



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.

2) Are you, (the RN) responsible for administering, infusing, injecting and/or slowly "pushing" a medication for this patient? Or, are you responsible for monitoring and recording vitals for a 1st DOSE of ? (patient has NEVER received the medication previously)?

Will Administration Record be Needed for this visit?

Administrations by the RN are **non-teach** therapies like IVIG, SubC injections, etc, in which the RN is responsible for administering the medication. Choose "No" if the patient/caregiver is on a self-infusing therapy, like TPN, Antibiotics, Hydration or if there is no infusion medication being managed by home health (chemo takedown, Accredo assessment, line care only).

A **first dose** refers **ONLY** to when a patient is receiving a medication for the **very first time** and must be monitored for adverse/allergic reactions. A patient completing their initial dose in the home, but has taken this medication before, is **NOT** a 1st dose.

Administration Record will NOT generate.

If you are unsure, please ask before proceeding. This question determines if an Administration Record is required or not.

No, the patient is on teachable medication or already independent. (Admin record will NOT generate)

No the patient is not on ANY infusion med (Admin record will NOT generate)

Yes, this RN is administering the medication (SubC, IV Push, Infusion)

Yes, this patient is receiving a medication during this visit that they have never previously had (1st Dose) and I will be monitoring for allergic reaction during and 30-60 minutes post infusion.

Next

Back

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

NEW/PENDING

IMPORTANT: This form must be completed & **signed by the Patient/Caregiver**, during the visit prior to providing hands-on care. All other forms for this visit will be **locked and unable to be accessed** until this form is "Verified & Saved."

Edit

Visit Overview

NEW/PENDING

Patient Name, DOB, and details related to visit length, time, and travel.

UPLOAD ATTACHMENTS and Files: (Please refer to the instructions sent during confirmation to see if any other documents are required to be supplemented with this visit)

Edit

Admission Note

NEW/PENDING

Patient/Caregiver signature required. Page 1 of the Admission packet; includes general visit information.

CONSENT FORM

Note

Please provide the HHC brochure to the patient/caregiver and allow them time to review the brochure and ask questions before signing this consent. Click ok to confirm you have provided the HHC brochure to the patient/caregiver.

Ok

that Home Care, LLC is not liable for any act or omission when following these orders. I understand that my care is under the supervision and control of my attending physician, and I consent

- 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.

0%

0 of 6 forms completed.

Patient Consents & Authorization to Treat

NEW/PENDING

IMPORTANT: This form must be completed & **signed** by the Patient/Caregiver, during the visit prior to providing hands-on care. All other forms for this visit will be **locked and unable to be accessed** until this form is "Verified & Saved."

14%

1 of 7 forms completed.

Patient Consents & Authorization to Treat

COMPLETE

IMPORTANT: This form must be completed & **signed** by the Patient/Caregiver, during the visit prior to providing hands-on care. All other forms for this visit will be **locked and unable to be accessed** until this form is "Verified & Saved."

Edit

ADMISSION ASSESSMENT

ADMISSION ASSESSMENT

NEUROLOGICAL / MENTAL STATUS

- **WNL (Within Normal Limits)**
- Disoriented
- Lethargic
- Impaired
- Tingling
- Seizures
- Numbness
- Tremors
- Dizziness
- Headache/ Migraine
- Syncope
- Weak Hand Grip
- DME / Other

SENSORY / EYES / HEARING

- **WNL (Within Normal Limits)**
- Impaired Speech
- Dysphagia
- Blindness
- Cataracts
- Glasses
- Contacts
- Deaf
- Glaucoma
- Hearing aids
- Partial Hearing
- DME / Other

MUSCULOSKELETAL

GASTROINTESTINAL


- **WNL (Within Normal Limits)**
- Inadequate Nutrition
- Inadequate Hydration
- Abdominal Distension
- Nausea
- Vomiting
- Special Diet / Ricks
- Diarrhea
- Constipation
- Tenderness
- Firm
- Bowels Sounds
- DME / Other

INTEGUMENTARY / SKIN

Admission Assessment

NEW/PENDING

Required at each admission (SOC) visit, full head-to-toe patient assessment and evaluation of the home environment.

