NURSING DOCUMENTATION

“PAINT THE PICTURE”

COSMOS HOSPICE, LLC
OBJECTIVES

By the end of this session you will have learned to:

• Apply general documentation guidelines
• Discuss general and disease specific considerations regarding eligibility criteria and documentation of decline
• Apply knowledge drawn from the assessment findings to properly document those findings
• Given a specific patient scenario, paint a masterpiece portraying quality patient care.

INTRODUCTION

We often compare documentation to painting a picture. A painting consists of many layers of paint, as documentation consists of many layers of information. Our documentation should answer the question, “What does the patient look like?”.

As we move through this in-service, think about how your documentation “paints” the picture of the patient, and reflect the quality patient care you give. Your documentation can be a masterpiece!

FIRST LET’S LOOK AT THE GENERAL GUIDELINES FOR DOCUMENTATION.

GENERAL DOCUMENTATION GUIDELINES

The increased specialization of practice, the complexity of patient problems and the new technology associated with it have contributed to multiple and varied services being provided to the patient. The clinical record is the only source of written communication for all team members. The team members not only contribute their unique and individual assessment of the interventions and outcomes, but may base subsequent actions on the events documented by other team members.

The importance of documentation in the medical record relates to the fact that this record is the:

• Only text that supports insurance coverage of denial
• Only evidence of the basis on which patient care decisions are made
• Only legal record
• Primary foundation for the evaluation of the care provided
• Objective source for the agency’s licensing and state surveyor review

IF IT WASN’T DOCUMENTED, IT WASN’T DONE!
The lack of documentation in a medical record is interpreted to infer that no nursing observations, interventions or communications were done. One of the best ways to avoid liability is not only to communicate, but to document that communication as well. Failure to accurately document vital information that would be used by other healthcare providers in rendering treatment can result in legal action. Proper documentation can indicate what communications were received from family, physicians or other personnel. In general, nurse’s notes should reflect factual information such as what is seen, felt and heard; what is being done for the patient and the patient’s response to that action or intervention.

**DOCUMENTATION TIPS**

It is imperative that the care giver provide clear and effective documentation. The following are common documentation tips which can help assist in this goal:

- Write legibly or print neatly. The record must be able to be read.
- Use permanent black ink.
- For every entry, identify the time and date.
- Write notes in consecutive and chronological order with no skipped lines or gaps.
- Write visit notes immediately following the visit.
- To correct an error, draw a line through the erroneous entry, initial and date.
- Use patient/caregiver/family direct quotes.
- Avoid abbreviations.
- Promptly document changes in a patient’s condition and the actions taken based on such change.
- Write down the patient/caregiver/family’s response to teaching and other interventions.

**THE INITIAL ASSESSMENT**

The admission assessment is an evaluation of the appropriateness for hospice. It consists of a review of the patient’s past and present medical history, a review of systems and the patient’s and caregiver’s actual and potential problems as they relate to the terminal diagnosis. The nurse admitting the patient completes the assessment and sets the foundation for hospice care, including the preparation of the PLAN OF CARE.

**PLAN OF CARE AND PIGs (PROBLEMS, INTERVENTIONS, GOALS)**

The Plan of Care is based on the initial nursing assessment and consists of four sections which include: the MAR, DME, supplies and the certification of terminal illness. The Plan of Care is developed at admission and at each certification period.

The Conditions of Participation for hospice, and Cosmos policy requires the
establishment of a Plan of Care. The plan **MUST** be established by the attending physician and one member of the team **PRIOR** to providing care. The plan must be reviewed and updated at intervals specified in the plan. The reviews **MUST** be documented in the medical record. These reviews and updates should be completed in such a way as to ensure that the plan of care continues to reflect the patient’s condition and to meet the **INDIVIDUAL** needs of the patient and family. The plan content just include an assessment of the patient’s needs and identification of services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient’s and family needs.

The goal of the POC is to help the patient live as comfortably as possible with emphasis on eliminating or decreasing pain and/or other uncomfortable symptoms. When documenting and planning care, consider actual and potential issues/problems. e.g. What is happening now and what is likely to happen in the future?

