COUNTY OF LOS ANGELES
CHILDREN'S MEDICAL SERVICES
HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE (HCPCFC)

CMS **Policy/Procedure (Revised 04-11-12)**
HCPCFC

Subject: Public Health Nurse Documentation Policy

PURPOSE

To standardize the documentation for HCPCFC Public Health Nurses.

SCOPE

Responsibilities of the Public Health Nurse (PHN) when documenting foster children's health information into the Child Welfare System/Case Management Services (CWS/CMS) database.

DEFINITION

Documentation is the process of inputting health information electronically into the CWS/CMS database.

POLICY

The PHN will adhere to documentation guidelines established in this policy when inputting health information into CWS/CMS.

PROCEDURE

1. **The PHN will document the contact note in PIE format(Delivered Service Log) PIE Charting: A written method used to communicate a case consultation as follows:**

    i. **Problem/Purpose- State the problem or purpose subjective and/or objective data supporting the stated focus.**

    ii. **Intervention- Nursing actions taken (record in contact not Health and Education Passport (HEP).**

    iii. **Evaluation- Evaluation of interventions and outcomes.**

2. The PHN will create a contact note (Delivered Service Log) for every entry.

3. The PHN will complete each contact note with the initial of their first name, full last name, and title at the end of the contact note (Delivered Service Log). Example: T. Works, PHN.

4. The PHN will write their initials and title in capital letters, and the date of entry in parenthesis after every entry into CWS/CMS Health Notebook. Example: (TW, PHN, 8/01/10).

5. The PHN will provide Children Social Worker (CSW) a Delivered Service Log for each consultation.

6. The PHN will save the consultation form and the Delivered Service Log for 2 years when health problems have been identified.

7. The PHN will document the source of health information into CWS/CMS, i.e. PM160, PMA.

8. The PHN will adhere to the PM160, F-Rate, Home Visit, PMA and any other policies pertaining to documentation.

9. The PHN will document all pertinent health information into CWS/CMS Health Notebook

10. The PHN will check for correct spelling and grammar before saving all documentation.

11. Do not use abbreviations of medical terminology or words that are not approved.

12. The PHN will record all interventions into the Children Medical Services Portal (CMS Portal) daily.

13. The PHN or PHNS will complete a contact if they are asked to review a case in CWS/CMS that is not part of their caseload.

PROCEDURAL GUIDELINES FOR DOCUMENTATION IN THE HEALTH NOTEBOOK

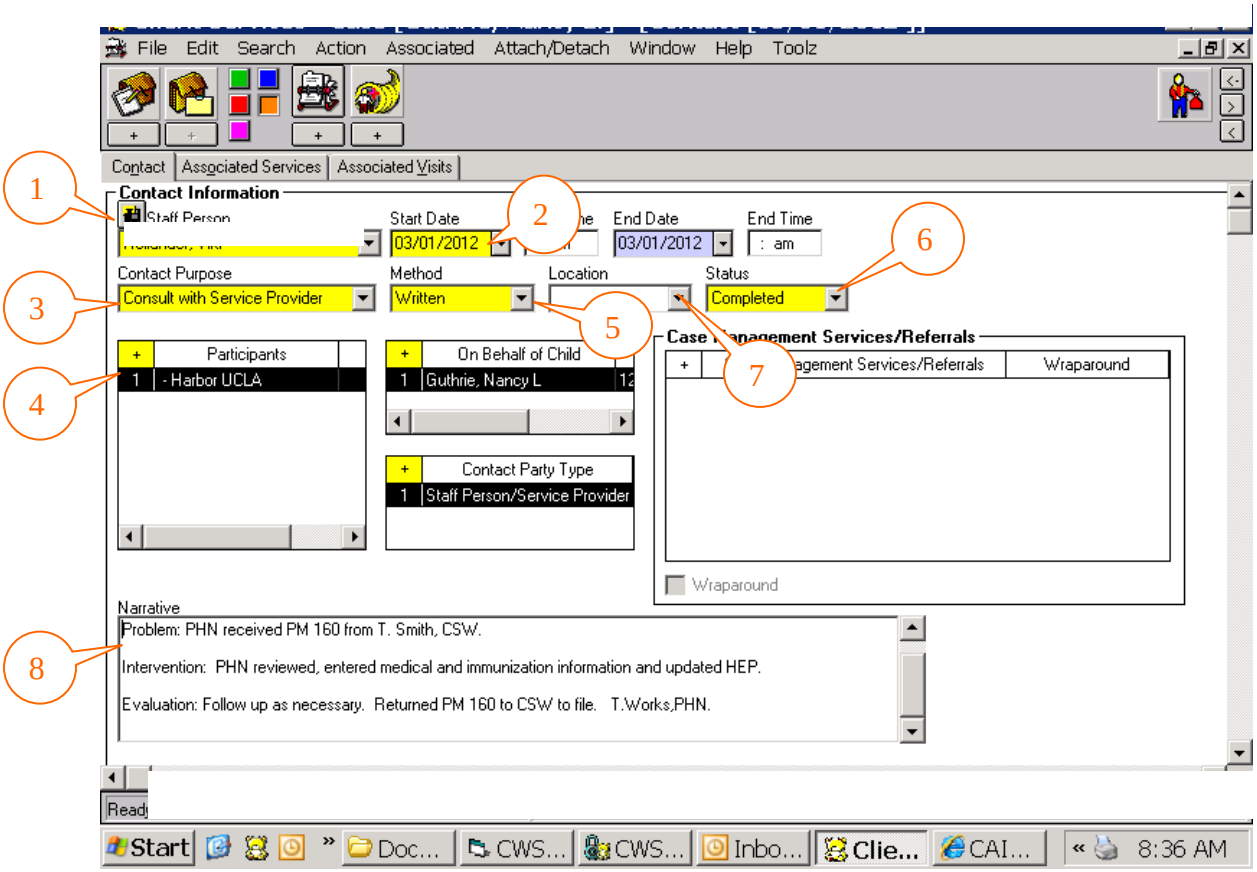
CONTACT: A written entry into CWS/CMS using the PIE format about a nursing intervention (s).

Problem/Purpose*:* A statement of how the PHN received the case consultation and a problem if known.

Intervention: The PHN assessment, observation, findings, and action taken.

Evaluation*:* Plan and or recommendation for follow up or completion of the consultation

Contact Example:

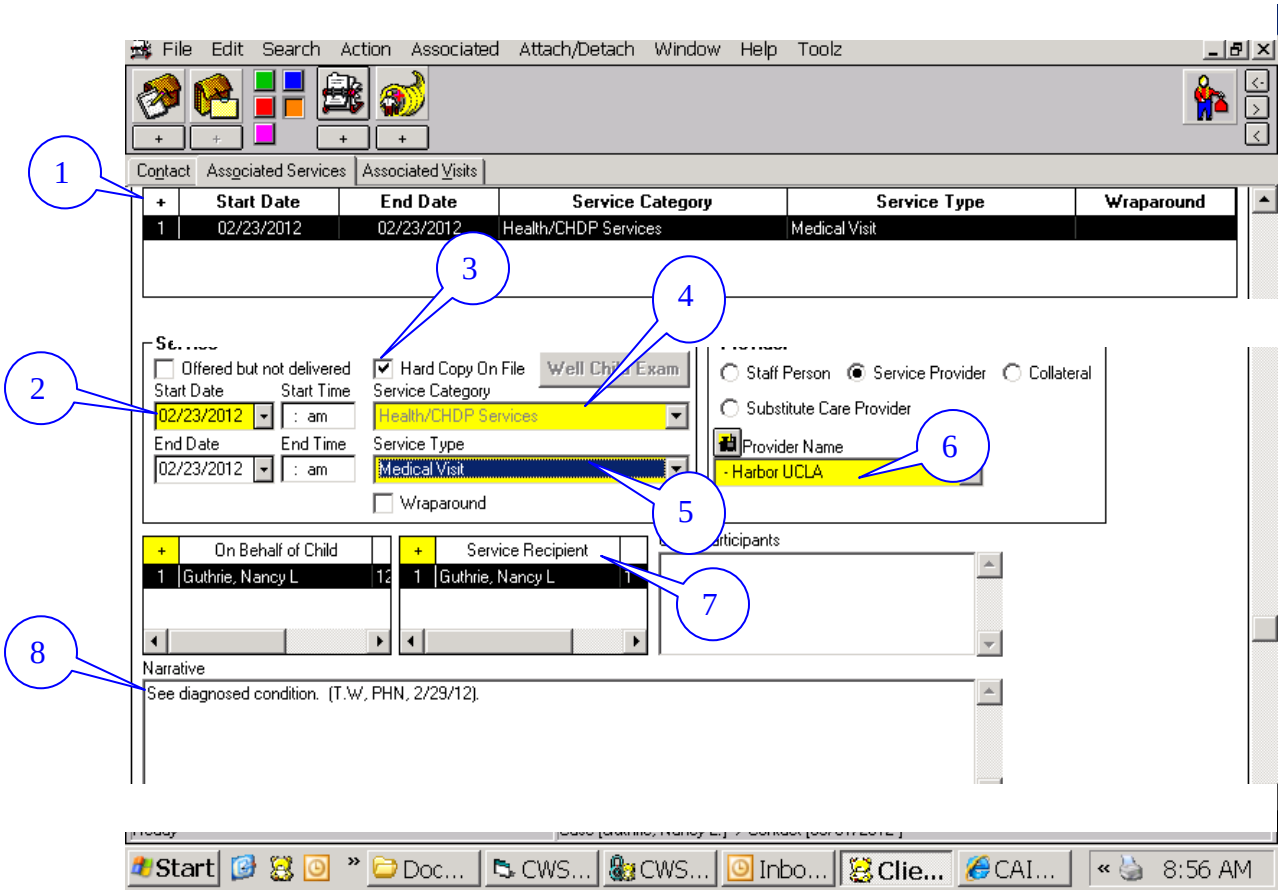


ASSOCIATE SERVICE SECTION:

1. Associate Services: Check the history of date of services first to avoid multiple dates of health services**.**

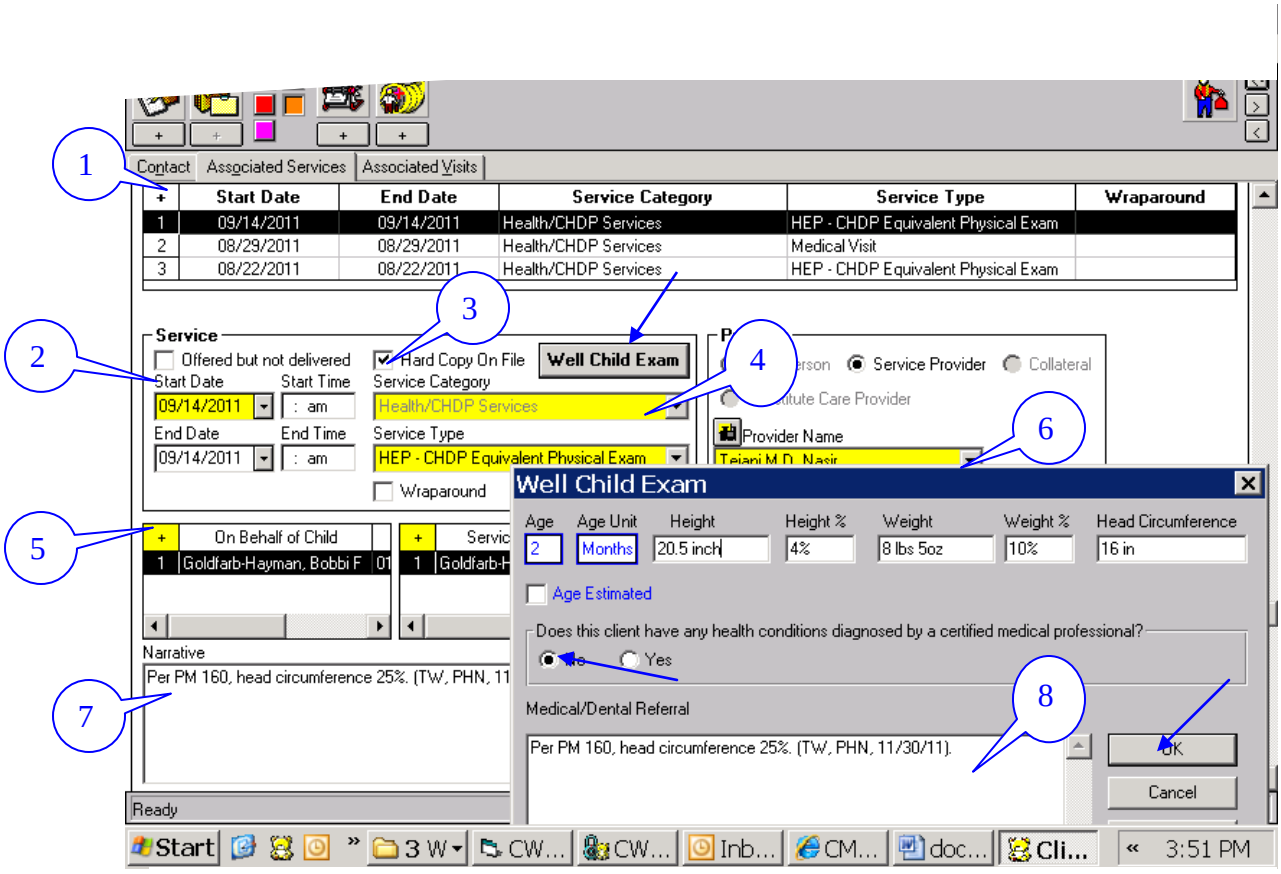
2. Associate Narrative box, Sick Visit: Document "See diagnosed condition of the Health Notebook."

Associated Narrative box, Sick Visit Example:

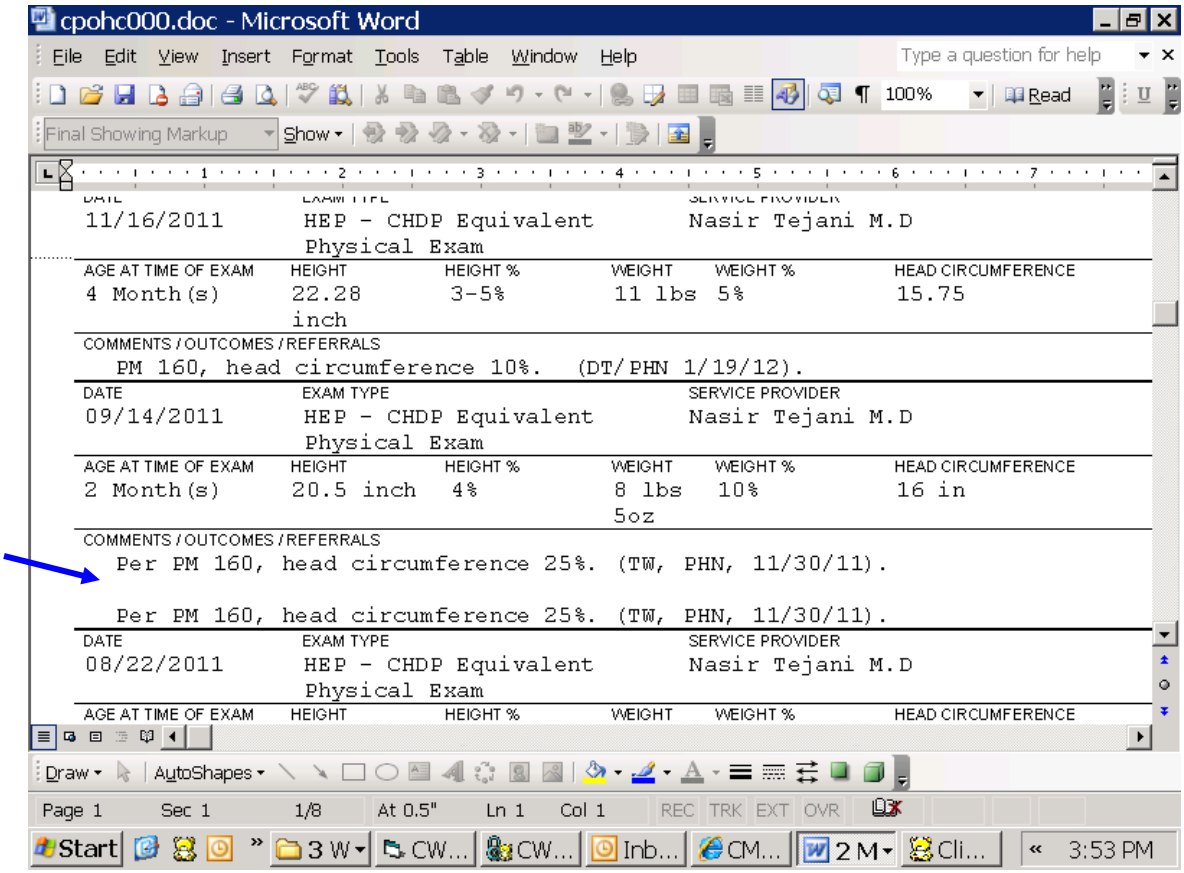


3. Associate Narrative box, Well Child Visit: Do not document any information in this box because when you print out the HEP, it will populate 2 entries in the well child section of the HEP.

