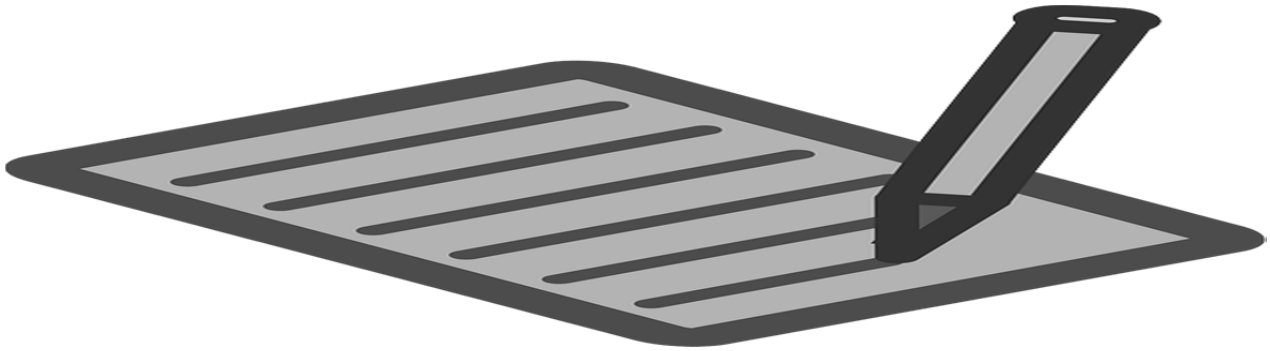

Documentation and Reporting – In-service August 2019

Documentation

Time Slips are ALWAYS due by **9am** every Monday. No exceptions! None, not even Holidays!
They must be 100% accurate & complete to be processed. If you turn in your time slips LATE, you will be paid LATE.
Always turn in your time slips the week they are due. DO NOT hold time slips to turn in with another week. Even if you only worked one day, we still need it the week they are due. If you DO NOT turn them in the week they are due, you are putting yourself at risk for disciplinary action. Your rate of pay for those hours may also be reduced to minimum wage, and if the time slips are for any prior month, other than the one we are in, your rate of pay **WILL** be reduced to minimum wage for those hours. They must be 100% accurate & complete to be processed.

This means:

1. They must have a time in and time out
2. They must be initialed daily by the client.
3. They must have the client's name at the top.
4. They must have the client signature at the bottom at the end of the week.
5. They must have the CNA's printed and signed name at the bottom.
6. They must have tasks checked daily. These must match what is assigned on the Care Plan.
7. They must have notes on the back when time is missed.
    a. "out" is not a note. "dr" is not a note. "hospital" is not a note. You must specify who had the app't, who went to the hospital, out where? We must have specific reasons as to why we missed service.
    b. You may have notified staffing of your absence but it is required to document on your time slip what that reason is.

8. They must have vital signs recorded as assigned on the individuals Care Plan.
9. They must be done in Blue or Black ink only.
10. They must be clean and neat.
11. You cannot use white out for any reason on a Time Sheet.
12. You must separate Time Sheets for separate months.
13. Do not put staples in your time sheet

Possible Scenarios:

1. Client does not want a bath
    a. Call the office immediately.
    b. Document on the back of the time sheet why the bath was not desired.(and make deviations)
    c. Ask supervisor what time you should leave due to refusal of bath.
2. Client not home
    a. Call the office immediately(before you leave the client's property)
    b. Document on the back of your time sheet that client was not home
    c. We as an agency need to try and locate the client.
3. Client tells you to leave early.
    a. Call the office immediately.
    b. Document on the back of your time sheet why they asked you to leave early.(make deviations)
4. You write an incorrect time on your time sheet.
    a. Make sure to correct time so it is legible.
    b. Have the Client initial the change.
5. Something spills on your Time Slip.
    a. Re-Do the Time Slip. We cannot put a NASTY Time Slip in the Client's record.

Time Sheets are a Medical Document which becomes a part of the Client's Medical Record when processed. You, as the Author of the Time Sheet must make any,and all corrections to this document.

Time Sheets must be complete, Correct and Legible to be put in a Client's Record.