 Edit

Admission Education Checklist & Acknowledgement

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 ADMINISTRATION

NOT APPLICABLE: Assessment / Line Care Only (no medications dispensed by pharmacy / managed by nursing)

Administration by RN (non-teach)

Patient / Caregiver Administration (teach)

Drug Preparation

Administration Method

Administration Technique

Potential Complications

Medication(s):

Medication 1: Name & Dose

Medication 1: Frequency

Medication 1: Route

Medication 2: Name & Dose

MEDICATION ADMINISTRATION

NOT APPLICABLE: Assessment / Line Care Only (no medications dispensed by pharmacy / managed by nursing)

Administration by RN (non-teach)

Patient / Caregiver Administration (teach)

Medication(s):

Medication 1: Name & Dose

Medication 1: Frequency

Medication 1: Route

Medication 2: Name & Dose

Medication 2: Frequency

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.

MEDICATION PROFILE

MEDICATION LIST

A complete Med Profile must include any/all **Infusion, Injection, Enteral Medications** including **Saline/Heparin Flushes** along with:

- Prescription Medications
- OTC Medications
- Home Remedies
- Investigational Agents

Start Date &
Drug Name Dose Route Freq

RN SIGNATURE

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
<i>Mickey Mouse</i>		TRAVEL TO Miles: 15	IVT (mins):
VISIT PURPOSE(S)		VISIT ARRIVAL TIME: 11:00 am	VISIT TOTAL TIME:
<input type="checkbox"/> Education / Teach <input type="checkbox"/> Assessment Only <input type="checkbox"/> Chemo Takedown <input type="checkbox"/> Access / De-access <input type="checkbox"/> Dressing Change <input type="checkbox"/> Lab Draw <input type="checkbox"/> PICC Pull		<input type="checkbox"/> 1 st Dose Infusion by RN <input type="checkbox"/> IVlg Infusion by RN Day ____ of ____ <input type="checkbox"/> SCig Infusion / Teach <input type="checkbox"/> Sub-C/IM Injection / Teach <input type="checkbox"/> Other Infusion / Teach	1 Hr Min TRAVEL FROM Miles: 15 IVT (mins): Travel Total Miles: 30 Total IVT Minutes:
		Next Visit: <input type="checkbox"/> To Be Scheduled <input type="checkbox"/> Needs Coverage <input checked="" type="checkbox"/> Confirmed w/this RN	

VITALS, PAIN & GENERAL ASSESSMENT

R E Q U I R E D	TEMP (F): 97.8 F	RESP/MIN: 18	NEURO/MUSCULAR <input checked="" type="checkbox"/> AAO <input type="checkbox"/> Confused <input type="checkbox"/> Forgetful <input type="checkbox"/> Numbness <input type="checkbox"/> Cramping <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness <input type="checkbox"/> Difficulty Speaking <input type="checkbox"/> Other:	GASTRO & NUTRITION <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Poor Skin Turgor <input type="checkbox"/> Inadequate Fluids <input type="checkbox"/> Other:	CARDIOVASCULAR <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Hypo <input type="checkbox"/> Hypertension <input type="checkbox"/> Arrhythmia <input type="checkbox"/> Chest Pain <input type="checkbox"/> Edema <input type="checkbox"/> Other:	URINARY <input checked="" type="checkbox"/> WNL <input type="checkbox"/> ↑ <input type="checkbox"/> ↓ Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Abnormal Color <input type="checkbox"/> Other:
	PULSE (bpm): 67	B/P: 110/72				
	PAIN (1-10): ___ <input type="checkbox"/> Denies Pain				ENDOCRINE <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Diabetic <input type="checkbox"/> Other:	RESPIRATORY <input checked="" type="checkbox"/> WNL <input type="checkbox"/> Cough <input type="checkbox"/> Dyspnea <input type="checkbox"/> Other:
	Location: <input type="checkbox"/> Dull <input type="checkbox"/> Constant <input type="checkbox"/> Sharp <input type="checkbox"/> Intermittent		<input type="checkbox"/> See Narrative Note <input type="checkbox"/> Updated List Attached			