Associate Narrative box, Well Child Visit Exam:



Associate Narrative box, Well Child Visit Example 2: populated to the HEP, showing 2 entries:



In the Health Notebook Sections (Blue Button in CWS/CMS): Summary, Diagnosed Condition, Observed Condition, Hospitalization, Medication, Medical Test, Referral, Immunization, Well Child, and Birth Record. The PHN is *required* to document as follow:

I. SUMMARY PAGE SECTION:

Use this section to summarize a foster child's *current major health* condition & information such as:

1**.** CCS, case manager, hospital medical record numbers.

2**.** List only major/chronic health conditions: Heart, Cancer, Asthma, CP, DM, Autism, Heart Surgery, Intracranial Shunt, G-Tube, etc. ***NOTE:*** These are not substitute diagnoses. The PHN must initiate the diagnoses in the diagnosed condition section.

3. If the medical condition is resolved, the PHN may document it as resolved, include date if known. Example: GERD: resolved per 561(a) dated 3/17/11.

4. Check small boxes: Sensitive Health, Regional Center, and/or Developmental Disability if applicable. (see example below): *** Note:** Sensitive Health box is only checked for HIV/AIDS. All the developmental disabilities must be diagnosed by Regional Center before the regional center and disability boxes can be checked.

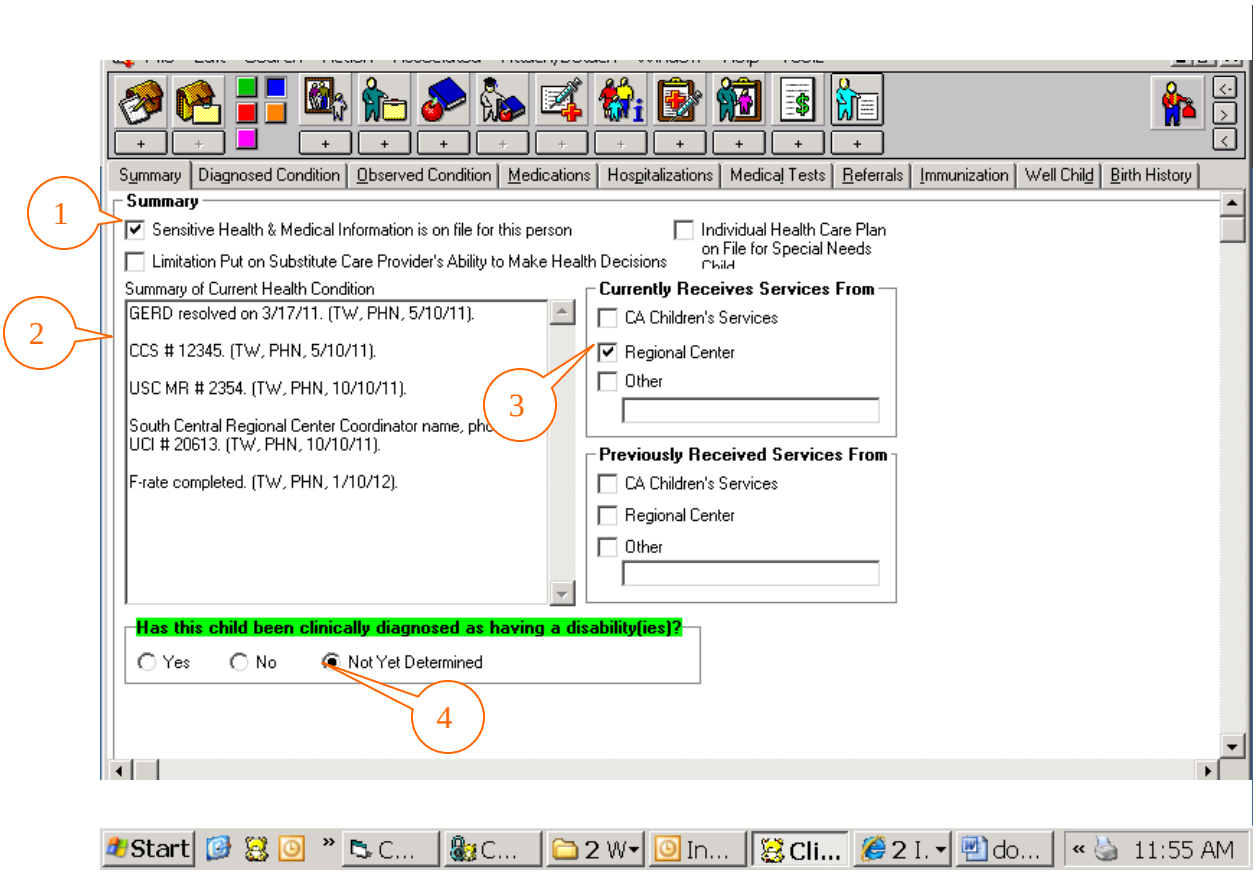
5. Document F-rate and date of completion *but not the F-rate level.*

6. Document the current specialist name and phone number, i.e. cardiologist, neurologist, and urologist.

7. Do not document PHN telephone calls, actions, unnecessary and lengthy information in this section.

8. Do not document treatment/medication (s) in this section.

Summary Example:



II. DIAGNOSED CONDITION SECTION:

Use this section to record any condition diagnosed by a clinician/specialist. Record as much information about the condition as possible. A diagnosis is required in order to enter additional health information in the Medication, Hospitalization, Medical Test, and Referral sections of the HEP. Use start and end dates to document child's health history.

Before entering a diagnosed condition follow the steps and example below:

1. Review all diagnosed conditions to avoid duplication.

2. Separate each diagnoses and treatments when diagnosed on the same date. List a diagnosed condition once.

3. **Alert box:** check it if applicable. See PM160 policy for details.

4. **The Health Problem Description Box:** Enter all subsequent visits related to the same diagnosis in a descending chronological order.

a. It is required to document the sources of services: i.e.: 561(a), (b), (c), PMA, PM 160, medical records, or clinician/specialist's notes.

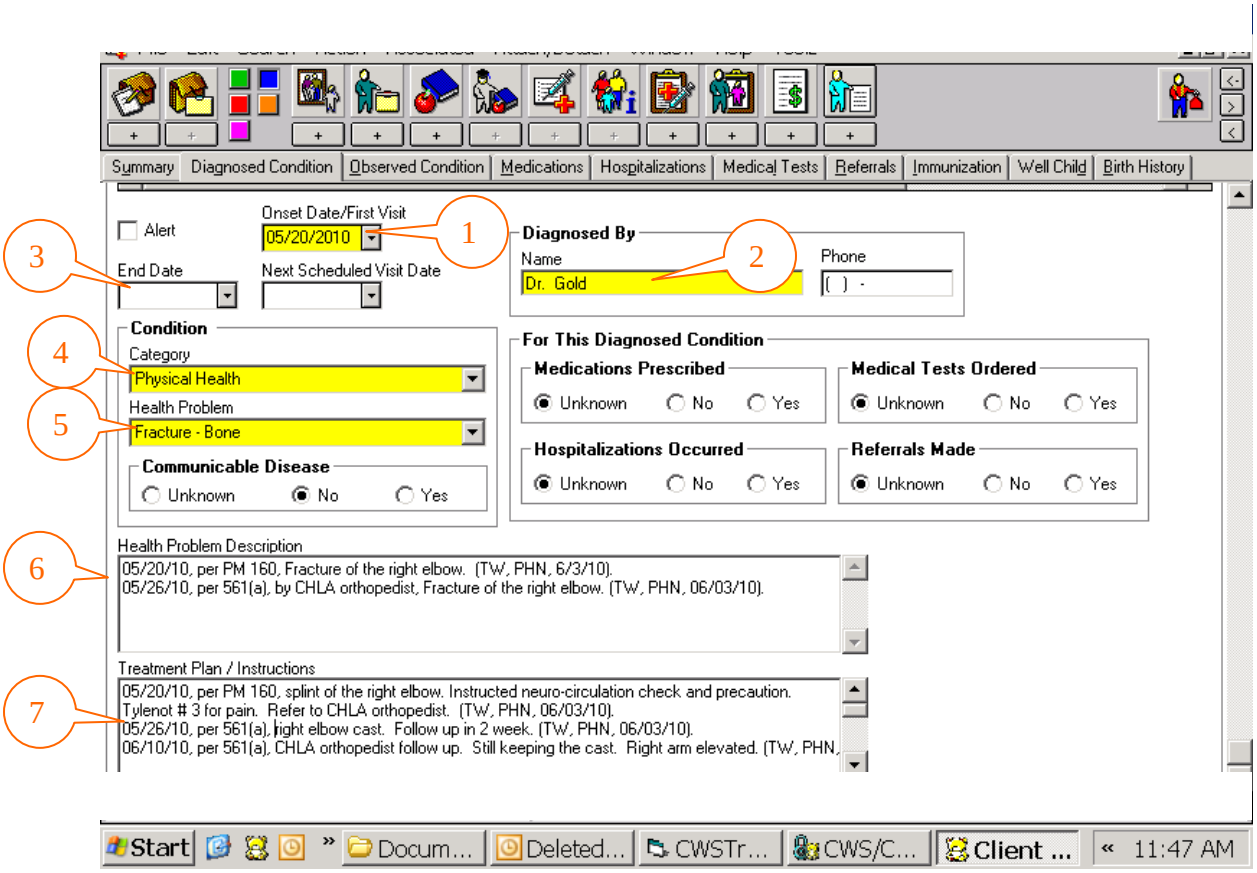
5. **Treatment/Instruction Box*:*** List all treatments as prescribed by the provider. Enter all subsequent treatments/instructions in a descending chronological order.

a. The PHN may go to medication, hospitalization, medical test or referral sections if applicable.

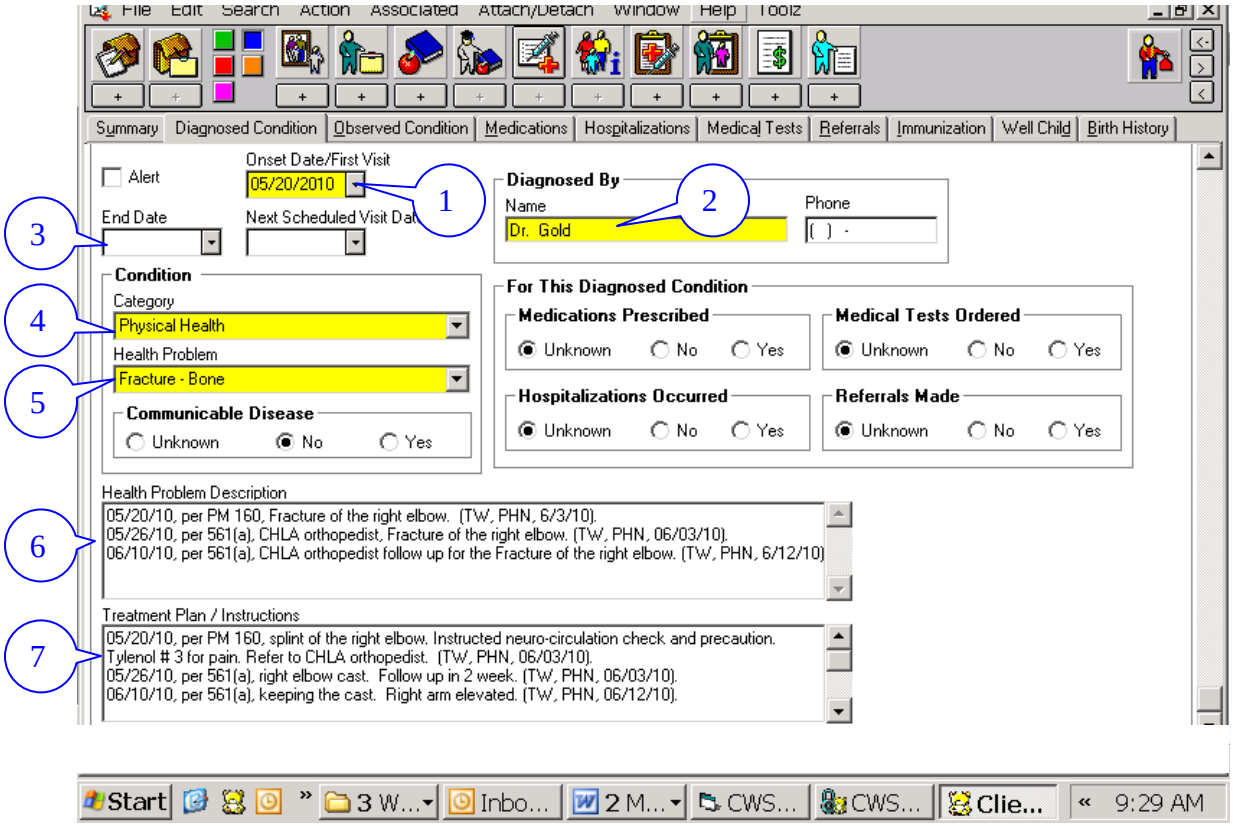
b. The PHN may document short term medications prescribed for 10 days or less.