Reporting

Call the NURSING SUPERVISOR IMMEDIATELY, and DOCUMENT if ANY of the following are noted:
1. T is > 99
2. P is > 100 or < 50
3. R is > 30 or < 10
4. BP is > 160/90 or < 90/50
5. CBG (blood sugar) is >250 or < 70
RESPIRATORY DIFFICULTY – Shortness of breath.
ANY CHANGE IN LEVEL OF CONSCIOUSNESS – Drowsy; sleepy.
URINE - Foul, cloudy, sediment present, bloody, decrease in amount, pain/burning upon urination.
SKIN - Any breakdown that is new in origin, or any worsening of existing breakdown site.
FALLS - Call Supervisor**,** Family member. Refer to: "Emergency Contact Info" in client's folder.
CALL 911 FIRST FOR EMERGENCIES, Then contact the D.O.N. immediately
RESPIRATORY DISTRESS – Gasping for air, severe wheezing, "can't breath".
CHANGES IN LEVEL OF CONSCIOUSNESS – Cannot awaken, slow to respond.
FALLS – If patient complains of pain DO NOT MOVE THEM!! CALL 911.

The above information is on the top of every care plan, it is your job as a CNA to make sure that any medical changes to your client must be reported immediately.

Possible Scenarios:

You arrive at your client, begin assisting with a bath and notice that your client feels rather warm, you take the clients temperature as outlined on the care plan. The clients temperature is 99.9 which you know is elevated from the normal temperature, so you share with the client, your client responds "I am fine", you let the client know that you need to report to the office and the client says "Please don't tell them", you should:

a. Record the elevated temperature on your timeslip.
b. Contact the DON as soon as possible without upsetting the client(step out and call or call immediately following your shift).

Your client calls you and gives you their new address they moved to over the weekend and tells you how to get there, you should:

a. Ask if they have contacted the office to let them know, even if they have, you need to call the office and let us know before you go to provide services.

REPORTING/DOCUMENTATION TEST- August 19

Name :_____

1. My Client has an odor coming from a wound on their leg; I should just ignore it since I am not supposed to do wound care.

   TRUE ☐ FALSE ☐

2. I took my clients vital signs, and their blood pressure is lower than normal but not as low as it says to report it, I should:

   ☐ a. Take it again to be sure then record and report it to the DON.
   ☐ b. Make up one that is close to the rest.

3. My client moved and I found out that they had not notified the Office so I should call right away.

   TRUE ☐ FALSE ☐

4. I arrive on Monday morning to my client and they let me know they had fallen during the night but I don't see any bruises and they seem fine, I don't need to tell anyone.

   TRUE ☐ FALSE ☐

5. I arrive at my client's home and they have an O2 concentrator and are smoking a cigarette, I should:
   ☐ a. Yell at them" what are you doing, you are going to blow the house up"
   ☐ b. Politely excuse yourself, go outside and call the Office to inform them.
   ☐ c. Call 911 in a frantic panic.

6. My client's care plan says "do not leave alone", it is time for me to leave and their caregiver has not returned, I can leave because I am sure the caregiver will be back in a minute.

   TRUE ☐ FALSE ☐

7. If I am not sure whether or not to report something, it is always better to report it anyway.

   TRUE ☐ FALSE ☐

8. TIME SHEETS ARE DUE BY_____AM ON MONDAY.

9. I MUST HAVE THE CLIENT INITIAL MY TIME SLIPS EVERY DAY.

   TRUE ☐ FALSE ☐

10. WHITE OUT IS ACCEPTABLE FOR MISTAKE CORRECTS.

    TRUE ☐ FALSE ☐

11. FOLLOWING THE CARE PLAN MEANS CHECKING EVERYTHING REGARDLESS OF WHAT IS ASSIGNED.

    TRUE ☐ FALSE ☐

12. I DO NOT NEED NOTES ON MY TIME SHEET FOR ANY REASON.

    TRUE ☐ FALSE ☐

13. TIME SHEETS MUST BE IN_____OR_____INK, ACCURATE, _____ AND NEAT.

14. I DO NOT NEED TO CALL THE OFFICE WHEN MY CLIENT REFUSES BATHING.

    TRUE ☐ FALSE ☐

15. THE BACK OF MY TIME SHEET IS FOR VENTING ABOUT MY CLIENT.

    TRUE ☐ FALSE ☐

16. IF I SPILL SOMETHING ON MY TIME SHEET I SHOULD JUST TURN IT IN LIKE IT IS AND I WILL STILL GET PAID FOR IT.

    TRUE ☐ FALSE ☐

17. SHOULD I SEPARATE MY TIME SHEETS AT THE END/BEGINNING OF THE MONTH?

18. TIME SHEETS DO NOT NEED TO BE TURNED IN ON A HOLIDAY.

    TRUE ☐ FALSE ☐

19. I CAN SUBMIT A PAPER WITH MY HOURS ON IT IF I RUN OUT OF TIME SHEETS.

    TRUE ☐ FALSE ☐

20. My timesheets are late, what should I do?

☐ a. Hold them until next week.

☐ b. Call and let the office know why they are late.

☐ c. Turn them in ASAP

☐ d. Both b and c