ACCESS N/A

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

MEDICATION(S) & NARRATIVE NOTE

<input checked="" type="checkbox"/> Medication(s) Administered by Patient/Caregiver (List Name(s) & Dose(s)): TPN, IV Daily
<input type="checkbox"/> Medication(s) Administered by RN (Details Required on Infusion Record note)
<input type="checkbox"/> 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.
<input type="checkbox"/> 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. <input checked="" type="checkbox"/> via phone prior to visit (Recommended) Screening Results: <input checked="" type="checkbox"/> Negative <input type="checkbox"/> Positive (Questionnaire attached) <input checked="" type="checkbox"/> upon arrival, prior to vitals/assessment **Required**
RN PRINTED NAME: Minnie Mouse, RN
RN SIGNATURE: <i>Minnie Mouse, RN</i>

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

Visit Overview

Arrival & departure times are entered in VISIT OVERVIEW

Administration Record

Administration Start time, titration vital time recordings, etc. are entered in ADMINISTRATION RECORD

The times entered in the separate sections must align in sequence

Visit Overview

Administration Record

EXAMPLE
The departure time cannot be prior to a vital recording time or the time of post administration vitals

MEDICATION CHANGES

The image shows a screenshot of a medical form. The top section is titled 'BASELINE VITALS' in a blue header. It contains four input fields: 'Temperature', 'Respiratory Rate', 'Pulse (bpm):', and 'Blood Pressure'. The bottom section is titled 'MEDICATION PROFILE' in a blue header. It contains three bullet points: 'No Changes', 'Updates in Narrative Note', and 'Updates in Attached Medication Profile'.

- 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.

VISIT PURPOSE(S)

Mark All that Apply *

- Education / Teach
- Assessment Only
- Chemo Takedown
- Access / De-access
- Dressing Change
- Lab Draw
- PICC Pull / Remove
- 1st Dose Infusion
- IVIg Infusion by RN
- SCIg Infusion by RN and/or Teach
- Sub-C or IM Injection (by RN or Teach)
- Other Infusion (by RN or Teach)

TRAVEL

SITE ASSESSMENT or ACCESS

REQUIRED: Site details

and assessment are required for the following:

- **All subsequent teaching visits** (including **Enteral** teaches)
- **Sub-Q Injections or Infusions visits** (Teaches & RN Administration)
- **PIV or PORT** (access, de-access, med administration)
- Visits for **Troubleshooting** (line occlusion, pump issues, med administration)
- **Lab Draw** visits
- **Line Pull/Removal** visits

• During this visit 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.).

• I confirm that I DID NOT provide teaching or instructions, visually assess or troubleshoot, access or deaccess, use and/or physically touch an access site for care, lab draw, medication administration, or other service during this visit

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 Type

- Hickman/Broviac/HOHN/Powerline
- Port-a-Cath
- Sub-C / Sub-Q
- Peripheral IV (PIV)
- Enteral
- Other
- PICC/Midline (no dressing change performed)
- PICC/Midline with Dressing Change

Location

Body Side

- Left
- Right
- Central

Body Part

- Hand
- Antecubital
- Chest
- Arm
- Abdomen
- Other

Needles & Lumens

Needle Gauge

Needle Length

of Sites

Site Assessment

- WNL
- Pain
- Infiltration
- Redness
- Swelling
- Irritation
- Flare/Streaking

Flush

- Flush Not Applicable during this visit
- Line Flush as follows

Blood Return

- Yes
- No

Flushes Easily

- Yes
- No

NS (Pre)

- Yes

NS (Post)

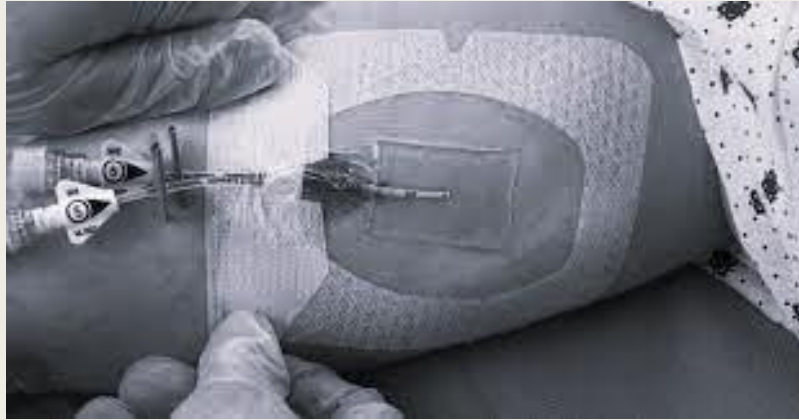
- Yes

Heparin

- Yes

If the line is flushed / locked with something **other than Heparin**, please make note of this in your narrative. ✕

