I want you to write down your morning routine that you do every morning.

Example:

1. Get up and brush teeth
2. Wash face
3. Put on house shoes and go downstairs to make coffee
4. Check my phone for messages
5. Check my e-mail and reply to any important ones.
6. Take a shower

Now, pass your list to the person next to you. Look it over.

Wait for further instructions from me.

Would you like to follow this person's schedule you were passed?

This is how your consumer feels, when they have to follow schedules that we demand they follow. You need to consider how they feel when working with them and let them have as much choice as possible.

"The Dynamics of Documentation" Part I

What Everyone Needs To Know (The HCS Program)

Presented By Julie Blacklock
From Twogether Consulting, Limited

What is The Provider Required To Document?

- Expectations from DADS
  (Survey Certification, Billing &/or UR Department)
  The Provider is required to document on the individuals we serve:
  - The Needs of the Individual
  - Assistance Given To or Received By the Individual
  - Supervision of Health and Safety of the Individual
  - Unusual Incidents *(Inappropriate Behaviors included)*
  - Injuries/Illnesses
  - Community Outings/Leisure Activities

What Does This Mean For Us?

- **Staff notes/Service Delivery Logs**
- **Training Program Data Collection**
- **Incident/Injury Reports**
- **Illnesses Reported**
- **Behavior Data Collections**
- **MARS (Med. Admin. Sheets)**
- **Treatment Sheets**
  - **(reposition Q 2 hrs, etc….)**
- **Others**

How Do I Meet the Requirements?

- **Complete all documentation in a timely manner**

- **Ensure that all the components are included**
- **Ensure the information is consistent**

What Should Be Documented in SDL's?

- **Name**
- **Date**
- **Location**
- **Begin/end times**
  - **Not necessary for RSS/SL SDL's**
  - **Not necessary for FC SDL's**
- **Signatures, initials**
- **Service provided**
- **Description, or checklist with comments**
  - **What service was provided**
  - **What the individual did**
  - **What you did to assist the individual**

What They Did, What I Did

What to include in SDL note/log:

- **Level of Assistance Provided/Received**
- **Progress Towards Training**
- **Unusual Or Inappropriate Behaviors**
- **Illness &/Or Injuries**
- **Outings/Recreation**
- **Family Contact**
- **Leisure Activities**
- **Special Events**
- **Supervision of Health & Safety**

Residential Support Services (RSS)

- **Checklists with comments**
- **<u>or</u> Old SDL's may be used**
- Clear Shift Change
  - 12:01 AM
- **Minimum of <u>2</u> notes/logs per day**
  - **Night-time assistance** must be noted-
    - Monitoring health & supervision of safety
  - **Why do they need** *<u>24 hr awake staff</u> (night)*
  - **What they did**-*training/service objs, ADL's,et..*
  - **What you did**-*type of asst. given or needed-meals, transportation, ADL's, etc….*
  - <u>or</u> Comment on ***unusual incidents*** *or events*
  - Date & sign

Supervised Living (SL)

- **1 note/SDL checklist per day vs.1 per shift**
- **Date, sign**
- **No Awake Staff Required-Nights**
- **Documentation describes**
  - **What They Did-** *Training/service objs, ADL's,etc…*
  - **What You Did**-*Type of asst. given or needed-meals, transportation, ADL's, etc….*
  - <u>or</u> Comment on ***unusual incidents*** *or events*
  - No Begin and End Times Required.

Supported Home Living & Community Support

- **Checklist with comments <u>or</u> SDL notes**
  - Checklist-date, begin & end time, signature, SHL codes, location codes
  - *SHL can provide certain non-f/f activities-see SHL checklist form*
  - *At least 1 note/SDL checklist per day of service.*

<u>Comments Should include:</u>

- *Progress toward training objectives*
- *Unusual incidents- illnesses, injuries &*
- *Special events- appts., outings, etc…*

- **For "Old" style SDL Logs/Notes only:**

Service obj's., training, transportation, incidents, special events-medical appts., illness, community outings, non-f/f billable activities,

Foster Care (FC)

- **1 Weekly Note or 1 Daily Note**
  <u>Or</u>
- **SDL checklist with daily/weekly comments**
- **Dates & Signature**

<u>Must have Notes or Comments to include:</u>

- ***Progress*** **toward training objectives**
- ***Unusual incidents*** **- illnesses, injuries, behavioral issues**
- ***Special events*** **- appts., outings, etc…**
- **<u>Level of Assistance Provided</u>**
  - **What they did**
  - **What you did**