**PAGE ONE OF THE PLAN OF CARE IS THE PLAN OF CARE.** Key documentation items on this page include:

- Making sure the certification period dates are correct.
- Including any significant co-existing diagnosis.
- Indicating if the patient has an advanced directive (only if we have a copy).
- Indicating code status – only patients who have executed a DNR can be listed as “no code” – all others are listed as “full code”.
- Completing the PIGs specific to each patient/family

The next part of the POC consists of DME and supplies. The admitting nurse lists DME, both patient owned and contracted DME. Remember, a physician order is requires for ALL equipment in use by the patient. Supplements such as ensure are listed under supplies. If the patient has a foley, list foley catheter size and balloon size. Please remember when writing a foley catheter order to write 16 – 18 french; 5 – 30 cc balloon. This will provide efficacy in implementation of the POC. Items such as diapers and pads are listed as incontinent supplies.

A crucial part of the POC is the MAR (medication administration record). This item begins upon admission. All medications taken by the patient are listed. These include prescriptions, over the counter, and herbal medications. The route, frequency and dose, as well as any specific indication for prn medications are listed. Oxygen is listed on the MAR. Wound care products that are considered medications such as triple antibiotic ointment are also listed here. The start date is the date the patient is admitted to hospice, even if they had been taking the medication previous to admission, followed by new medications which start date will be when the physician order for that medication was received. Be sure to initial next to the medications that hospice provides for regulatory purposes.
5.

This brings us to the certification of terminal illness. The verbal order for certification is taken from the medical director and must be dated no more than five days before, and no later than two days after the beginning of a new certification period. The medical director must sign and date the certification within thirty days of the verbal order. We cannot submit a claim for payment until the certification of terminal illness is signed. Core team member signatures are also needed on the certification.

Upon admission the nurse will include PIGs to cover the patient until the first home visit. After the case manager makes the first home visit they will develop a PIG for any additional problems noted on that visit. These PIGs guide the care and interventions the team follows. Documentation MUST REFLECT the intervention and direction of care set forth in the PIGs. Each PIG should be completed based upon the patient’s problems and necessary interventions. Remember every PIG must be reviewed and dated at the time of each recertification at a minimum.

SOME OPERATIONAL REMINDERS FOR USING PIGs:

- Where appropriate, document the reason for the problem, e.g. alteration in physical comfort related to pain.
- If the intervention statement includes multiple individuals (hospice nurse, patient, caregiver, family, SNF staff) be sure to include who will perform the intervention.
- Note the responsible party/discipline next to each intervention.
- Include the date the problem is initiated, revised or resolved. Each problem must have a start date noted.
- Every problem must have at least one goal. You add/delete goals the same way you would an intervention.
- Be certain you have a PIG for each problem listed on the POC.

REMEMBER PIGs DIRECT INTERVENTIONS! YOU SHOULD PERFORM INTERVENTIONS AT EACH VISIT. IF YOU DO NOT PERFORM AN INTERVENTION FOR TWO OR MORE VISITS, ASK YOURSELF, WHAT DOES THIS PATIENT NEED TODAY? AND WHY ARE THEY ON HOSPICE?

HHA PLAN OF CARE

The HHA POC is prepared upon admission. The services of an aide are assigned based on patient and caregiver need. The Conditions of Participation state that home health aide services must be available and adequate in frequency to meet the patient’s needs.

Depending on the extent of the patient’s needs, and the ability of the caregiver to meet these needs, the frequency of visits may range from two times per week or more as necessary. We will often decrease or increase the aide visits as patient’s needs often change during a certification period. Remember to always get an MD order for frequency changes.
6.

On the first case manager visit, the HHA Plan of Care is taken to the patient’s home/facility and placed in the hospice folder. The HHA POC must be reviewed with the aide prior to the aide’s first visit. The HHA POC must also be reviewed and revised as necessary at each certification period. The revised copy of the POC is then taken to the patient’s home/facility.

**NURSING NOTES**

The nurse’s note is a blank canvas. The words you choose, or the documentation, paints the picture of the patient.

As you begin to assess the different systems, ask yourself: What is the primary diagnosis? What are the co-morbidities? At the end of the assessment ask yourself: How does my documentation of assessment findings validate hospice eligibility for this patient? Reading the assessment should give the reader a vivid picture of the patient you are describing and will justify ongoing hospice eligibility either through decline, eligibility criteria or hospice management of symptoms.