6. End Date the diagnosed condition if supported by medical documentation.

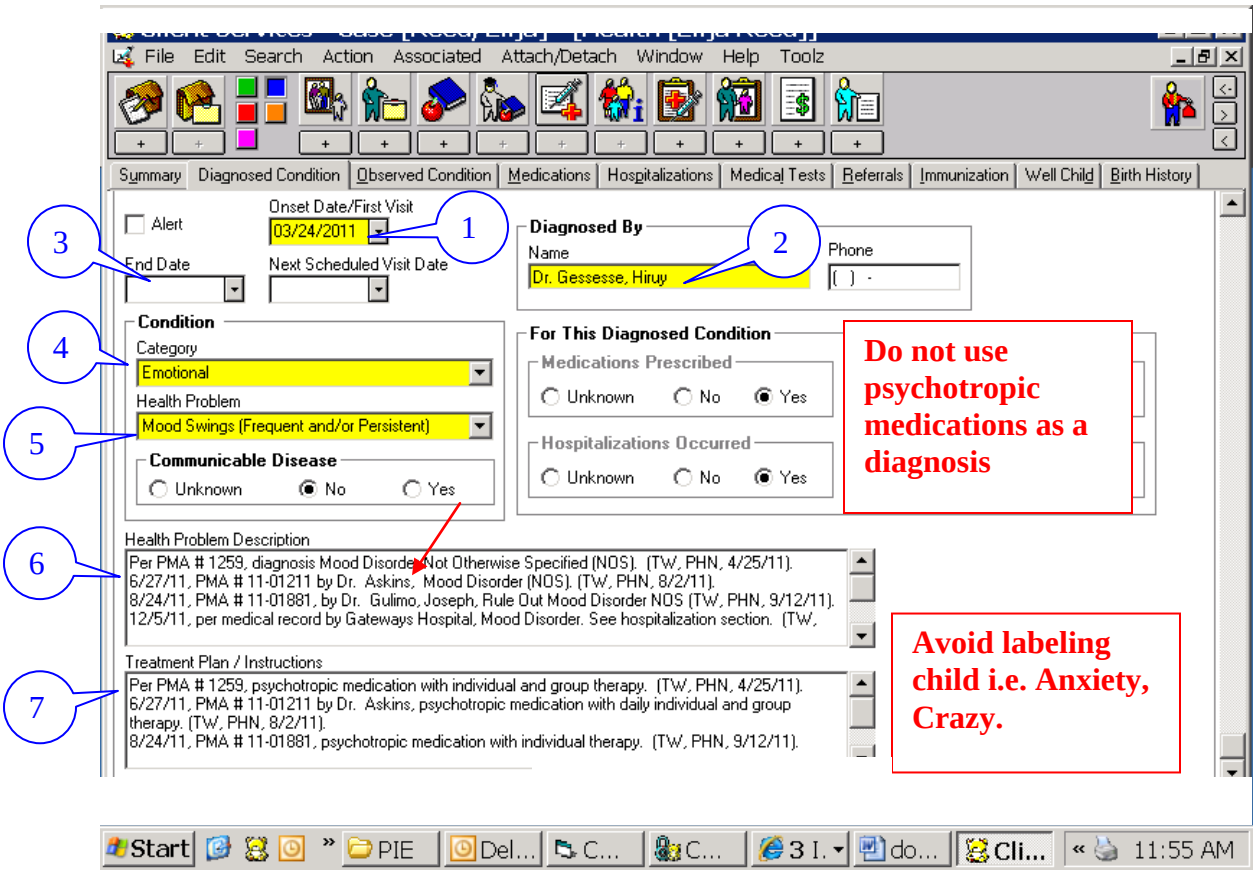
Health Problem Description and Treatment Example 1: PM160, 561(a)



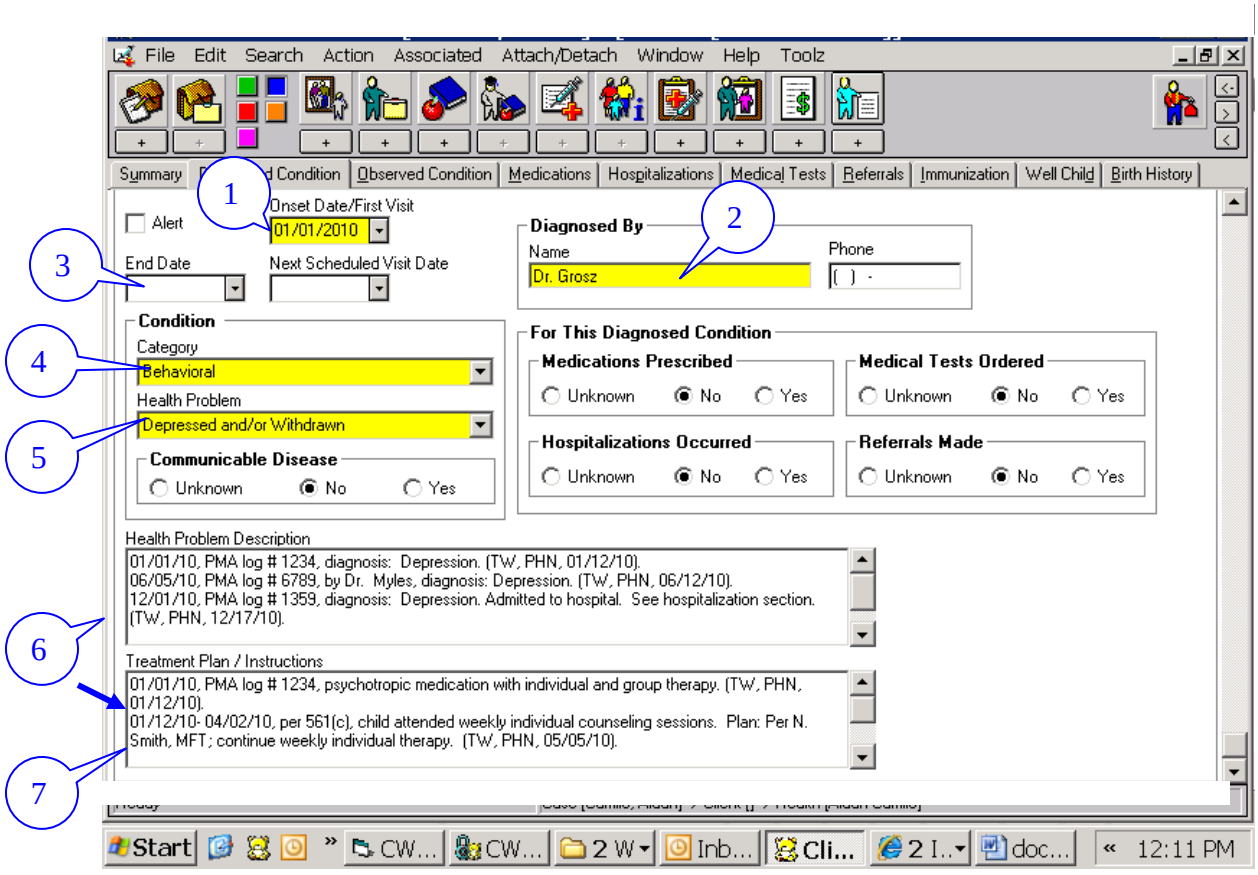
Health Problem Description and Treatment Example 2: PM160, 561(a)



Health Problem and Description Treatment Example 3: PMA example:



Health Problem and Description Treatment Example 4: PMA example, how to enter multiple 561(c):



III. OBSERVED CONDITION SECTION:

Use this section to record any conditions observed by a PHN. Record as much information about the condition as possible. Use start and end dates to document child's health history. Observed conditions will only print to passport if the alert box is checked.

IV. MEDICATION SECTION:

Use this section to document prescribed medications. These medications must be tied to a "Diagnosed Condition."

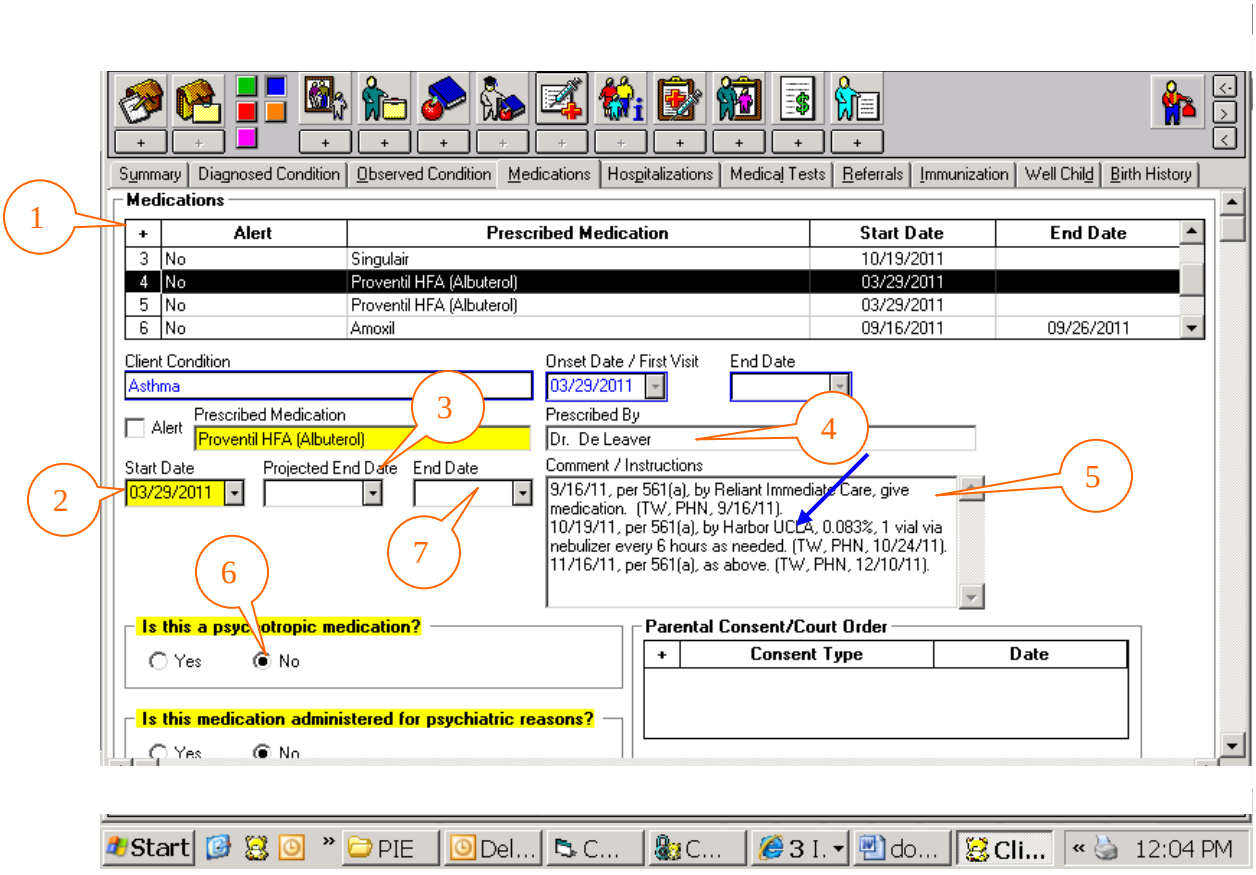
1. **In the Prescribed Medication Section:** Enter the name of the medication only.

2. **In the Comment Section:** Enter the date of services in a descending chronological order, the source of information, dosage, route, and frequency ordered by a clinician/specialist.

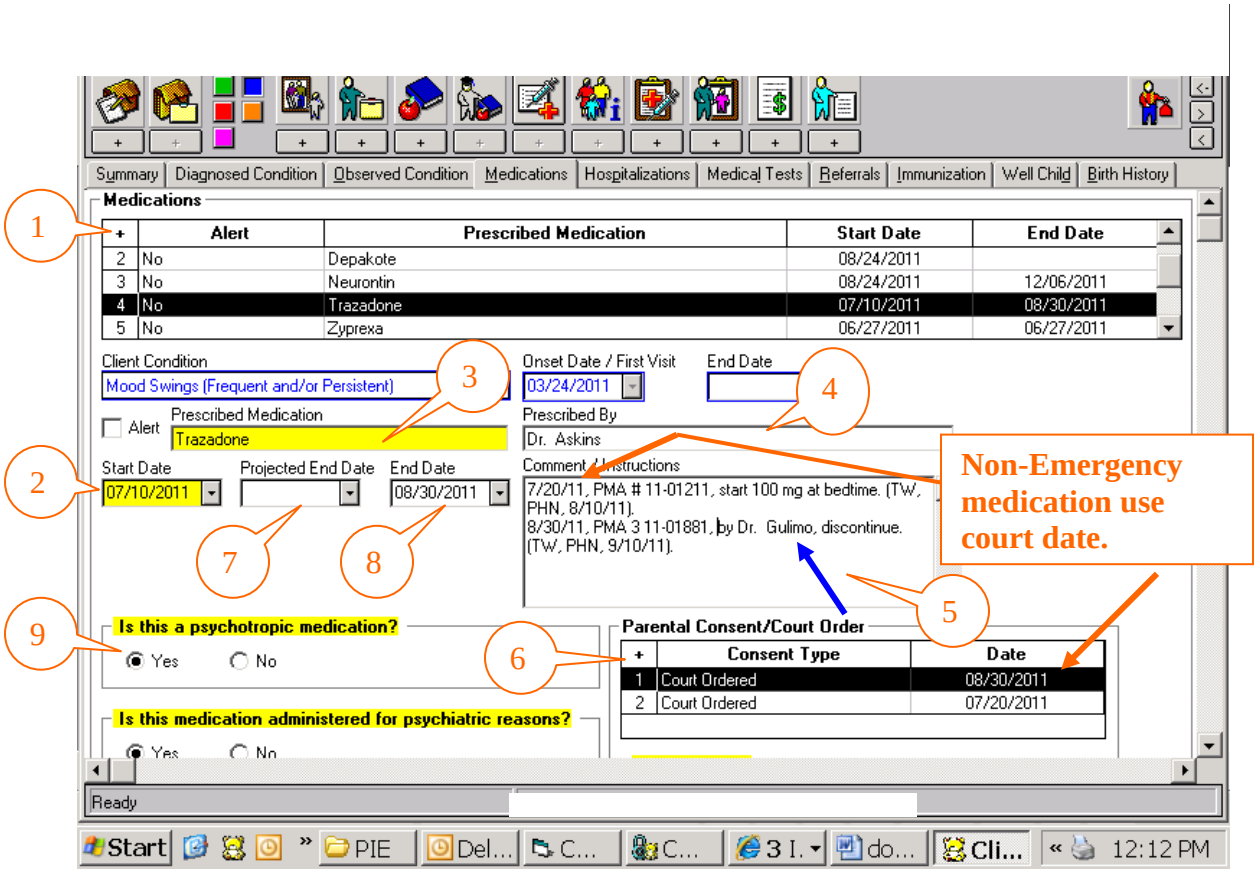
3. End Date the medication/s when appropriate.
4. Use this section for long term medication(s).

5. Do not document medications prescribed for 10 days or less in this section.

Medication Example from the PM160 and 561 (a): How to enter in the Comment/Instructions box:



Medication Example from the PMA: Non-Emergency Medications. How to enter medications in the Comment/Instructions box:

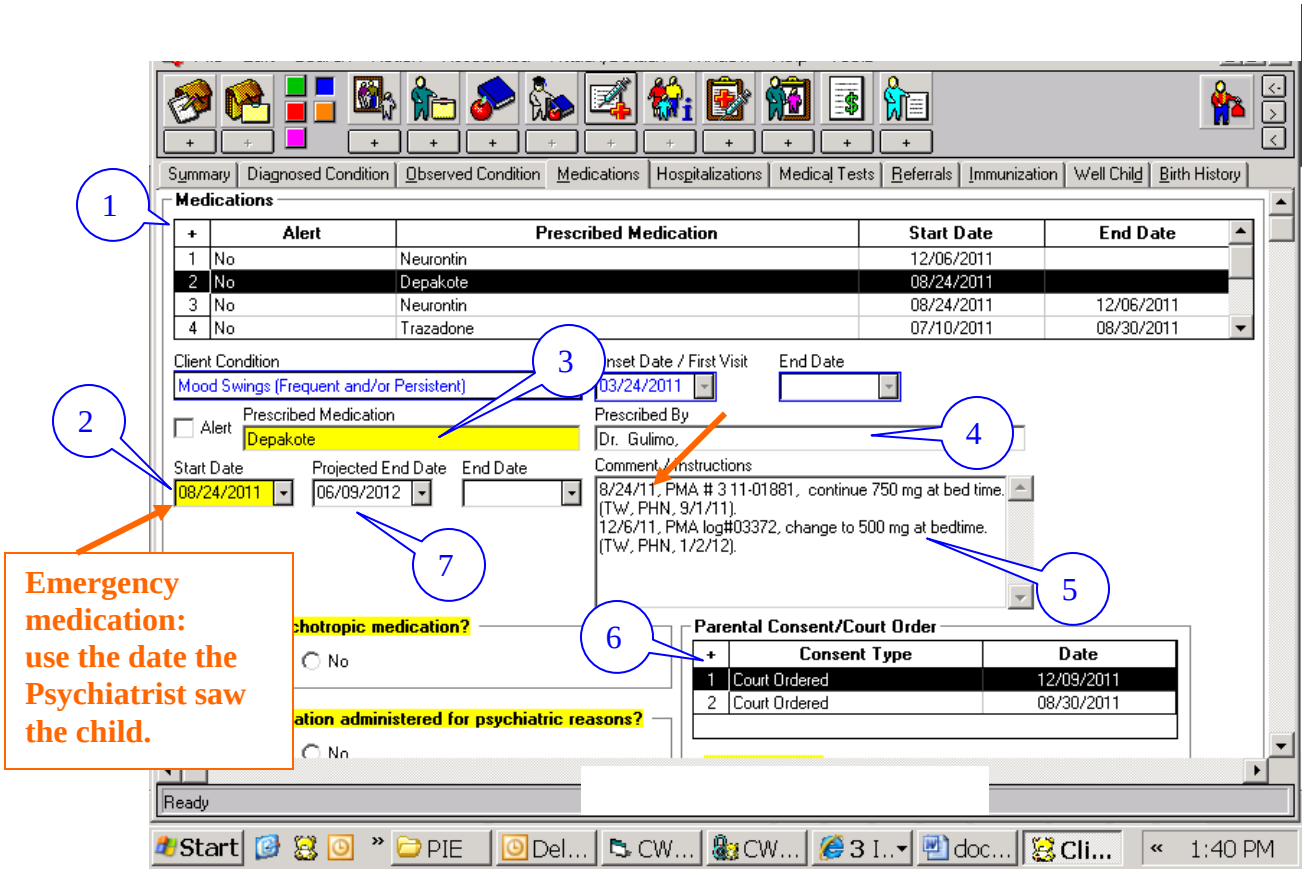


*** In the Comment /Instruction box: Non-emergency case: enter the current court date (current PMA).**

*** Projected End Date Medication: 180 days or 6 months from the date of the current court approval date (current PMA).**