Day Habilitation

- **Weekly /Daily note <u>or</u>**
- **SDL checklist with daily/weekly comment**
- **Begin Time & End Time**
  - **(Consumer's Time vs. staff time)**
- **Location: Place & Address**
- **2 hrs = ¼ day & up to 5 hrs= 1 day**
- **No work related activities or sleeping billed**
- **What they did**
- **What you did**
- **Unusual incidents or special events**
- **Pre-voc activities ok**

Supported Employment/ Employment Assistance

- SDL with checklist
  - (daily comments if app.)
- Or note
- Progress or Lack of Progress towards objs.
- Document vocational activities
- Document attendance of meetings/staffings
- Document phone calls to employer/individual/SC

Respite

- Pretty much any comments or just checklist is okay

Give Yourself Credit!

- **Use key words to describe action**
  - **Physically assisted**
  - **Verbally prompted**
  - **Hand-over-hand assistance**
  - **Physically redirected**

What happens if we don't?

- **Loss of funding**
- **Loss of resources**
- **Loss of jobs**
- **Loss of license/contract**

Don't forget!

Your documentation effects:

- **Consumer's Services**
  - **Type**
  - **Amount**

- **Provider's Reimbursement**
  - **Money used to provide services**
  - **To pay staff**

RN Delegations

- How Does RN Delegation Affect The Staff Documentation?
- RN must ensure all items mentioned in NSP
- RN must assess and train staff/UAP's on delegated routes and/or tasks.

FC Exemption

- What expectations does the RN have of the FC Provider ?
  - Consults returned to nurse from physicians in timely fashion
  - Contacting RN Prior to Giving PRN Psychotropics
  - Reporting to Nurse Health Status Changes
    - Illnesses/Medical Complaints
    - Any Administration of PRN's (good practice)
    - Medical appts.
    - Hospitalizations (Admissions/Discharges)
    - Injuries

SB 1857 (RN Deems UAP Appropriate To Administer Meds. per Oral, Topical, & Metered Dose Inhaler)

- Who is considered a UAP?
- What Can The UAP Do Concerning SB 1857?
- What about other routes?
  - Nasal, Ear drops, Eye drops, Sublingual, Per G/T, Rectal, Vaginal, etc…
- What about other medical tasks?
  - (Ex: stoma care, G/T feedings, Nebulizer Treatments, CPAP, Vitals, Blood Sugar checks, etc…)

Other Nursing Expectations

- RSS/SL, SHL, FC, DH, or any other direct care staff contracted or employed by the provider, may not administer or assist with any medically related tasks (HMA's), until the RN Delegates them to do so, or if they are FC exempted.
- They may also be deemed appropriate to administer oral, topical, metered dose inhaler routes (and only these routes), without delegation, through (SB1857)
- Another possibility is that the CRA agrees to be responsible for supervising the staff in these HMA's. (as opposed to RN)

Nursing Service Plans

- What is the NSP?
- Who Carries Out The NSP?
- What is my role as a direct care staff with the NSP?
- Where Can I see the NSP?
-

MARS

- Document on MARS at time medication given
- Sign name on MARS (somewhere)
- Initial on day and time of appropriate MARS given
- Notify Nurse For Med. Errors, document med. error on MARS.
- Be aware of how nurse wants you to document med. errors on MARS

NURSING DIAGNOSES & CONCERNS	GOALS/OBJECTIVES	STRATEGIES/ IMPLEMENTATION
Skin Integrity Intact <u>Problem Issue:</u> Hx of Decubitus	**Skin Integrity** -Consumer will be free of pressure sores and Decubitus, rashes and skin breakdown	**Skin Integrity-** Instruct staff to reposition Q 2 hours and to check for reddened areas, hot spots, discoloration, swelling and any skin breakdown at bathtime, changing or during stoma care. -Staff will document on repositioning checklist Q 2 hours. -Staff will record in progress notes and notify nurse if any of these signs of breakdown are noted. -Staff will give a frequent bolus of H20 in addition to flushing with H20 before and after G/T feedings and/or meds are administered. Staff will thoroughly clean rectal and groin areas after BM's and adult brief changes and apply A&D ointment as per orders. Staff will thoroughly clean stoma area prior to brief changes and at bathtime. Staff will apply moisturizing lotion to body following bath. Joe will wear "booties" when in bed to prevent pressure sores. Nurse will discuss status of consumer concerning skin integrity with the direct care staff at <u>as needed.</u> <u>Nurse will</u> review MARS (lotion and A& D), skin integrity dc notes, repositioning checklists in order to evaluate for any noticeable changes in skin integrity monthly. Nurse will re-assess plan as needed.