**ASSESSMENT**

We must complete a nursing assessment at least once a week, and more often is the patient’s condition is changing rapidly. You should obtain vital signs at each visit. Patient weight (or arm and thigh girth) must be documented at the minimum of once per month. You should always note is the patient has a caregiver present during your visit. If a caregiver is present make note of their understanding and participation with the interventions done. Patient medications are to be reviewed each visit. Physically look at the medications to see if the patient has started or stopped a medication we were not made aware of. Also document social support for every patient each visit.

**PHYSICAL ASSESSMENT CUES**

**Neurological**
If the patient is disoriented note the type(s) of disorientation (person, place, time). Is the patient confused, lethargic, combative, depressed, non responsive? Is speech aphasic, garbled, inappropriate? What is the quality and quantity of the patient’s sleep pattern?

**Musculoskeletal**
Note is the patient ambulates independently, and note the distance at least monthly. Remember, if someone has to support the patient when ambulating this is CONTACT GUARD assistance. Is the patient bed or chair bound? If the patient has contractures, note the location. How is the gait? How many falls have been of reported? Has the patient needed an increase/decrease in assistance with ADLs? Have these changes influenced the Karnofsky scores?
7.

**PAIN**
If the patient has pain in multiple locations, number each location and document the pain for that location by number on the pain scale. List medications (type, route, dosage, frequency) that the patient is taking to relieve pain; including medication taken for breakthrough pain (and other prn pain medications). Note the patient’s relief after taking the pain medications next to the numbered locations. Note if there is not relief and what interventions are taken to strive for relief. EVERY patient’s pain level must be assessed at EACH nursing visit.

**SKIN**
Note the locations of any skin tears or bruising. If the patient has IV access, note the relevant information. Document lesions, mottling, cyanosis, pallor, redness, jaundice and skin temperature.

**WOUNDS/DECUBITUS**
Document and number any decubitus ulcers or wounds. Note is there is drainage, tunneling, odor or granulation. Note if the area is unchanged, improved, or worsened. Document all wound parameters in centimeters (length, width, depth, drainage, etc). Wound numbers should always be consistent from visit to visit (#1 will always remain wound #1). All wounds must be assessed by the nurse a minimum of once per week (more often for frequent dressing changes).

**PULMONARY**
If the patient has rales, rhonchi, wheezes or diminished breath sounds, note the affected lobes and fields. If the patient is dyspnic on exertion or while ambulating, note the results in dyspnea. If the patient is using oxygen, note the frequency of use and flow rate (remember when writing oxygen orders to always write 02 at 2 – 5 liters via nasal canula; this will reduce the chance of error and forgetting to write an order when we have to adjust the flow rate). Describe any cough, apenic episodes and Cheyne Stokes breathing.

**CARDIAC**
If the patient has peripheral edema, note the grade per each affected extremity. For patients with lower extremity peripheral edema, check pedal pulses each visit. Note if pulses are present, absent, or diminished. Always get an abdominal girth on cardiac patients as a lot of the time this is where they hold the increased fluid, particularly if they sit is a recliner with their legs elevated. Note chest pain, both verbal and non verbal cues. When does chest pain occur? How is it relieved? Is there neck vein distention?
NUTRITION
If the patient has abdominal distention/ascites, obtain an abdominal girth measurement at EACH visit. Note the type of diet the patient is on and/or dietary supplements (type, frequency, amount). Note the patient’s appetite (good, fair, poor, increased, decreased). Note possible causes of poor appetite (mouth lesions/ulcers). Note bowel sounds (present/not present, and to what degree). Is there a feeding tube? Difficulty swallowing? (with solid foods/liquids)?

ELIMINATION
Note the date of the patient’s last bowel movement at each visit. Note if the patient has experienced any alteration in elimination since the last visit. Does the patient complain of diarrhea/constipation? Is the patient impacted? (if yes, what meds are they taking?) Are they incontinent of bowel? When? (during the day? at night?)

GUI
Is the patient incontinent of bladder? When? If the patient has a foley note at each visit, the size and date last changed. Is the patient retaining urine? Do they complain of dysuria? Is there hematuria? Is the patient experiencing oliguria (no urine output)?

