @ ____ml/hr

MEDICATION(S)

DRUG NAME	DOSE	VOLUME
Remicade	500 mg	250 ml

LOT # AND EXPIRATION DATE(S) FROM VIAL(S)

LOT #: 23A076P1; EXP: 2026 - FEB; 100 mg vial; X 5 vials

SIDE EFFECTS / AD. REACTION

☒ None ☐ Headache
☐ Hypertension ☐ Fever
☐ Hypotension ☐ Chills
☐ Vomiting ☐ Rash
☐ Pain / Myalgia ☐ Nausea
☐ Other:

*All Adverse Reactions & Side Effects must be documented in detail in the narrative note.

ADMINISTRATION: ☐ SIVP ☐ SC Injection ☒ Gravity/DAF ☐ Pump:

START: 11:00 @ 125 ml/hr END: 13:00 TOTAL TIME: 02:00

TIME	RATE	TEMP	PULSE	RESP/MIN	B/P
Baseline Vitals from Page 1:		98.4 F	60	18	115/64
11:15	ml/hr	98.3 F	62	20	116/62
11:30	ml/hr	98.4 F	63	20	114/60
11:45	ml/hr	98.4 F	65	18	116/65
12:00	ml/hr	98.5 F	64	20	117/63
13:00	ml/hr	98.3 F	62	20	116/62
	ml/hr				
	ml/hr				
	ml/hr				
	ml/hr				
	ml/hr				
	ml/hr				
	ml/hr				
POST: 13:10 -		98.4 F	62	20	115/60

NARRATIVE NOTES

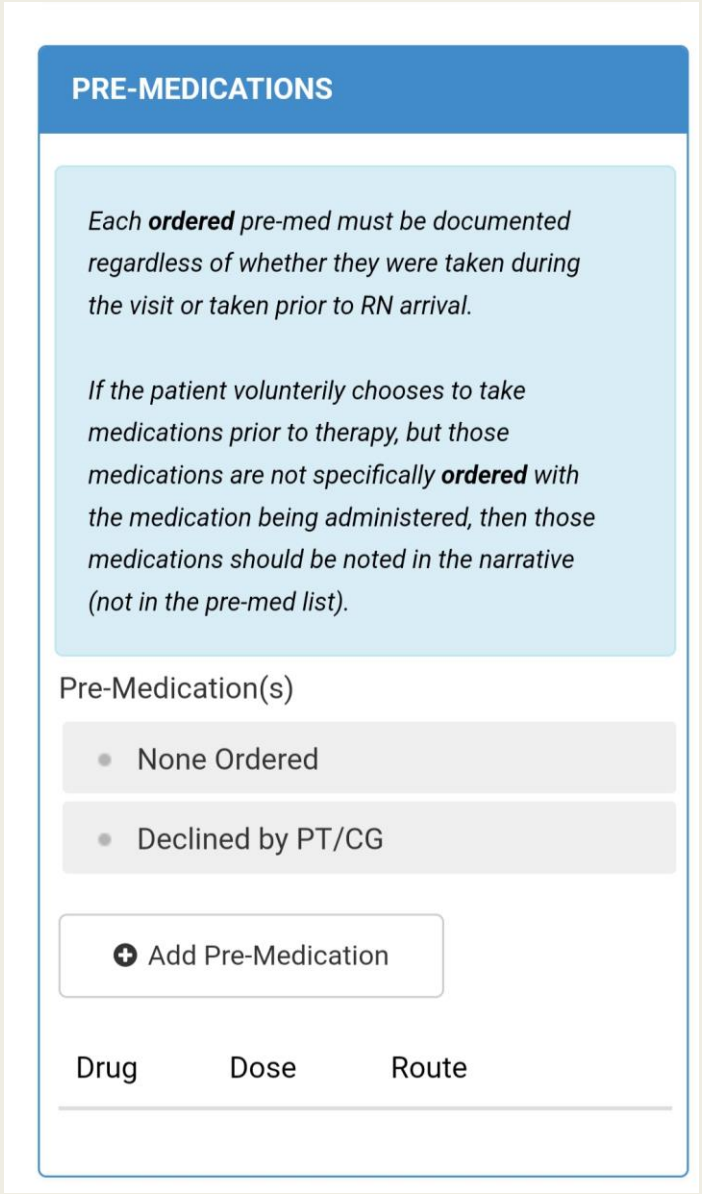
Each Remicade vial mixed with 10 ml sterile water as instructed by pharmacy. Allowed to fully reconstitute. 50 ml NS removed from 250 ml NS bag as instructed by pharmacy. Remicade added to NS bag when reconstituted Infusion started on gravity flow tubing with micron filter at 125 ml/hr over 2 hours. Patient rested in recliner watching TV. When infusion completed PIV flushed with NS and then removed. Gauze and pressure applied and once bleeding stopped Band-aid placed. Patient tolerated infusion with no ADR. Patient instructed to seek medical help if experiences any ADR after nursing has left.