*** Note: End Date medication using the current court approval date (current PMA) or when child no longer takes medication.**

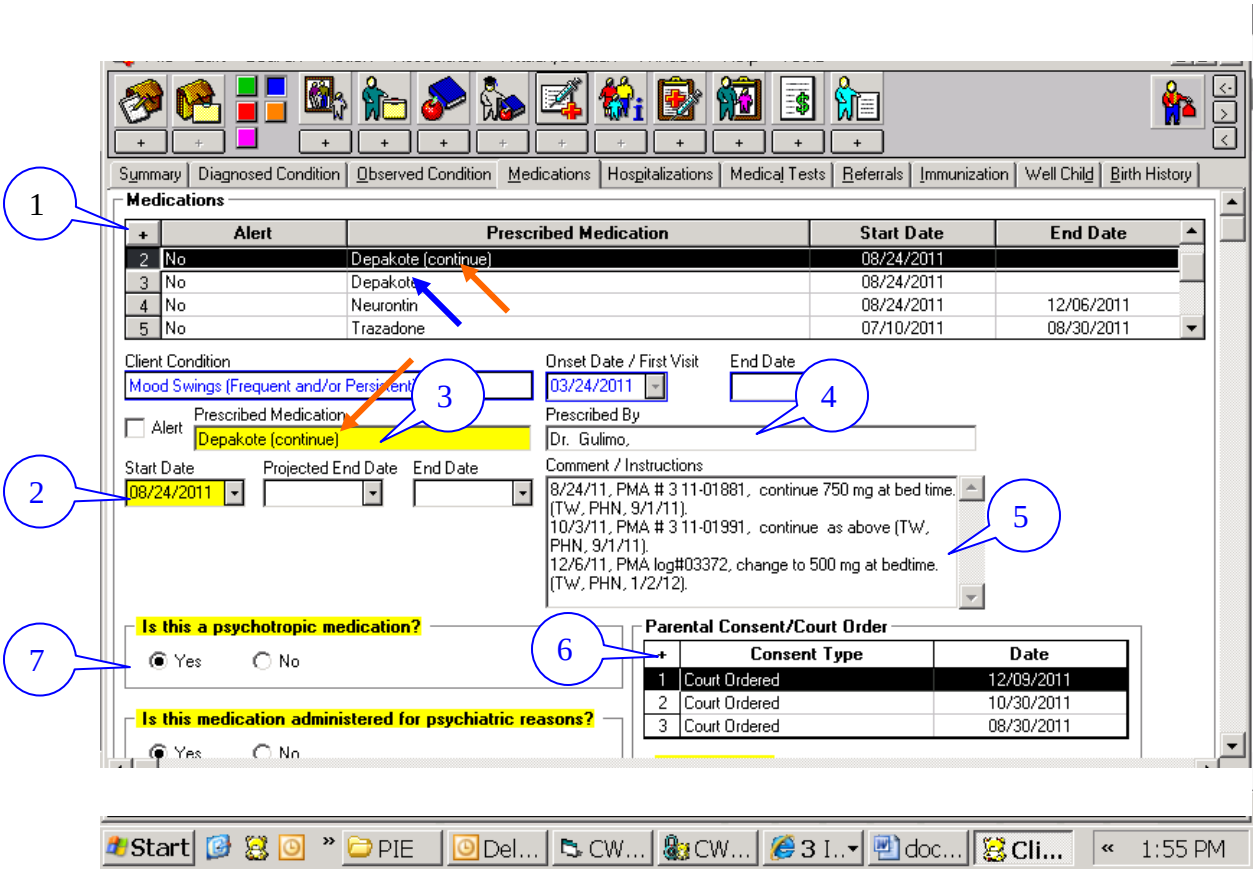
Medication Example from the PMA: Emergency Medication. How to enter the PMA in the Comment/Instructions box:



*** In the Comment/Instruction box: Emergency case: enter the date the psychiatrist saw the child (JV 220A #5 or after # 17 where the doctor signed).**

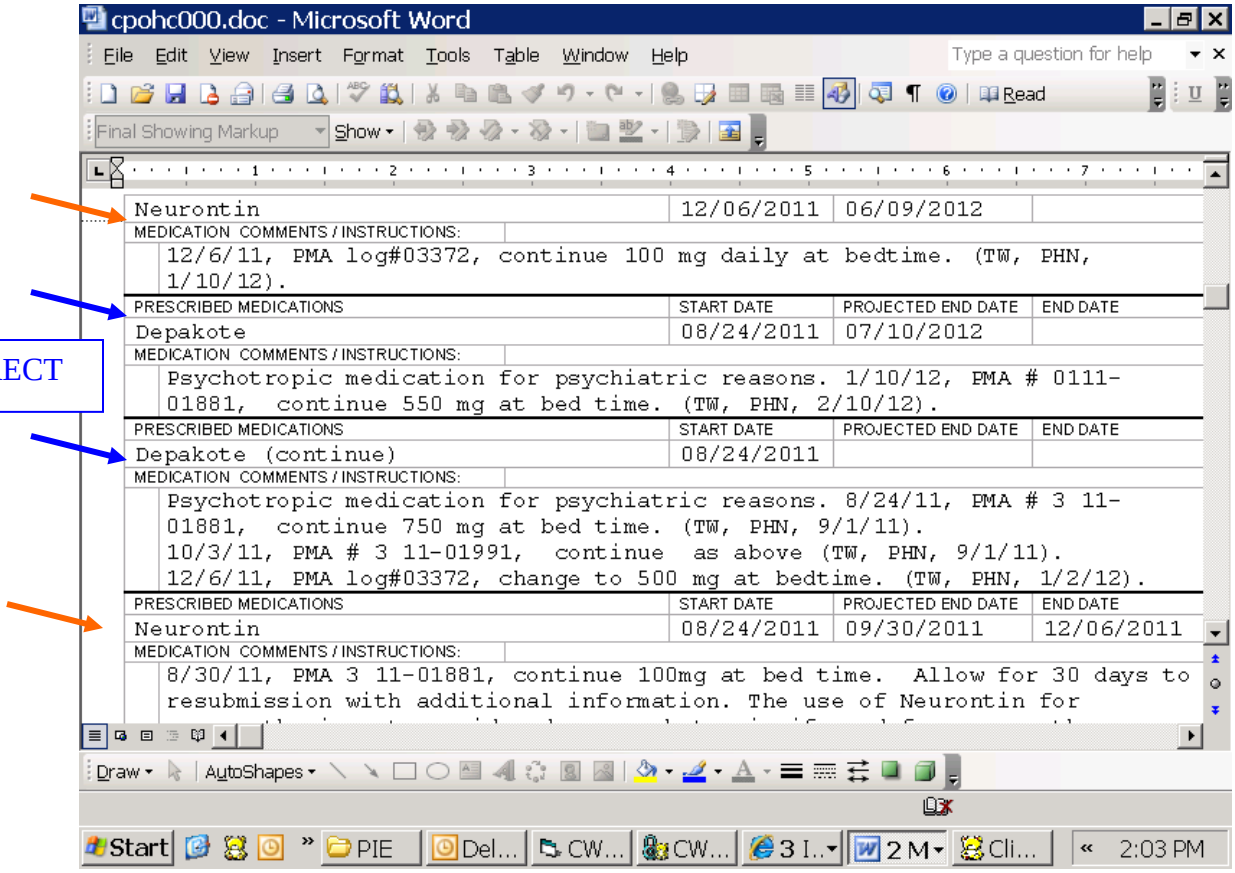
*** Project End Date Medication: 180 days or 6 months from the date of the current court approval date (current PMA).**

Medication Example from the PMA: How to End Date psychiatric medications when the Comment/Instructions box runs out of space:



Medication Example from the PMA: The HEP appears in a chronological order when you print it out.

CORRECT



Medication Example from the PMA: Do not End Date the medication when the space of the Comment/Instructions box has ran out. When you print the HEP, it will not print out in chronological order.

INCORRECT

DO NOT END DATE!!!!!

CURRENT HEALTH ISSUES

HEALTH PROBLEM	ONSET DATE/FIRST VISIT	NEXT SCHEDULED VISIT DATE
Other Behavioral Condition	07/03/2003	
DIAGNOSED BY: NAME	**DIAGNOSED BY: PHONE**	**COMMUNICABLE DISEASE?**
Dr. Gold		☐ YES ☒ NO ☐ UNKNOWN

HEALTH PROBLEM DESCRIPTION
07/03/03, PMA # 0023, diagnosis: Depression. (MX/PHN 07/20/03).

TREATMENT PLAN / INSTRUCTIONS
07/03/03, PMA # 0023, psychotropic medication with individual therapy. (MX/PHN 07/20/03).

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Concerta	01/01/2006	07/07/2006	

MEDICATION COMMENTS / INSTRUCTIONS:
Psychotropic medication for psychiatric reasons. 01/01/06, continue 54 mg once at night. (MX/PHN 01/10/06)

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Prozac	01/01/2006	07/01/2006	

MEDICATION COMMENTS / INSTRUCTIONS:
Psychotropic medication for psychiatric reasons. 01/01/06, continue 20 mg once at night. (MX/PHN 01/10/06)

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Concerta	07/07/2004		01/01/2006

MEDICATION COMMENTS / INSTRUCTIONS:
Psychotropic medication for psychiatric reasons. 07/07/04, PMA # 1234, continue 54 mg-1 tabet twice a day. (MX/PHN 07/10/04).
01/02/05, PMA # 1235, change to 54 mg -1 tablet at night. (MX/PHN 01/10/05).
07/07/05, PMA 0012, change to 54 mg in morning & 38 mg at night. (MX/PHN 07/15/05).

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Prozac	07/07/2004		01/01/2006

MEDICATION COMMENTS / INSTRUCTIONS:
07/07/04, PMA # 1234, continue 20 mg-1 tabet twice a day. (MX/PHN 07/10/04).
01/02/05, PMA # 1235, change to 20 mg -1 tablet at night. (MX/PHN 01/10/05).
07/07/05, PMA 0012, change to 20 mg in morning & 10mg at night. (MX/PHN 07/15/05).

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Concerta	07/03/2003		07/07/2004

MEDICATION COMMENTS / INSTRUCTIONS:
Psychotropic medication for psychiatric reasons. 07/10/03, PMA # 0023, start 54 mg- 2 tablets twice a day. (MX/PHN 07/20/03).
01/01/04, PMA 0211, take 1 tablet twice a day. Approved for hospital stay and 2 weeks after discharge. (MX/PHN 01/10/04).

PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Prozac	07/03/2003		07/07/2004

MEDICATION COMMENTS / INSTRUCTIONS:
Psychotropic medication for psychiatric reasons. 07/10/03, PMA # 0023, start 20 mg- 2 tablets twice a day. (MX/PHN 07/20/03).
01/01/04, PMA 0211, take 1 tablet twice a day. Approved for hospital stay

V. HOSPITALIZATION SECTION:

Use this section to document anytime a child has been hospitalized (medical and psychiatric hospitalizations). Document the admission date, discharge date, client condition, and hospital name for every hospitalization. The hospitalization must be tied to a "Diagnosed Condition".

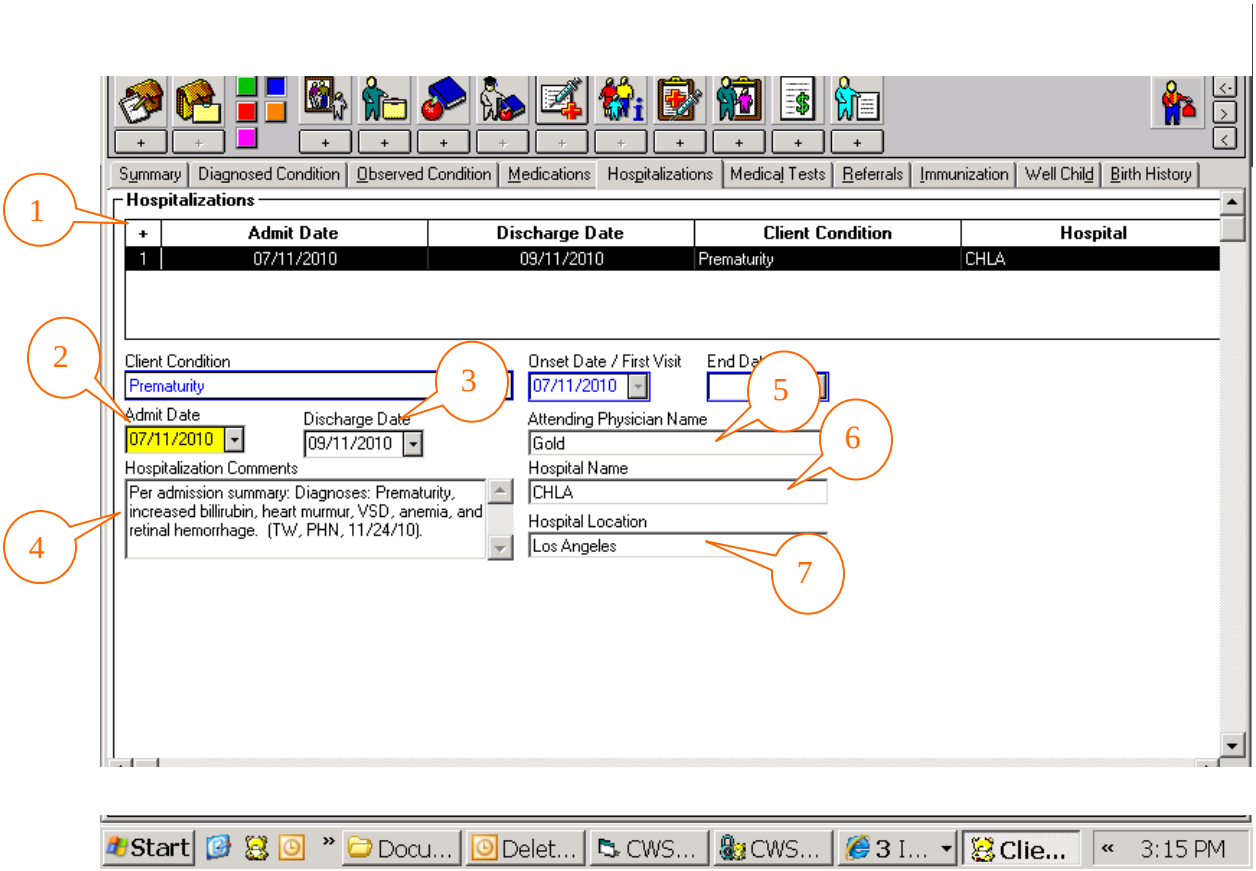
1. **In the Hospital Comment Section**: Document source of information, then the child's hospitalization information such as diagnosis (es) and discharge summary. Document treatment and follow up plan in the Diagnosed Condition Section.

2. Do not document Intravenous drip rates, Oxygen liter per minute increments, daily medications and lab results in this section.