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

Lab Details

Labs Drawn?

Yes

No

Labs Drawn From

Access Above

PIV

Lab Facility

REMINDER

Your narrative note must include a detailed clinical statement regarding the lab draw procedure. ****EXAMPLE:** Line flushed with NS, then 10mL blood drawn for waste. Blood specimen drawn for ordered labs in (1) lavender & (1) gold tube. Extension tubing & micro claves changed. Line flushed with NS and Heparin.

ok

Labs Drawn?

Yes

Medication

- When RN is responsible for administering the medication(s) choose “During this visit, non-teach infusion/injection medications were administered 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.

MEDICATION DETAILS: Non-Teach, Self-Administered or None

Most nursing visits are in relation to at least one prescribed infusion, injection, or enteral medication (most often TPN, Abx, Hydration, IVIG, etc.). Accredo assessment-only visits, chemo takedown visits, and monthly port flush visits are the only typical visits in which medications are not ordered.

• During this visit, non-teach infusion/injection medication(s) were administered and monitored by this RN. Administration details will be documented on the Administration Record.

• Medications ordered for this patient are teachable and self-administered by the Patient/Caregiver. The Name, Dose and Frequency of these medication(s) is noted below. These medications are related to the services provided during this visit, but may or may not have been administered during the visit.

• This patient is not being managed for any prescribed infusion, injection or enteral therapy medication(s). This skilled nursing visit is not in relation to or for the management of any ordered medication(s).

Narrative Note

NARRATIVE NOTE

Narrative Note must contain a minimum of three (3) **clinically detailed** visit elements. The narrative note should summarize the visit's primary purpose(s) and clinical procedure(s). Details of RN administered medications should be noted on the Administration Record.

1000 characters available

RN SIGNATURE

- 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 HYDRATION Only None

DRUG	DOSE	ROUTE	DRUG	DOSE	ROUTE
Acetaminophen	650 ml	PO			

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:

NARRATIVE NOTES

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:					
11:15		98.4 F	60	18	115/64
11:30	ml/hr	98.3 F	62	20	116/62
11:45	ml/hr	98.4 F	63	20	114/60
12:00	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				
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	ml/hr				
	ml/hr				
	ml/hr				
	ml/hr				
POST: 13:10	-	98.4 F	62	20	115/60

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:

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.

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



ADMINISTRATION RECORD

Pre-Medications

PRE-MEDICATIONS

Each **ordered** pre-med must be documented regardless of whether they were taken during the visit or taken prior to RN arrival.

If the patient voluntarily chooses to take medications prior to therapy, but those medications are not specifically **ordered** with the medication being administered, then those medications should be noted in the narrative (not in the pre-med list).

Pre-Medication(s)

None Ordered

Declined by PT/CG

Drug	Dose	Route
<hr/>		

- 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

HYDRATION

Hydration Provided

- None
- Pre-Hydration
- Post-Hydration
- Concurrent Hydration
- Hydration Only (List Below as the Primary Medication)

MEDICATION(S) ADMINISTERED

 Add Medication

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)

The image shows a software interface for medication administration. It is divided into two main sections. The left section, titled "MEDICATION(S) ADMINISTERED", contains a button labeled "+ Add Medication" and a table with columns for "Drug Name", "Dose", and "Volume". Below this is another section titled "MEDICATION ADMINISTRATION" which includes a "Delivery Method" dropdown menu with options: "Slow IV Push", "Gravity", "IV Pump / Homepump / Syringe Driver Pump", and "Sub-C or IM Injection". There is also a field for "Administration Start Time" with a digital clock showing "00:00".