Was infusion slowed/stopped due to adverse reaction?* ☐ Y ☒ N
*All Adverse Reactions & Side Effects must be documented in detail in the narrative note

Infusion Completed? ☐ Y ☒ N If no, amount infused:

RN PRINTED NAME: Minnie Mouse, RN **RN SIGNATURE:** Minnie Mouse, RN

ADMINISTRATION RECORD

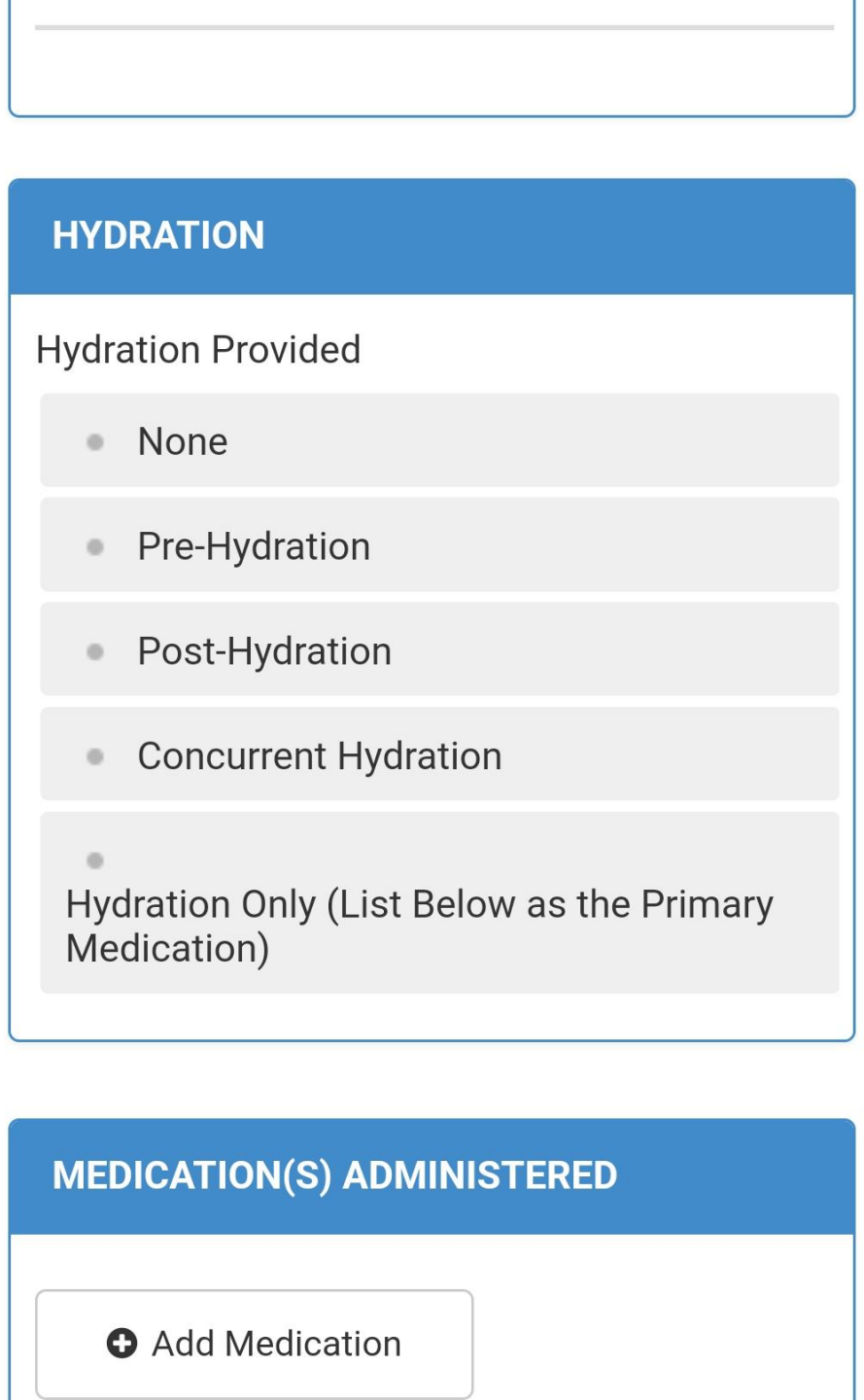


Pre-Medications

- Check orders carefully for pre-medication orders
- If medications are ordered, they have to be documented as administered or declined. If given, make sure to document the correct dose. If declined, the narrative must indicate the name(s) of the pre-meds declined and the reason why.
- If the patient chooses to take pre-meds voluntarily (i.e., not ordered), this is okay, but document in the narrative note (NOT the pre-med section).
- If patient declines pre-meds that are not prn, the MD needs to be notified, so reach out to agency and let them know as well as narrate in your note. Agency will reach out to pharmacy/MD for order changes.
- PRN orders may be written as “prn” or “patient may take their own supply”