3. Do not document weekly follow up phone call(s) which should be listed under the contact.

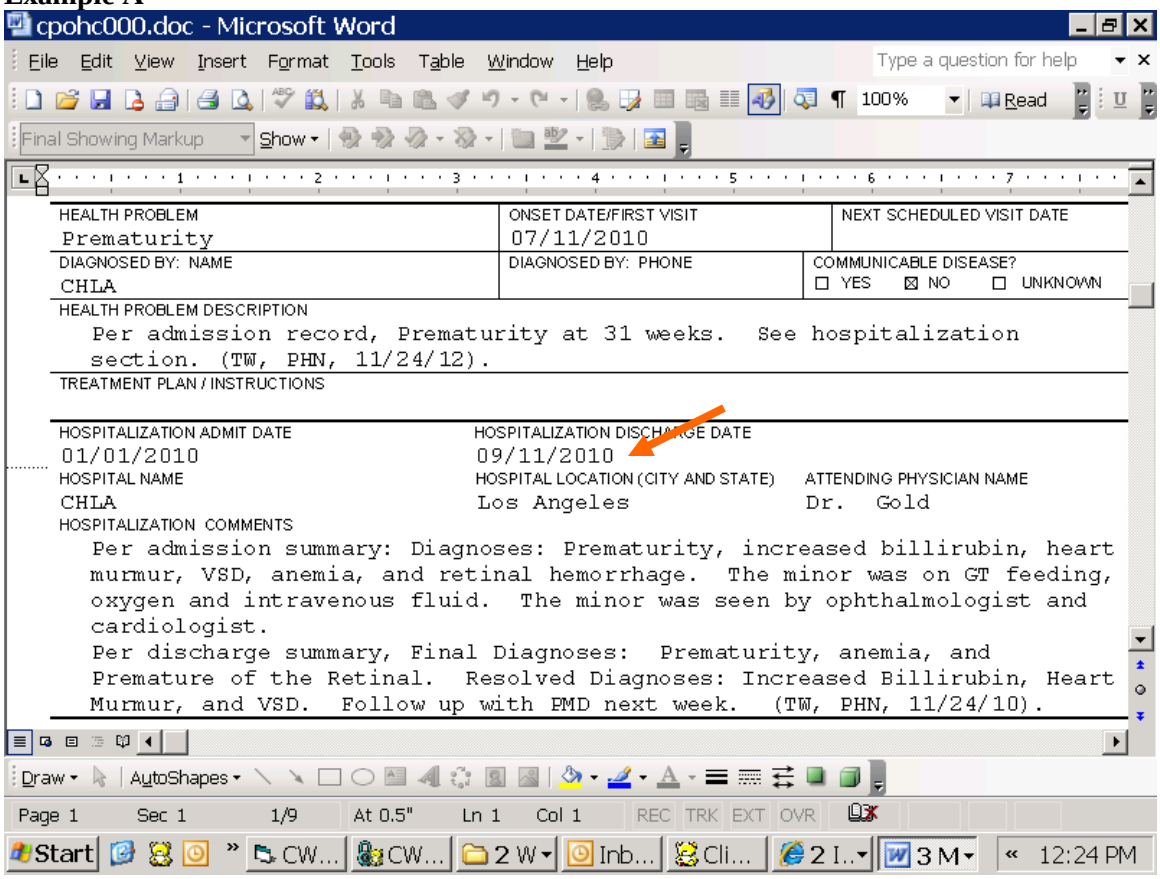
4. Do not transcribe the entire discharge summary into the contact or Hospitalization Comment Box. Document the admission and discharge diagnosis in the Hospitalization Comment Box. See hard copy.

Hospitalization Example:

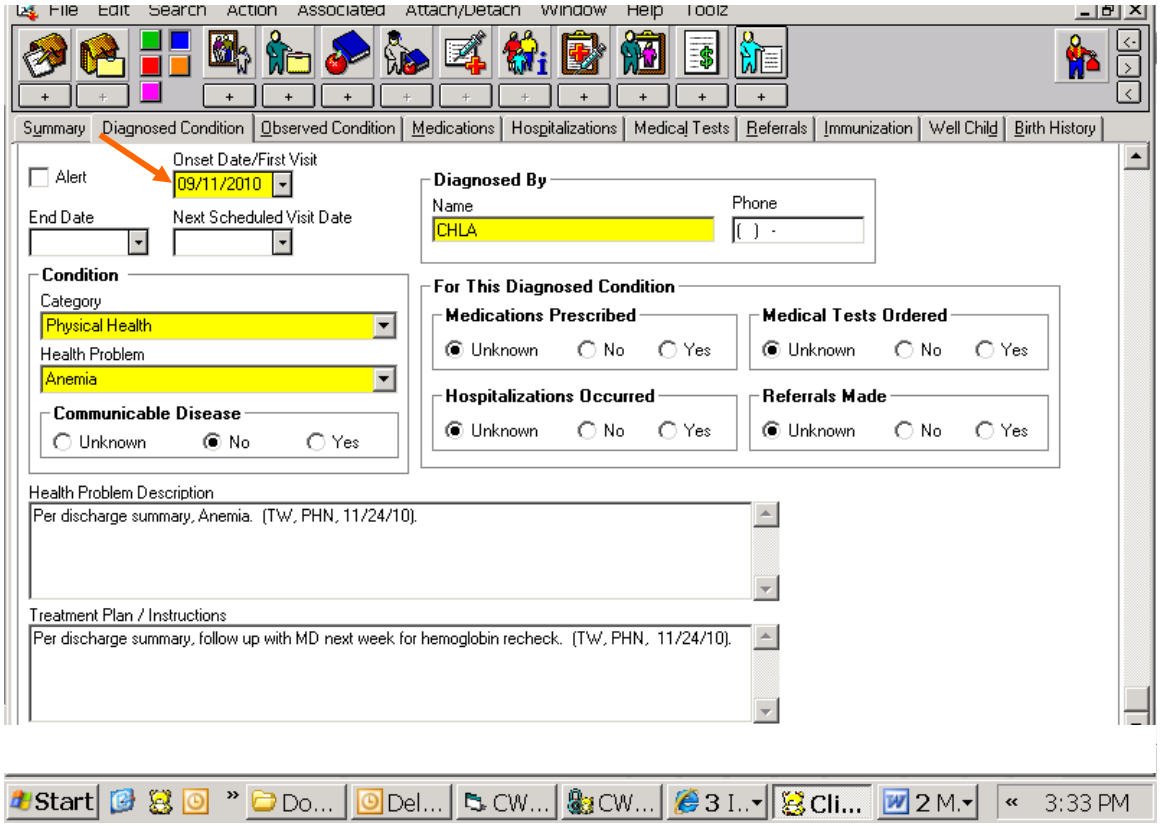


Prematurity Hospitalization Example: Upon discharge, for the unresolved diagnosis, go to the Diagnosed Condition section and click the (+) sign. The start date for the unresolved diagnosis will be the discharge date:

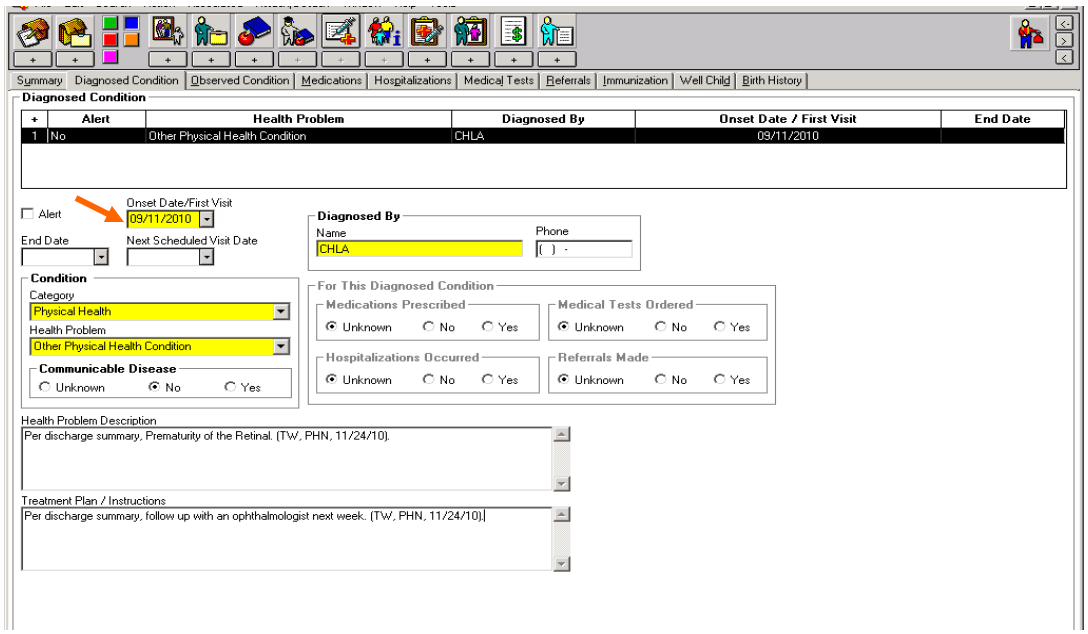
Example A



Example B.



Example C.



VI. MEDICAL TEST SECTION:

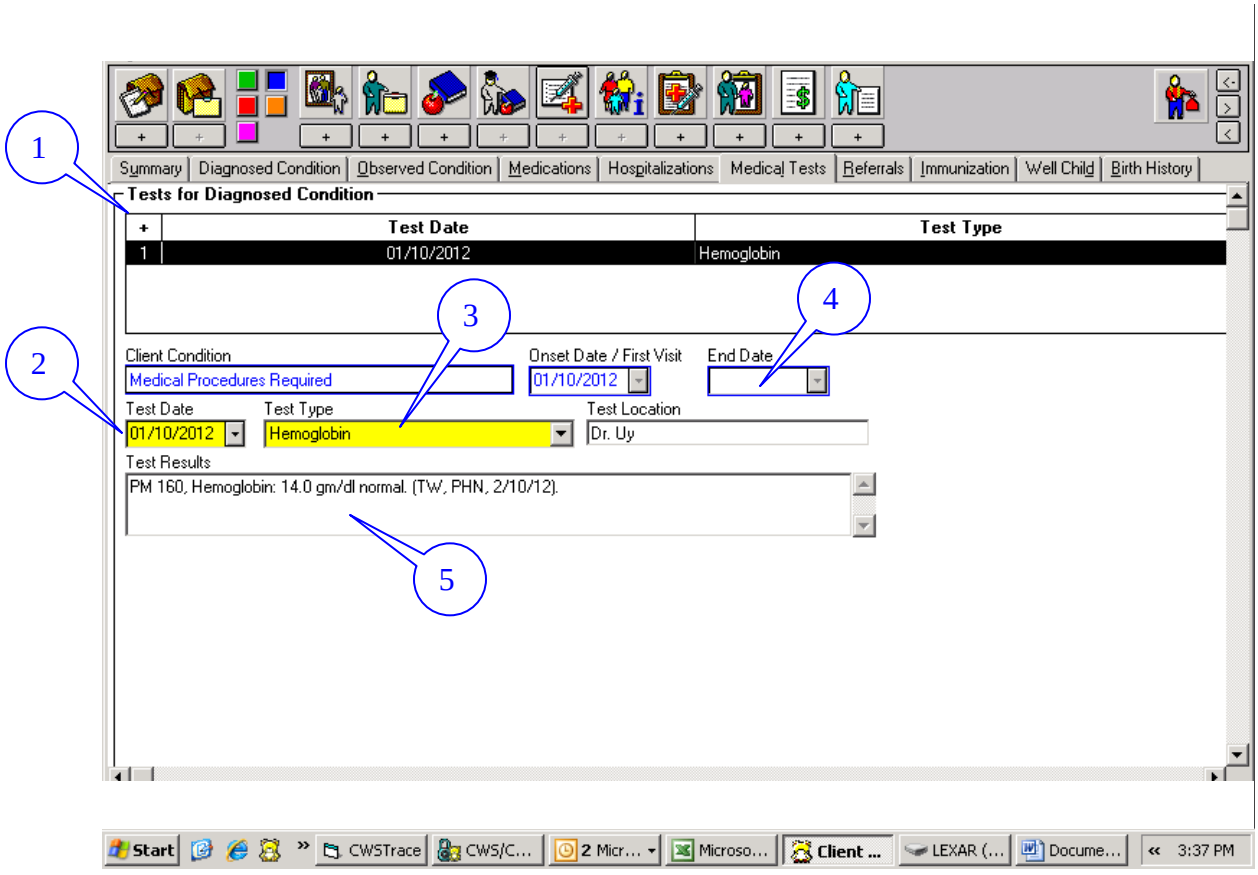
Use this section to document any medical tests ordered for a child. The medical tests must be associated with a "Diagnosed Condition" or "Medical Procedure Required" if there is no related diagnosis.

1. **In the Test Result Section:** Document source of information, test results, hearing, vision, blood pressure, and urine analysis, etc.

2. Do not document BMI in this section.

3. Do not end date medical procedure; change date of the test accordingly.

Medical Test Example:



VII. REFERAL PAGE SECTION:

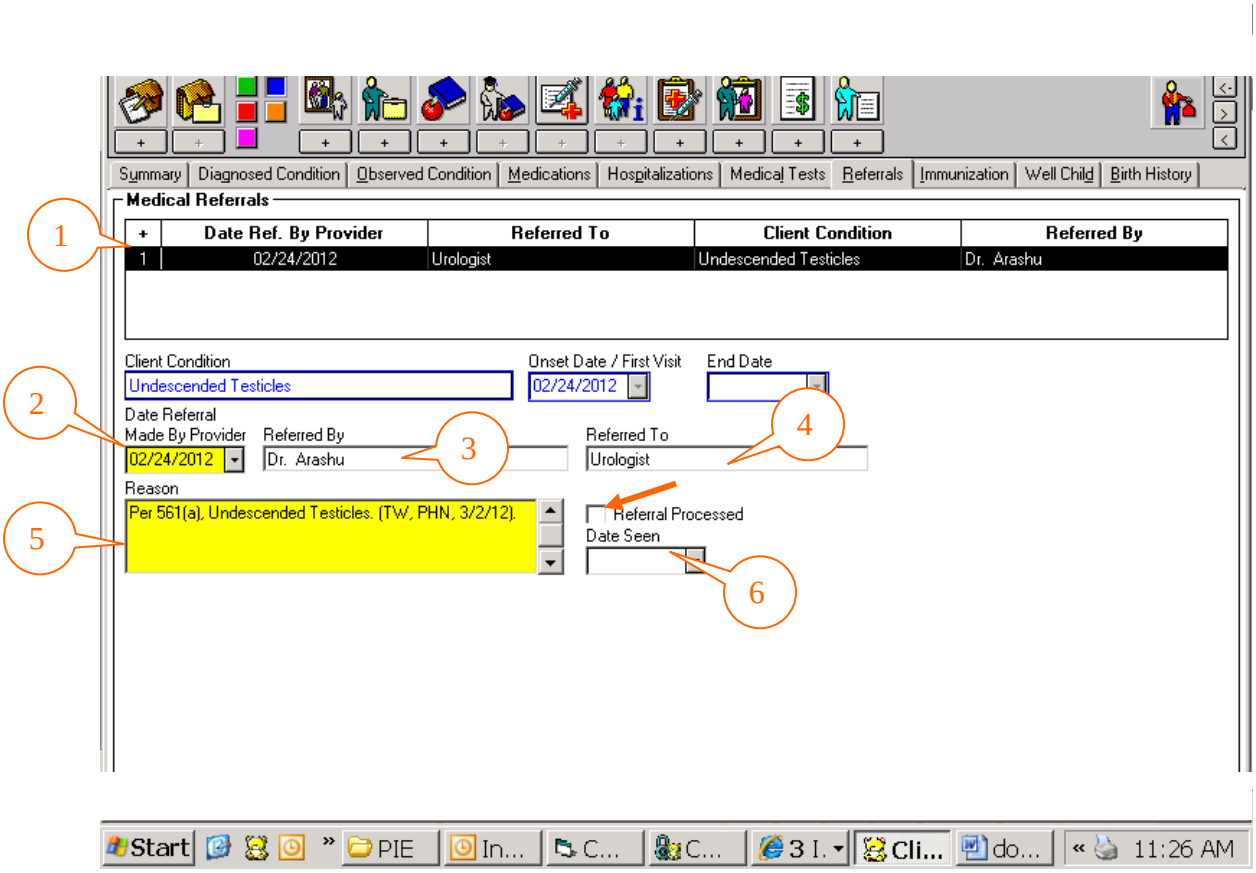
Use this section to document any medical referrals made on behalf of a child by a Clinician/Specialist, PHN or Children Social Worker (CSW). The referrals must be associated with a “Diagnosed Condition”.