The right section is a modal window titled "Medication Administered" with a close button (X). It contains a light blue informational box that reads: "If therapy is divided over multiple days **or** the ordered dose allows for +/- deviations, please document the **exact** dose administered during this visit." Below this, there are input fields for "Drug Name" (containing "Remicade") and "Dose Administered". A "Submit" button is located at the bottom right of the modal. The background of the interface is dimmed when the modal is open.

Lot # and Expiration Date(s) from Vial(s)

Record the Lot number(s) and Expiration Date(s) for each unique vial of medication administered, including IV pre-meds.

For multiple vials with the same information, indicate "x3" rather than entering the same information 3 times.

Example: Lot #123456 Exp Date
11/22 x3 vials

Vial Information

Add'l Vial Info:

Add'l Vial Info:

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.

9:22 81%

homecare.com

MEDICATION ADMINISTRATION

Delivery Method

- Slow IV Push
- Gravity
- ✓ IV Pump / Homepump / Syringe Driver Pump
- Sub-C or IM Injection

Type of Pump/Device

Curlin

Pump/Device Type: You can describe a homepump as a **Med Ball, Elastomeric, or Homepump**. Common **IV Pump** types are Curlin, CADD, Bodyguard, Sapphire, Vista, Zyno. **Syringe Driver Pump** types are Freedom 60, Grasby, EMED and Baxter AS