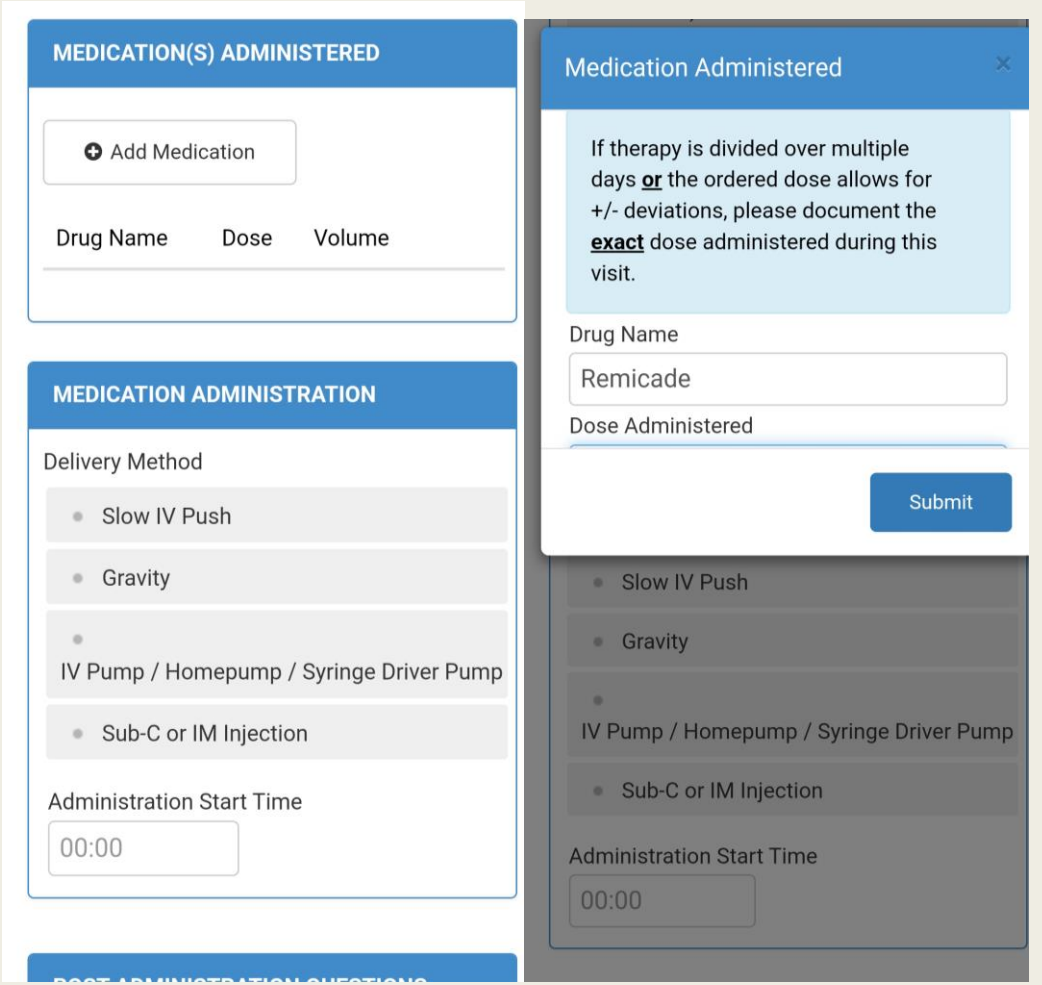
Hydration

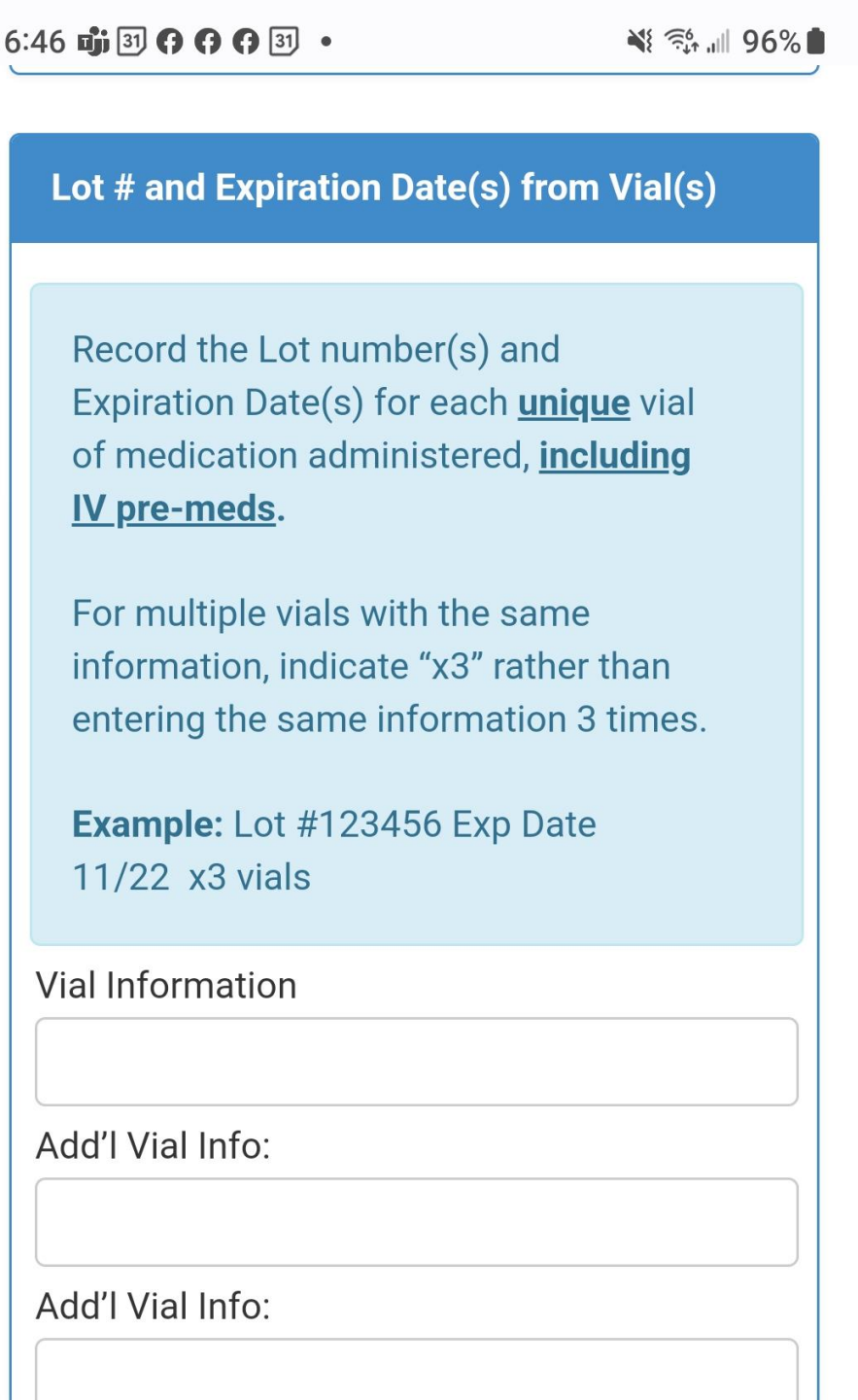
- Hydration charted under Hydration section if given pre, post or concurrent with another infusion, NOT under the Administration section
- Hydration Only charted under infusion if it is the Primary Medication; list in the Medication(s) Administered section and record the infusion in the Administration Record section