1. **In the Reason Section:** Document source of information and referral information.

2. All referrals must be entered. Document follow up referral (s) as needed.

3. Enter date seen by the Specialist and check Referral Processed Box if known.

Referral Page Example:



VIII. IMMUNIZATION SECTION:

Use this section to document a child's immunization history.

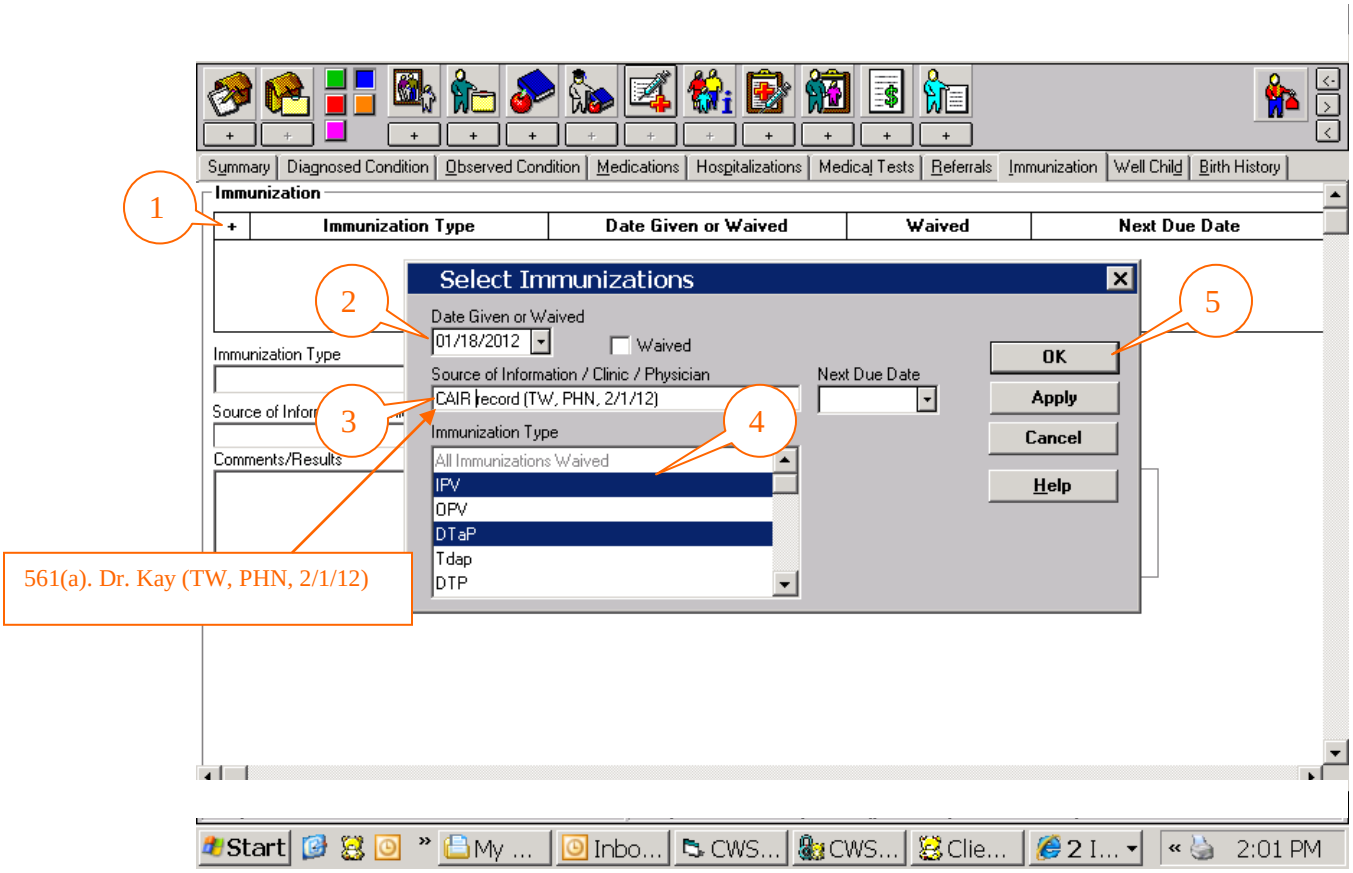
1. Document the type and sources of vaccine as indicated in the medical record.

2. Record combination vaccines separately, *i.e.: Pediarix=DTap/HepB/IPV*

3. For positive PPD- document the millimeters of induration if known and the result of the chest x-ray, medication prescribed in the Immunization Comment Section. Document treatment and follow up in the Diagnosed Condition and Medication Section.

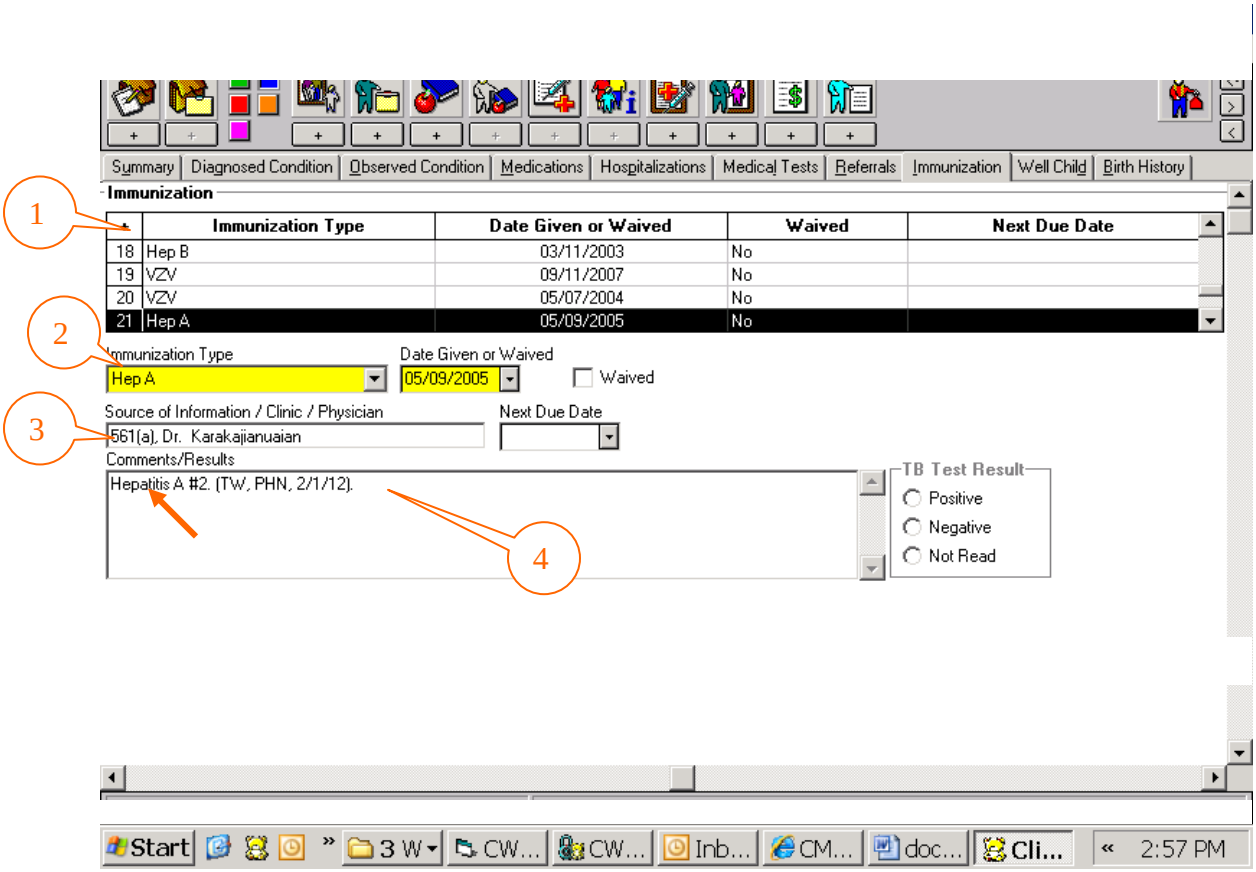
4. Access California Immunization Registry (CAIR) if applicable. Print CAIR record and input all immunizations.

Immunization Example 1:



Immunization Example 2:

How to document information when the provider's name is too long and you are not able to enter it in the small box:



IX. WELL CHILD SECTION:

Use this section to record information regarding a Well Child Exam: Medical/Dental.

-In Medical/Dental Referral Section:

1. Document source of information (i.e. 561(a), (b), Medical record, PM 160).

2. Document the BMI percentile for children 2 years of age and older and head circumference percentile for children less than 2 years of age.

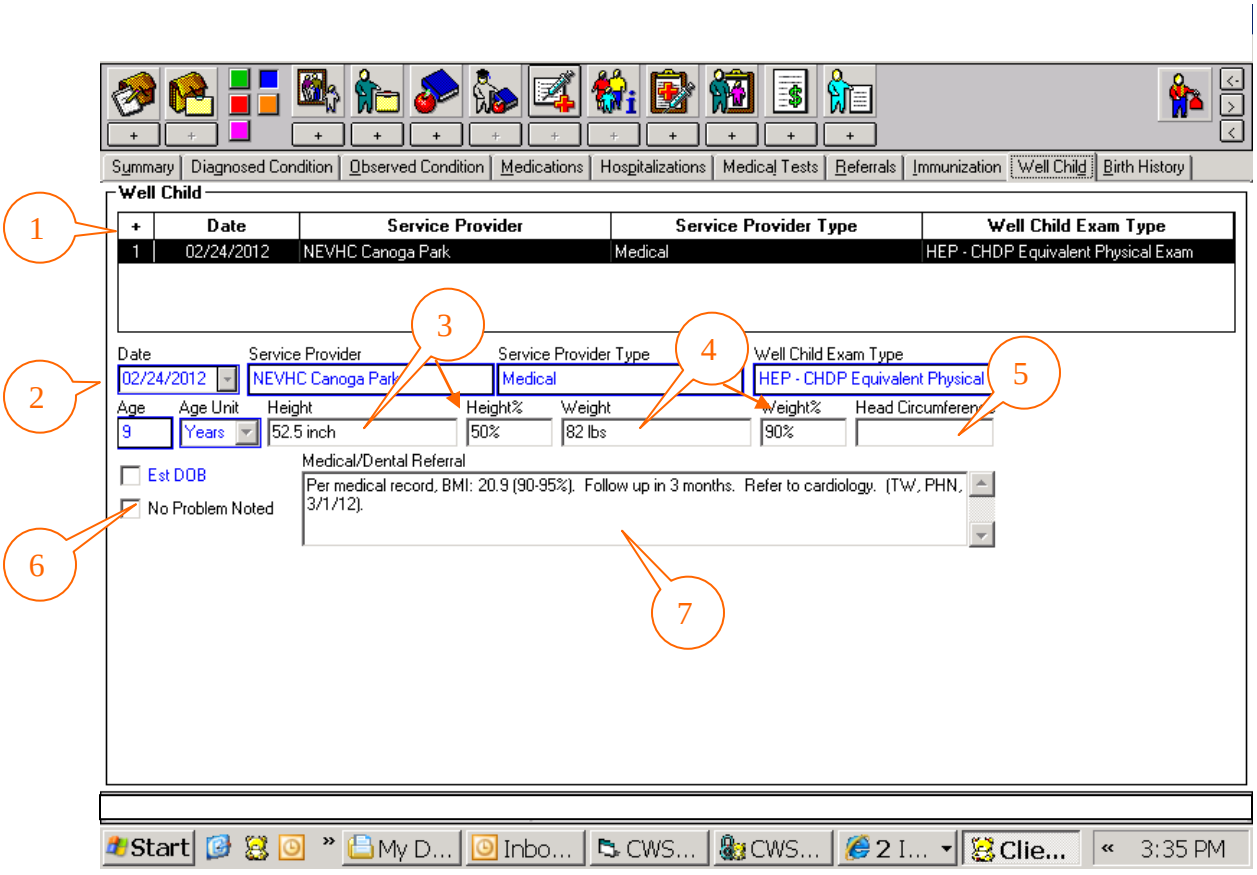
3. Document annual dental: i.e. Exam, X-ray, and cleaning. No referral at this time. Do not leave the box blank.

4. Document any pertinent health information from the PM160 or 561(a) (b) that is not being documented elsewhere in the Health Notebook.

5. Document any diagnosis (es) under the diagnosed condition section.

6. May direct readers to other areas of the Health Notebook where additional health information related to this exam has been mentioned, i.e. Cardiology referral made.

Well child Example:



X. BIRTH HISTORY SECTION:

Use this section to enter birth history information and toxicology screening. Document information regarding the parent's health problems ***that are significant to the child's health,*** i.e.: drug use during pregnancy, history of mental illness, and Diabetes.

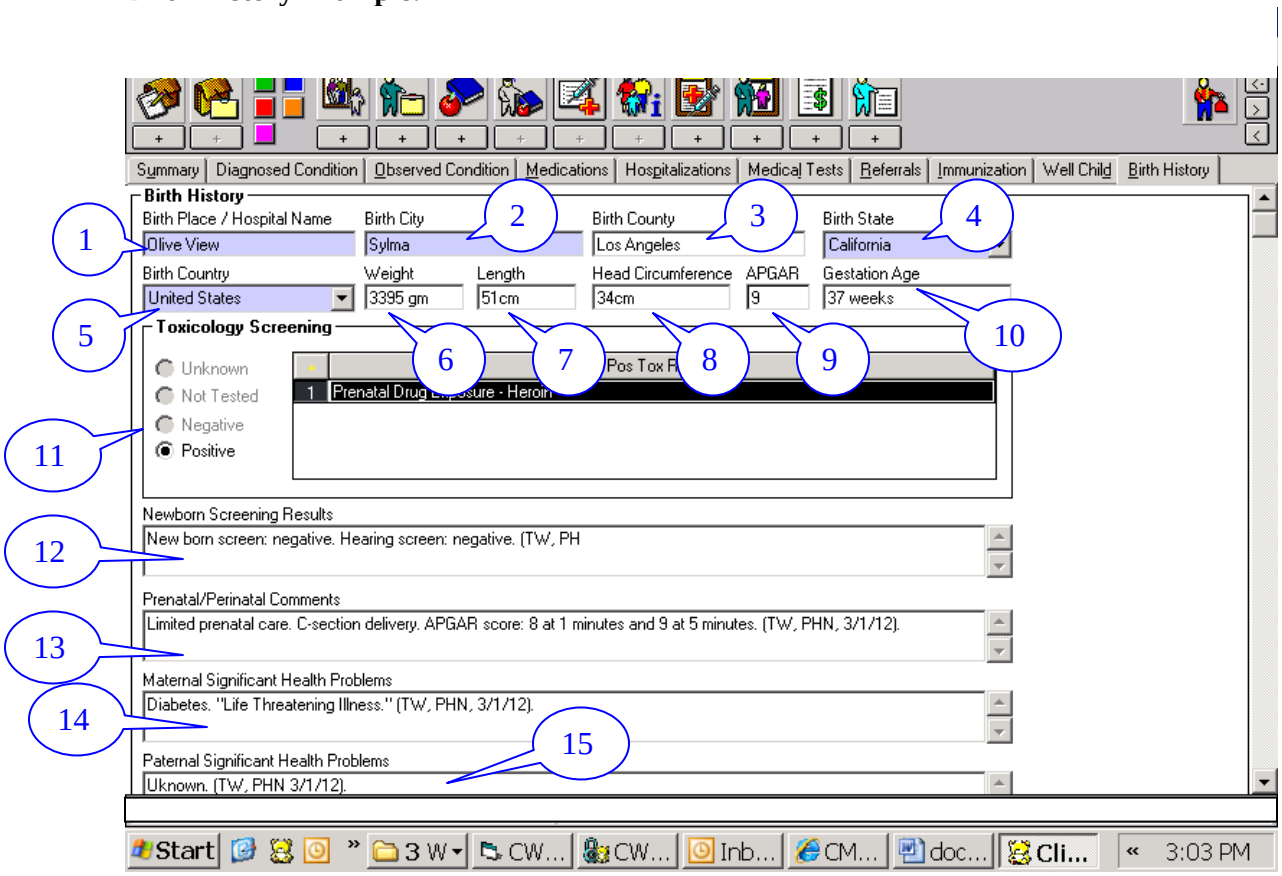
1. Newborn Screening Results: Document newborn screening and hearing screening results.