COMMENTS/GENERAL STATUS
Patient and primary caregiver comments should be documented for each visit when comments are made related to problems addressed. A general statement must be made for each nurse’s visit. Summarize your assessment findings making particular note of indications that the patient is declining – use these statements on your IDG summary.

e.g. Patient states tried to put on shirt this morning, but only got one arm in before becoming short of breath. States he had to rest five minutes before he could continue dressing. Pt. states his appetite is poor and he is sleeping more. He is weak and now requires full assist with bathing and dressing which is a decline over the past thirty days.

INTERVENTIONS
Review the PIGs for each patient prior to your visit and address the interventions and education performed during your visit. Interventions should reflect what you have identified as patient needs through the PIGs.

e.g. Intervention Response Follow Up

O2 increased to 4L Uses continuous O2 Will assess effectiveness next visit

TEACHING
Note all teaching that is performed during your visit. Provide specific information regarding who was taught, the content and the individuals understanding of the content.
This is an intervention. Document any written materials that have been left so others can reinforce during future visits. e.g. Instructed patient/caregiver to keep feet elevated when seated. The patient/caregiver stated understanding.

HHA/LVN SUPERVISION GUIDELINES

An RN must perform HHA supervisory visits every two weeks for every patient being seen by a home health aide. The aide does not have to be present. If the aide is not present the RN will review the aide’s performance with the patient/caregiver. An RN must perform LVN supervisory visits every month for every patient being seen by an LVN. LVN supervisory visits MUST be observed.

IDG UPDATE SUMMARY

This summary must be completed before every IDG meeting. It is completed by every case manager for every patient on their caseload every two weeks. The case manager notes all primary problems that required intervention. The case manager CLEARLY documents the patient’s decline and the reasons they remain hospice appropriate. The other core team members will document patient issues and interventions. The LMD should note recommendations for changes in care. This summary is used to document the overall assessment of the patient’s condition and patient/family comments as they relate to the hospice diagnosis. This the opportunity to document decline. Key areas that should be noted included:

- Level of consciousness
- Weakness
- Appearance of skin
- Weight loss/appetite
- Chest pain/shortness of breath
- Decline in performing ADLs

For those patients that are non responsive and cannot show further decline, we would write the statement: Any further decline would result in death.

DECLINE

People with terminal illnesses have numerous needs for care, including physical needs, symptom control and pain management, especially at the end-stage of the disease. Disease progression is unique to each patient and each disease should be described in detail related to the patient’s life. Statements of general decline and disease continues to progress to not adequately describe the patient’s condition or disease process. If a patient is declining it should be specifically noted that the decline is indicated by …………. 
Document why the diagnosis supports a terminal prognosis. Provide past history where possible to illustrate decline. Illustrate decline in detail. Make comparisons – last week the patient ambulated fifteen feet before he became short of breath. This week the patient became short of breath and had to rest after ambulating ten feet.

Summarize the recent progression of the illness. e.g.
Patient reports SOB at rest and has chest pains with the least bit of activity. LE edema (feet and ankles) remains at 4+ even with an increase of lasix of 20 mg/day. Karnofsky score of 40. Unable to do any activity without discomfort. Uses O2 @ 2L via nasal canula to sleep. In continent of urine at night with increasing episodes throughout the day.

The quality of care we provide is the MOST important service we can offer, and it should be reflected in our documentation. Our documentation is the masterpiece that portrays our quality of care.
PAINT THE PICTURE
POST TEST

1. The lack of documentation in a medical record is interpreted to infer that no nursing observations, interventions or communications were done.
   True False

2. Interventions are your future plans for the patient.
   True False

3. The Plan of Care must be established before giving care.
   True False

4. What do assessment questions include?
   A. What is the primary diagnosis?
   B. How does my documentation validate hospice eligibility?
   C. What are the co-morbidities?
   D. All of the above

5. A PIG directs the care that is given.
   True False

6. There is a direct connection between the degree of ADL needs and the Karnofsky score.
   True False

7. It is most important to have an exact score on the Karnofsky (42 or 47)
   True False

8. The IDG Summary must be completed before every IDG meeting.
   True False

9. The IDG Summary is the primary opportunity to document decline.
   True False