Medication

- Include drug name, the dose and volume
- The volume is the TOTAL amount you are infusing (i.e., Order is for Remicade 500 mg. Each 100 mg vial is mixed with 10 ml sterile water and then added to NS. Chart the volume as 250 ml – NOT 50 ml)
- For drugs that have a +/- 10% - chart the amount GIVEN, not the amount on the order (i.e., Order is for Recombinante 4200 units q 24 hrs – amount given 4289 units, chart 4289 units as the dose)





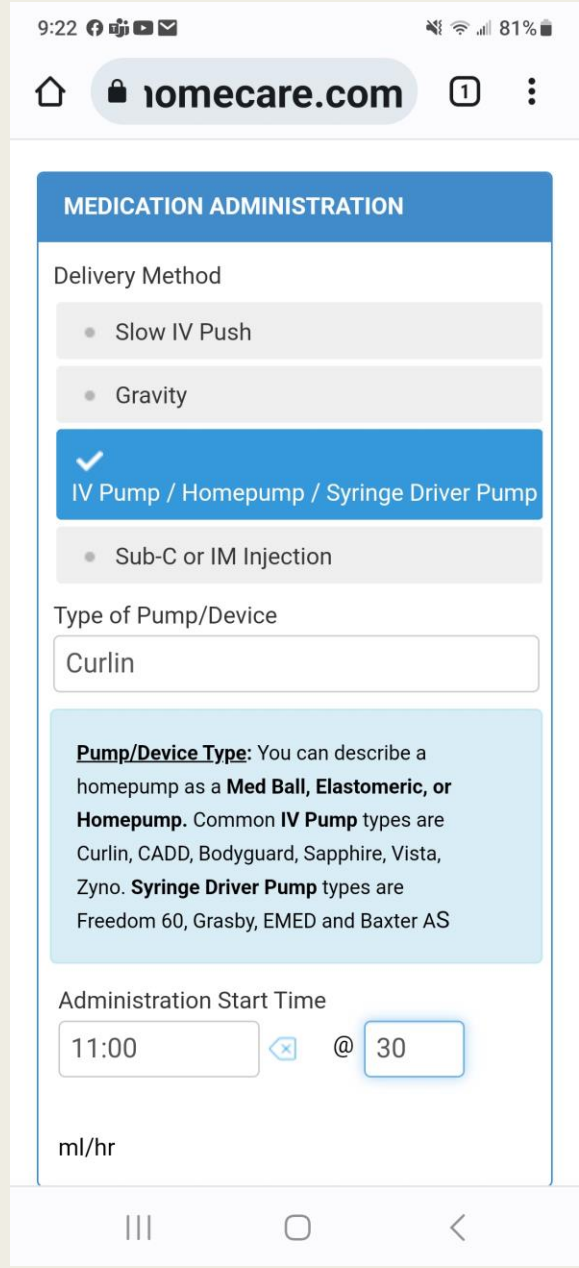
LOT # and Expiration Date

- Double check lot# and Expiration Date(s) when adding – they must be correct
- If the lot numbers are all the same may chart the LOT # and the EXPIRATION date once and then chart how many vials (i.e., x4 vials)

Administration Record

- Include START and END time, Logiforms will calculate the TOTAL time,
- Vital Sign Guidelines – Take VS at start of infusion, every 15 minutes for the first hour, then hourly or with any rate change thereafter; then 5 – 10 minutes post infusion (this applies to ALL infusions, not just ramp up infusions)
- For infusions that are an hour or more there should be at least 5 sets of vitals for the first hour. (i.e., Start, at 15 minutes, at 30 minutes, at 45 minutes, at 1 hour)
- For IM/SC injections there should be two sets of vitals.