2. Prenatal/Perinatal Comments: Document Prenatal care; APGAR scores at 1 minute and 5 minutes post delivery; and method of delivery.

3. Maternal Significant Health Problem: Document: maternal prenatal history, chronic medical history, i.e. asthma, HTN, "Life Threatening Illness"; or Unknown if no information (do not leave blank).

4. Paternal significant Health Problem: Unknown if no information is available.

Birth History Example:



XI. SERVICE PROVIDER SECTION:

Use this section to record any healthcare provider who renders services to the child.

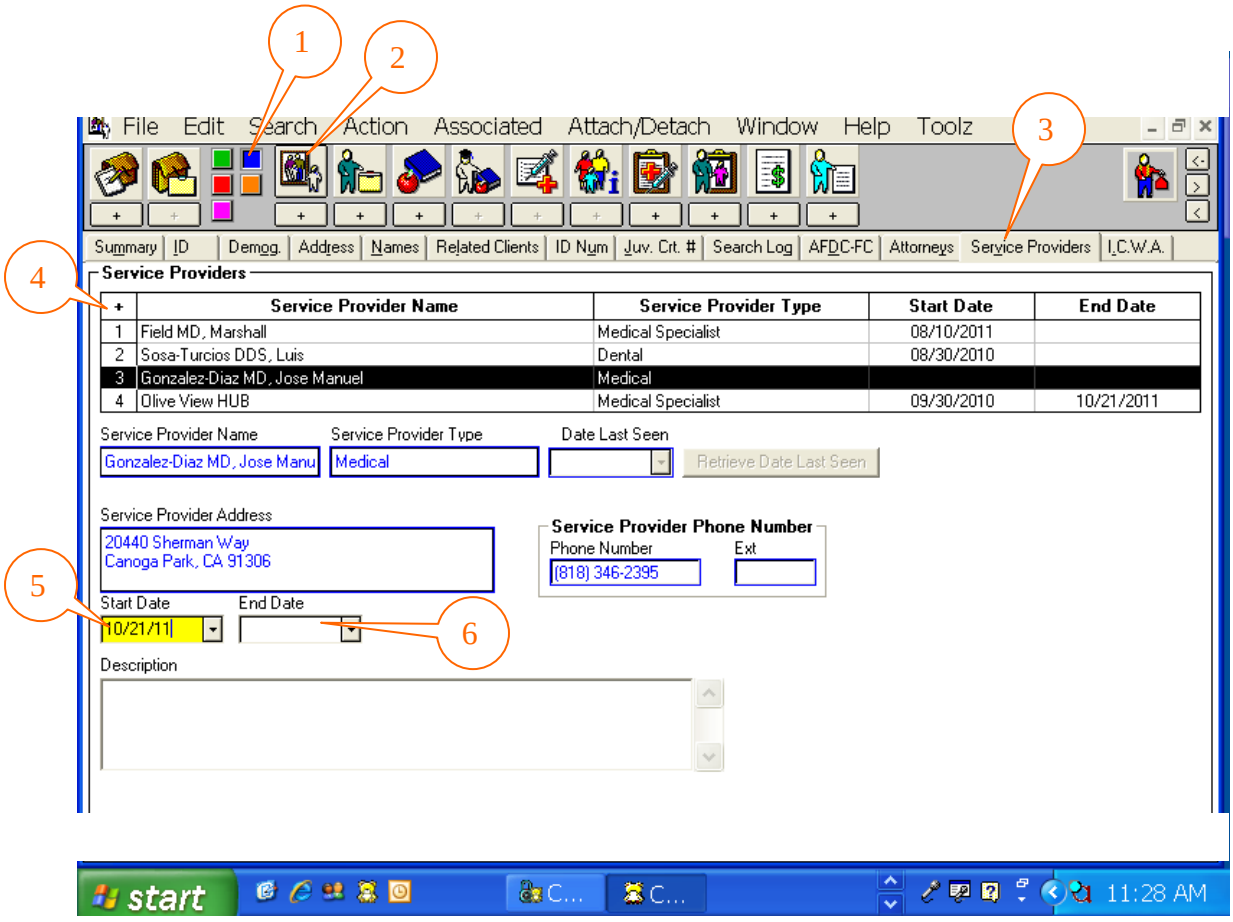
1. The child service provider's information should include the initial and last date of services address and phone numbers.

2. Update the current service providers according to the current medical documentation.

3. Delete all duplicate service providers.

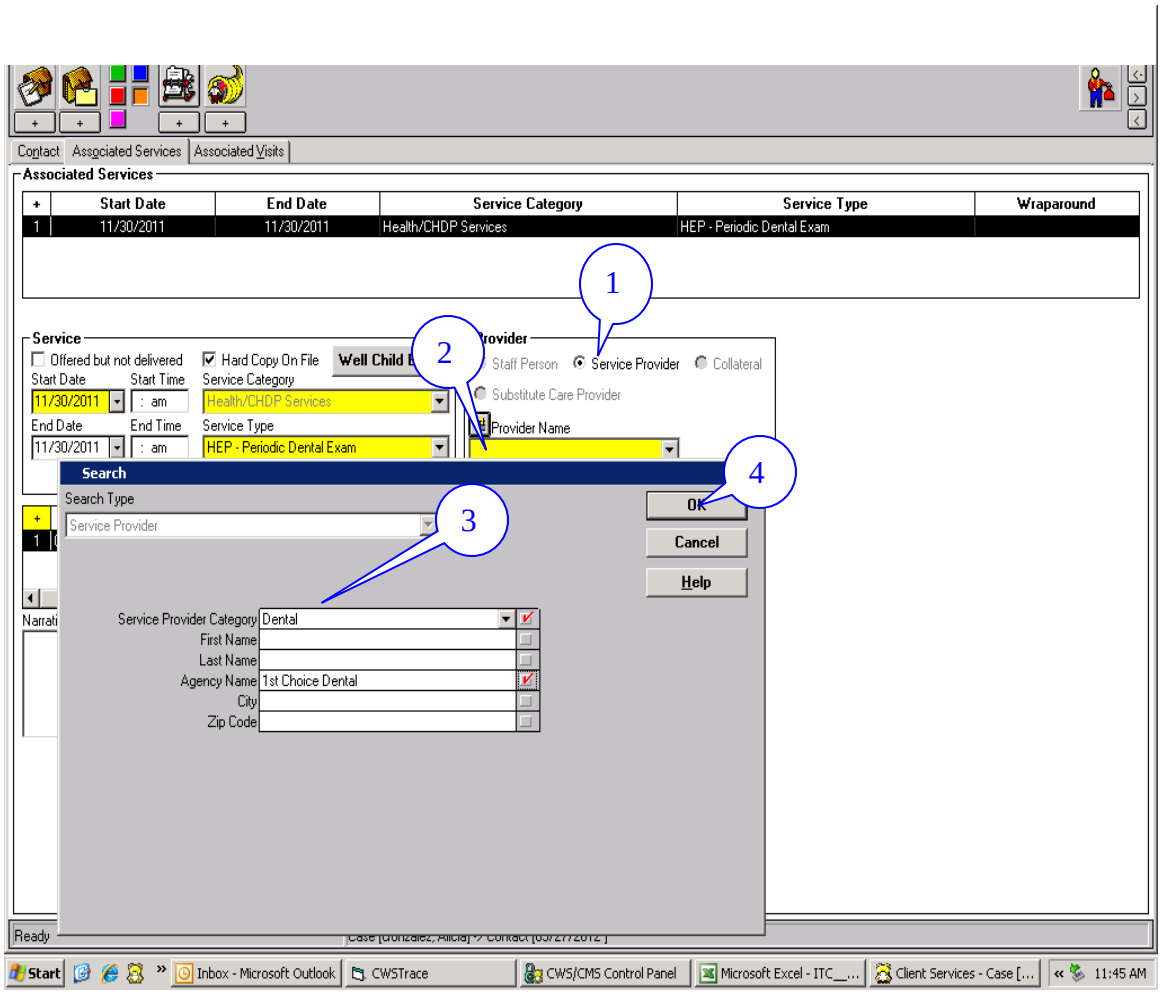
4. End date service providers who no longer provide services to the child.

Service Provider example 1:

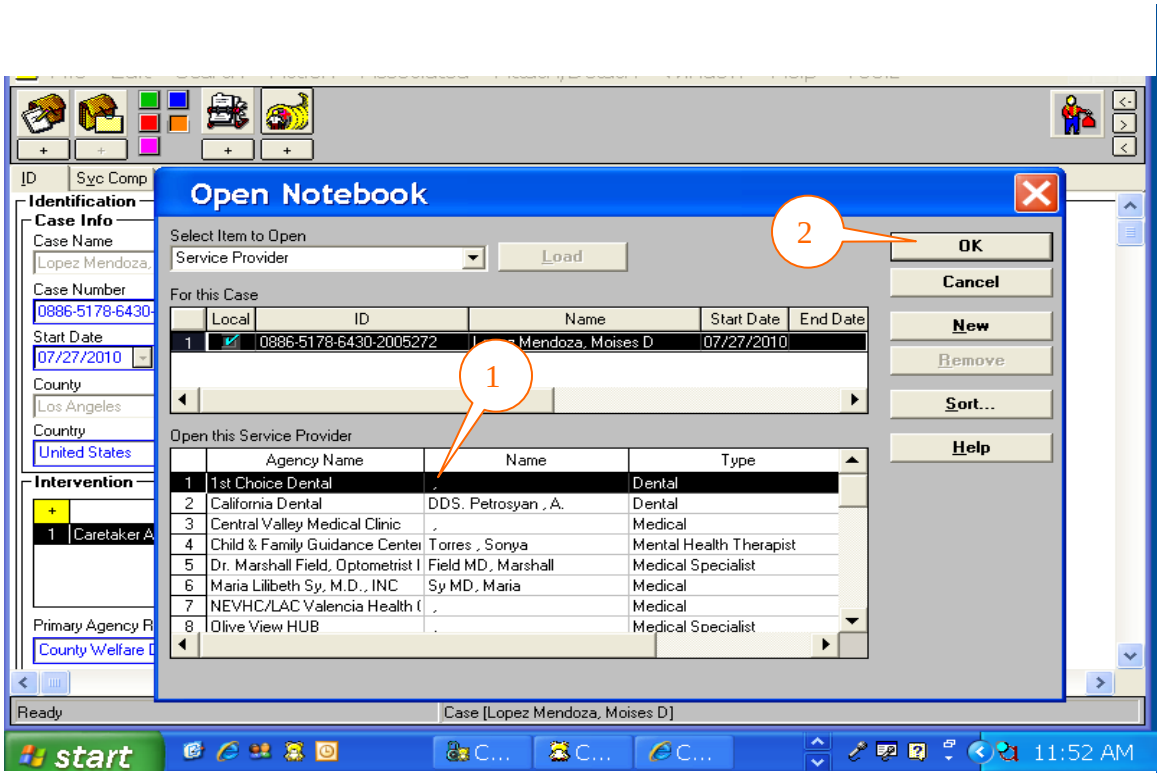


Service Provider Example 2:

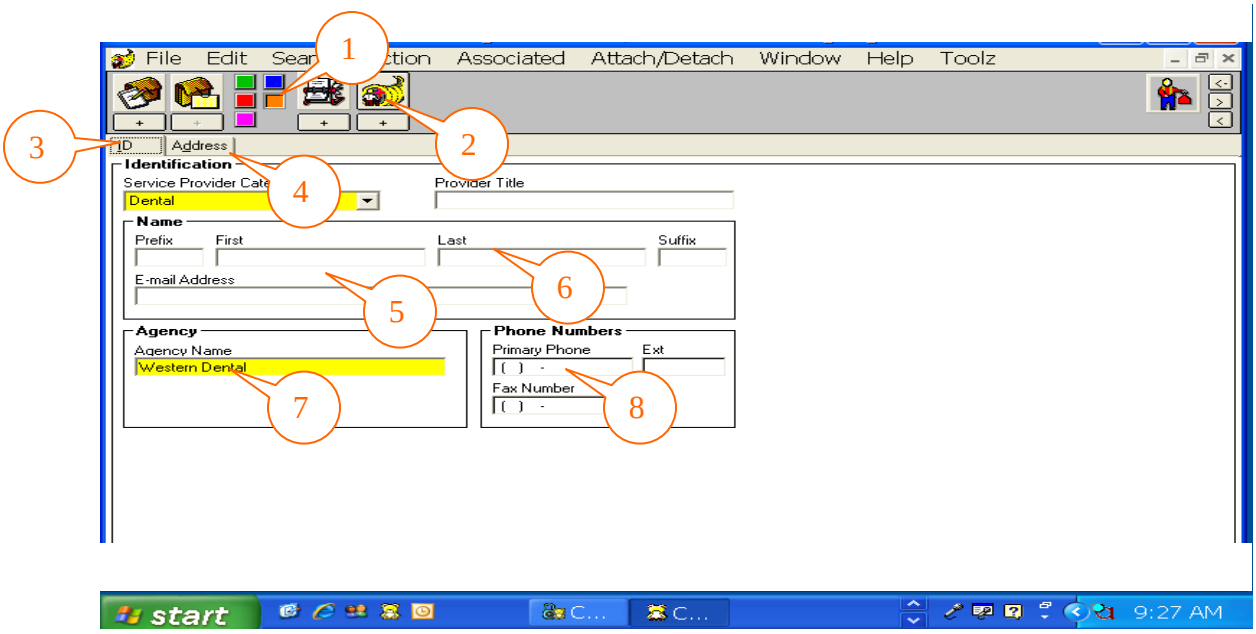
When you cannot find the provider you should use the search type:



After you find the provider click OK, the open notebook will appear.



Service Provider Example 3: How to add the address and phone number of the provider:



XII. F-RATE SECTION:

A DCFS specialized care rate given to caregivers who care for children with special health care needs (medically fragile children).