Administration Start Time

11:00 @ 30

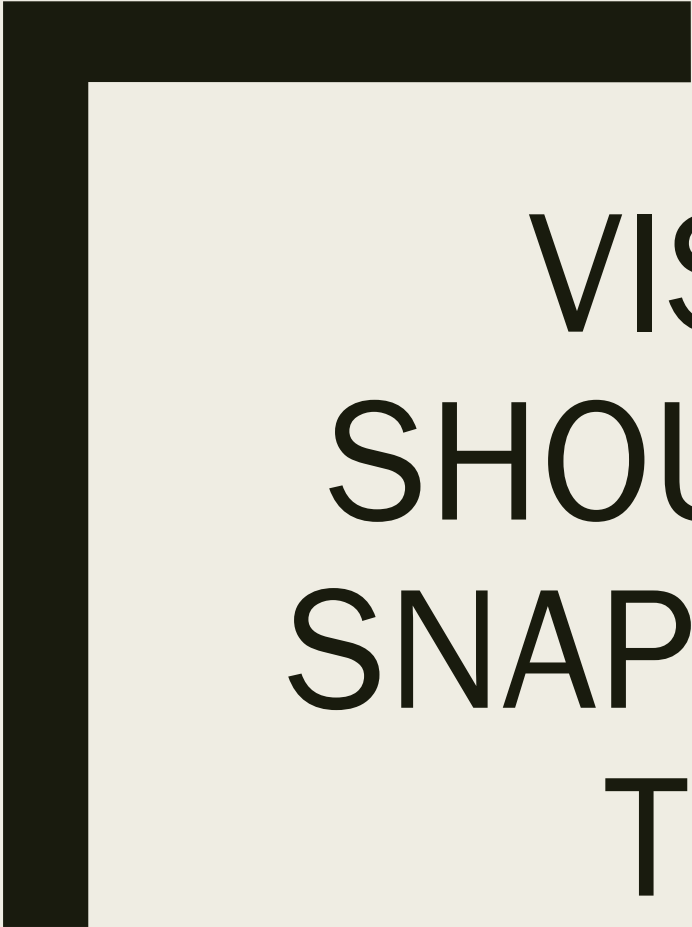
ml/hr

Narrative

Your narrative should include a snapshot of the infusion

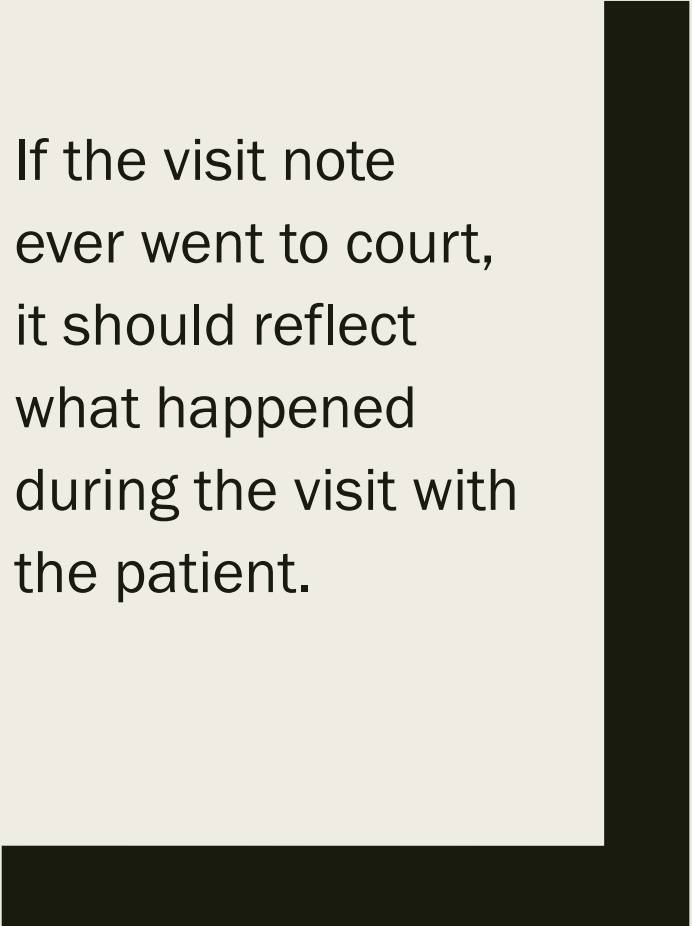
- How the medication was mixed
- Infused from bottle or pooling bag
- Use of a vented spike
- Use of filter tubing
- Flushing of line with NS and Heparin
- Removal of PIV at end of infusion along with use of gauze, pressure and band aid
- De-access of Port and band aid applied
- How patient tolerated 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

The image shows a digital form with two main sections. The top section is titled "NARRATIVE NOTES" in a blue header. Below the header is a large, empty rectangular text area. At the bottom of this text area, it says "1200 characters available". The bottom section is titled "RN SIGNATURE" in a blue header. Below the header is a large, empty rectangular area with a horizontal line near the top, intended for a signature.



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/Broviac/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)

Arm Circ: _____ cm
 Length from Insertion: _____ cm

PICC (no dressing change)

Last Changed: _____

Hickman/Broviac/HOHN

Port Sub-C PIV

IMPORTANT INFO / REQUIREMENTS FOR FACTOR

- ▶ DO NOT mix medications or spike vial(s) until a patent IV has been established and flushed.
- ▶ Determine the dose and volume to be administered from the orders provided by HHC.
 - NOTE: Orders for Factor typically allow +/- 10% deviation from the ordered dose. For example, an order to administer 2200 u to this dose as possible, but it could be anywhere from 1980 units up to 2420 units, as that is 10% less or more than the dose
 - Document the **exact** number of units given, **NOT** the ordered dose. In the example above, if your vial(s) were equal to 198
 - ALWAYS check each vial closely and add up the units to ensure you are giving the correct dose per the orders, even if the pa
 - If you are unsure about the dosing volume, DO NOT guess. Reach out to the Agency immediately for assistance.
- ▶ Make sure to record the lot numbers and vial expiration dates.
- ▶ If the client is being treated for an **active bleed**, your narrative **MUST** include:
 - Is there bruising? Is bruising improving?
 - Is the client using ice or other pain relief methods?
 - How many doses of medication are on hand?
 - Are there any supplies needed or supply issues?

VISIT PURPOSE(S)

Education / Teach 1st Dose Infusion by RN

Assessment Only IVIg Infusion by RN

Chemo Takedown Day _____ of _____

Access / De-access SCIG Infusion / Teach

Dressing Change Sub-C/IM Injection / Teach

Lab Draw Other Infusion / Teach

PICC Pull

EDUCATION:

Independent w/ Verbal/Demonstrated Understanding

Verbal Understanding of Therapy/Care Plan

Additional Education/Teaching Visit Needed