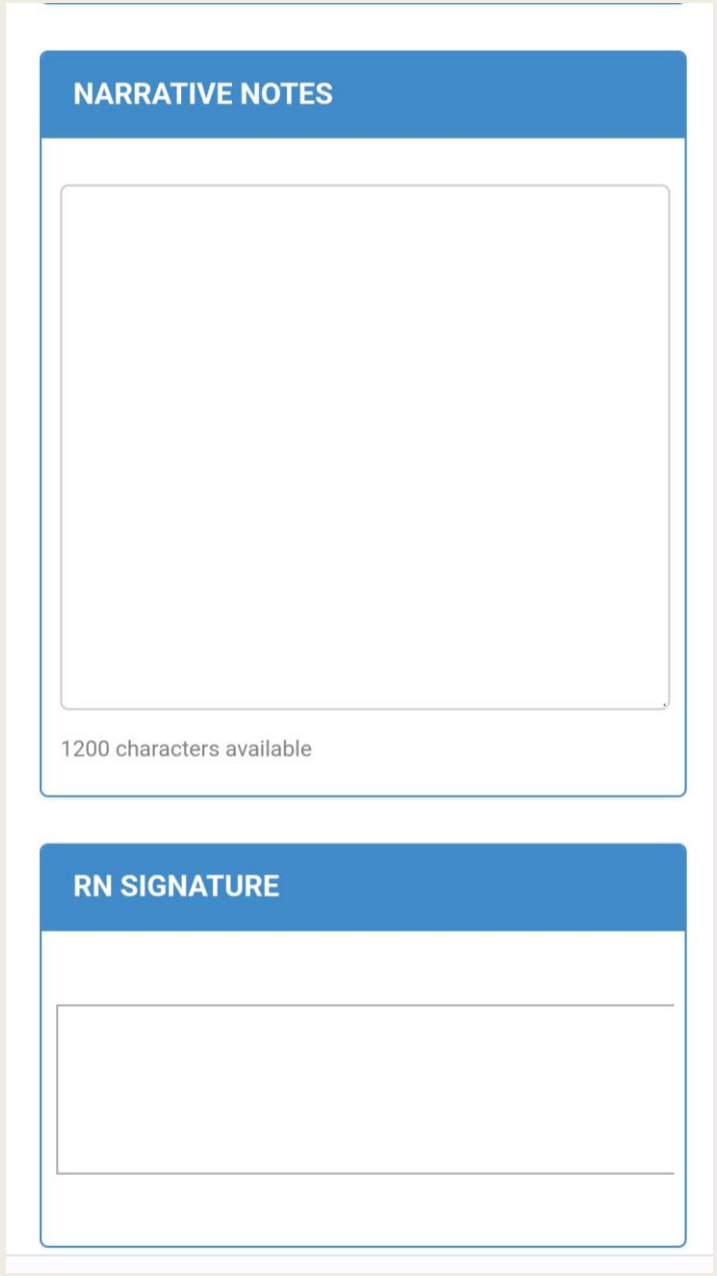
IMPORTANT: ARRIVAL time must be BEFORE the start of your infusion and that DEPARTURE time is after the completion of the infusion.



Narrative

Your narrative should include a snapshot of the infusion

- How the medication was mixed
- Infused from bottle or pooling bag
- Use of a vented spike
- Use of filter tubing
- Flushing of line with NS and Heparin
- Removal of PIV at end of infusion along with use of gauze, pressure and band aid
- De-access of Port and band aid applied
- How patient tolerated the infusion
- Any adverse reactions and side effects in detail
- If Agency is contacted during visit include why, the resolution and the length of time involved
- if first dose a set of vitals at end of infusion should be in the narrative



VISIT NOTE SHOULD BE A SNAPSHOT OF THE VISIT.

If the visit note ever went to court, it should reflect what happened during the visit with the patient.

CHANGES to Logiforms

- **PICC** will be changed **to CVC (no dressing change)** – will require date dressing was last changed.
- **Hickman/Brociac/HOHN** will be changed to **Hickman/Broviac/HOHN with dressing change**
- **Updated Visit Purpose(s)** – to allow for instructions/reminders, the "SC/IVP Injection" option will be modified to "Sub-C/IM Injection / Teach." Therefore, for Factor Patients, the RN will choose "Other Infusion / Teach" option. This then will allow for the special instructions/reminders (shown to the right) to appear.
- **Updated Education (Admission Only):** to allow for more clear/concise wording of education elements, specifically when Education relates to an infusion by the RN (non-teach).
- **Medication Profile** - Due to recent audits by CHAP and the state, starting early 2024, there will be changes in the Medication profile. Logiforms will populate the Medication profile every 90 days for RN to update. If patient's name and DOB are correct this will be automatically pulled into Logiforms. Currently the nurse is REQUIRED to ask at every visit if there are any medication changes since the last visit and narrate in the note. (Coming early 2024)