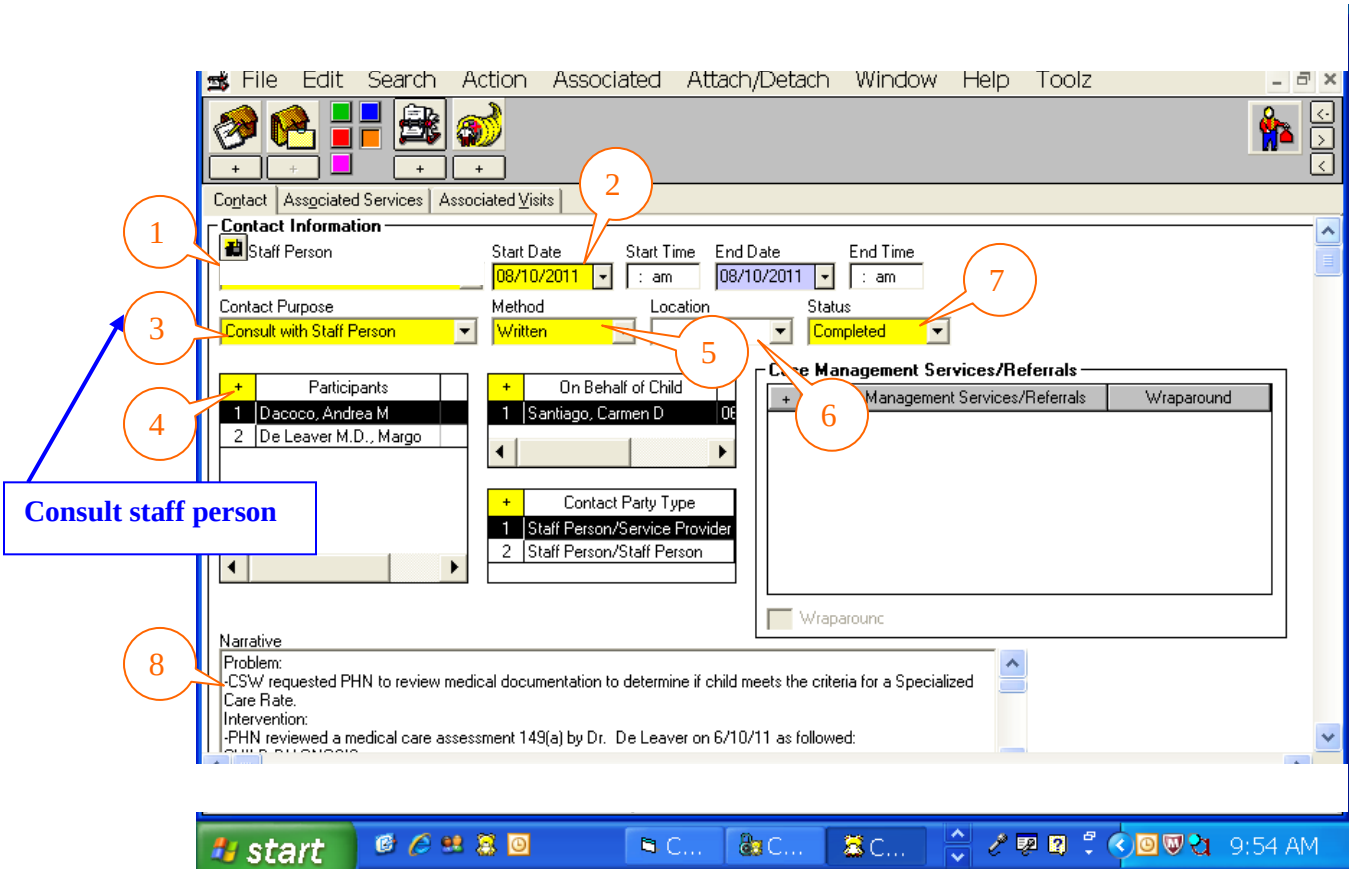
1. Adhere to DCFS F-rate policy 0600-505.10 and 0900-522.11.

2. Use the approved F-rate template.

3. Copy and paste the F-rate template into the contact.

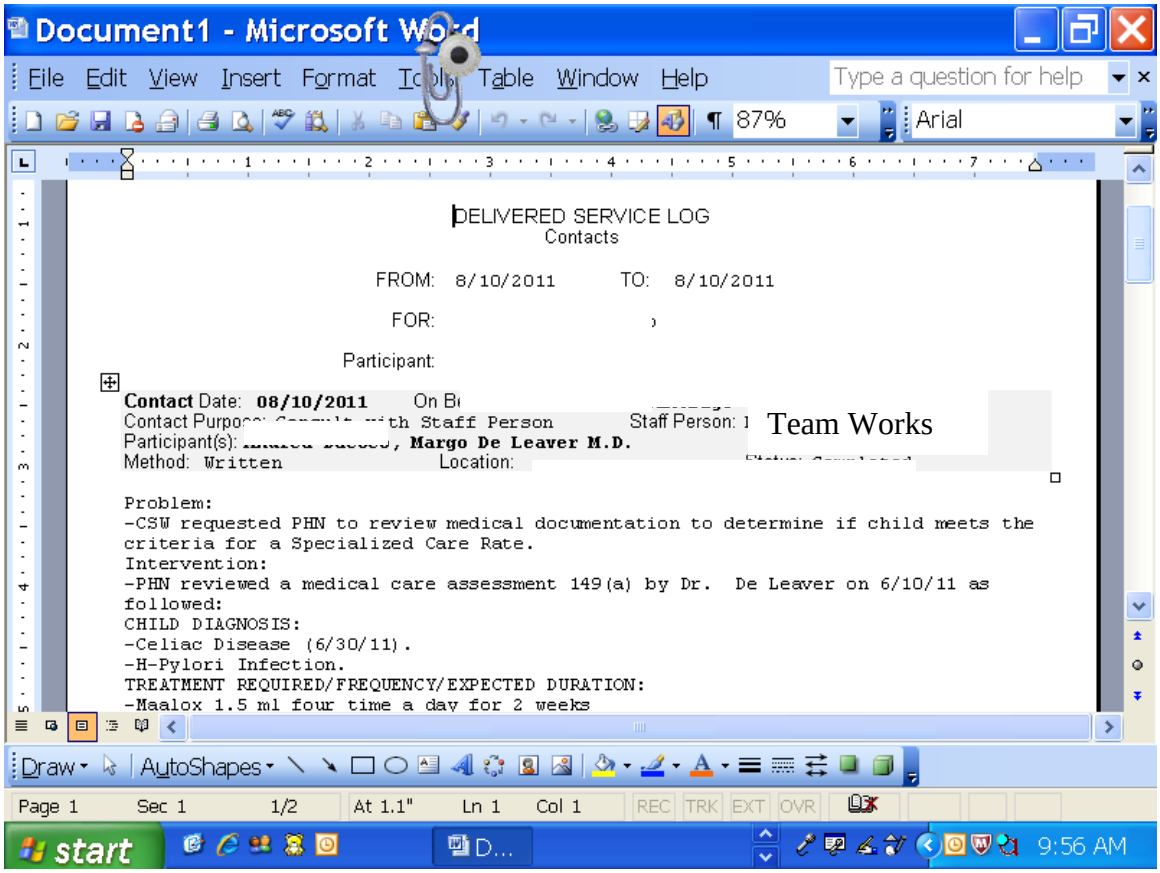
4. Print out the PHN F-rate progress note to provide to CSW

F- Rate Example 1:



F- Rate Example 2:

-Copy and paste your F-rate into your contact.



XIII. CHILD FATALITY, DEATH REVIEW, AND CRITICAL INCIDENT REPORT:

A report sent by DCFS administration when a child has been injured or expired.

1. Document into CWS/CMS how, when, and why PHN received the case consultation as soon as received.

2. Notify the Public Health Nursing Supervisor (PHNS) immediately.

3. Obtain the purple folder and medical records as soon as possible.

4. Review and summarize medical records and send it to your PHNS. The PHNS will send it to the Nurse Manager (NM).

5. When you complete a report, use the guidelines below. Use DCFS 418 form and PIE format:

    a) Date consultation request received.

    b) SCSW/CSW.

    c) Date and description of the incident.

    d) Location of the child.

    e) Current status of the child.

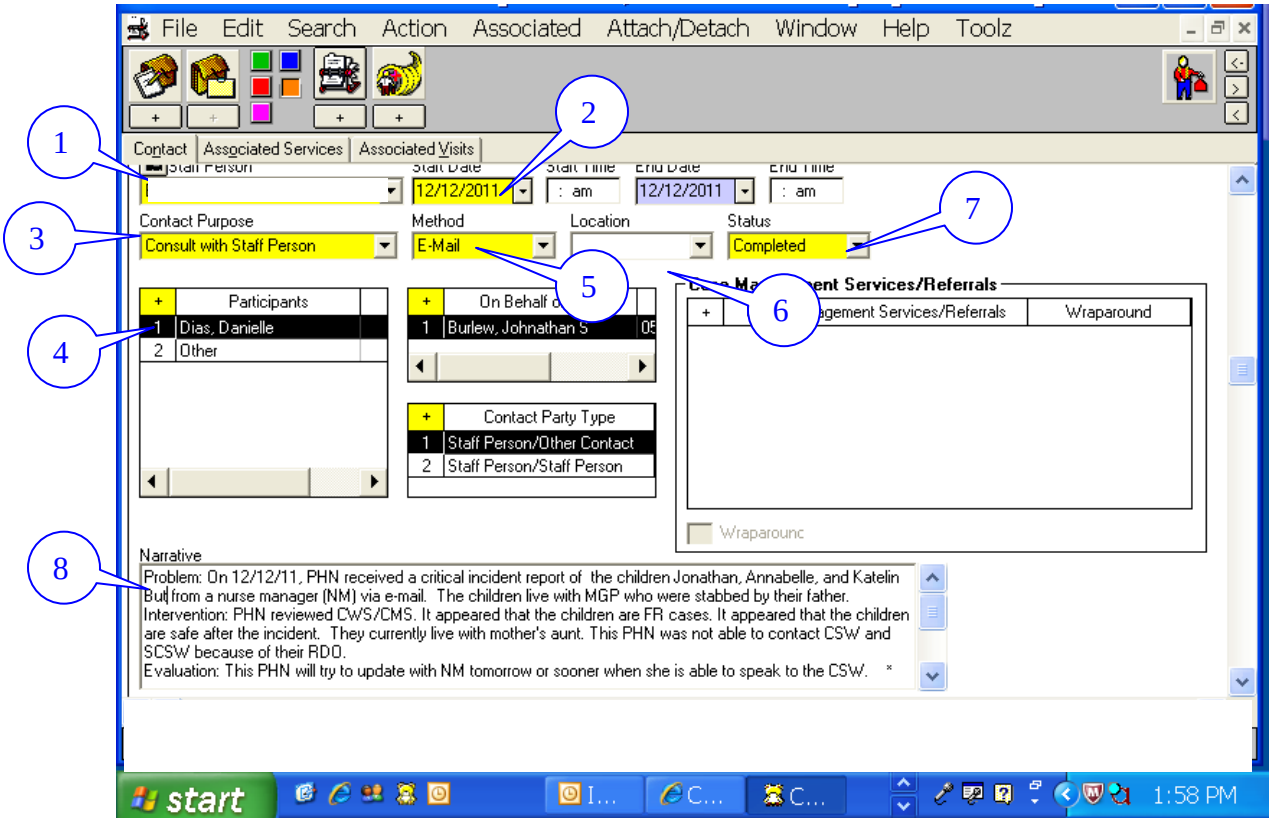
    f) Current status of the sibling (s) if known.

    g) Summary of the investigation and plan of care.

    h) Outcome.

6. Copy and paste the summary into the contact only.

Child Fatality, Death Review and Critical Incident Report Section (Delivery Service Log) example:



XIV. DCFS QUALITY REVIEW SERVICES AUDIT (QRS):

The QRS is a DCFS audit which reviews a child's records to assess the comprehensive care of the child.

1. Notify the supervisor if asked to participate in a DCFS audit immediately.

2. Obtain the purple folder and review the case prior to the audit date.

3. Document into CWS/CMS how, when, and why PHN received the audit.

XV: NURSE TO NURSE REPORT:

The Nurse to Nurse (N2N) report form will be utilized when transferring a case from one PHN to another PHN within the HCPCFC and DCFS programs. The purpose is to foster the continuity of care and ensure standardization of case transfer from one PHN to another.

2. The PHN assisting the CSW prior to case transfer will complete the N2N report form prior to transferring and give report to the newly designated PHN.

3. Upon completion of the N2N report form, the PHN will forward the report to the PHNS and PHN involved via email.

4. Create a contact indicating that you sent/received N2N report.

XVI. HOSPITAL LOG:

A hospital log is used to alert DCFS administration and the CSW/SCSW about hospitalized children who are receiving health care or awaiting placement.

1. When using the hospital log, document all pertinent information according to the Hospital Log policy.

XVII. OBESITY, OVERWEIGHT, UNDERWEIGHT, and FAILURE TO THRIVE (FTT):

According to the American Academy of Pediatrics:

a) FTT: BMI is equal to or less than 3rd percentile.
b) Underweight: BMI is greater than 3rd and less than or equal to 5th Percentile.
c) Overweight: BMI is ranging from 85th percentile to 94th percentile.
d) Obese: BMI is ranging from 95th percentile to 98th percentile.
e) Obese (severely): BMI is equal or greater than 99th percentile.

1. Enter BMI into the special project section in CWS/CMS.

2. Under the diagnosed condition section, enter height, weight, and BMI.

3. Graph the height, weight, and BMI using the Center for Disease Control and Prevention chart (CDC).

4. Contact the provider/caregiver to discuss weight management and document the plan of care.

5. Refer to an agency that assists with the child's condition.

6. PHN will provide literature and reinforce education to the caregiver/child as needed.

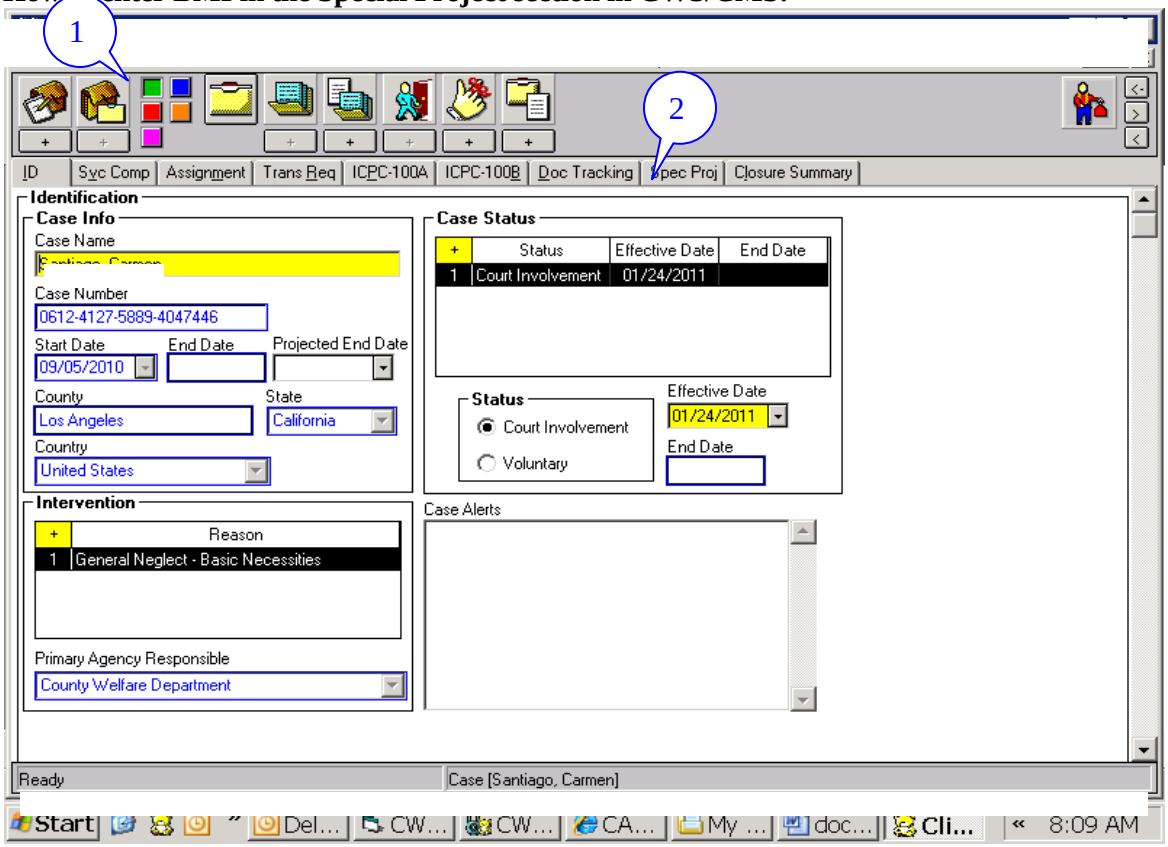
7. Follow up in 6 months or sooner if indicated.

8. Provide the CSW a contact (Delivery Service Log).

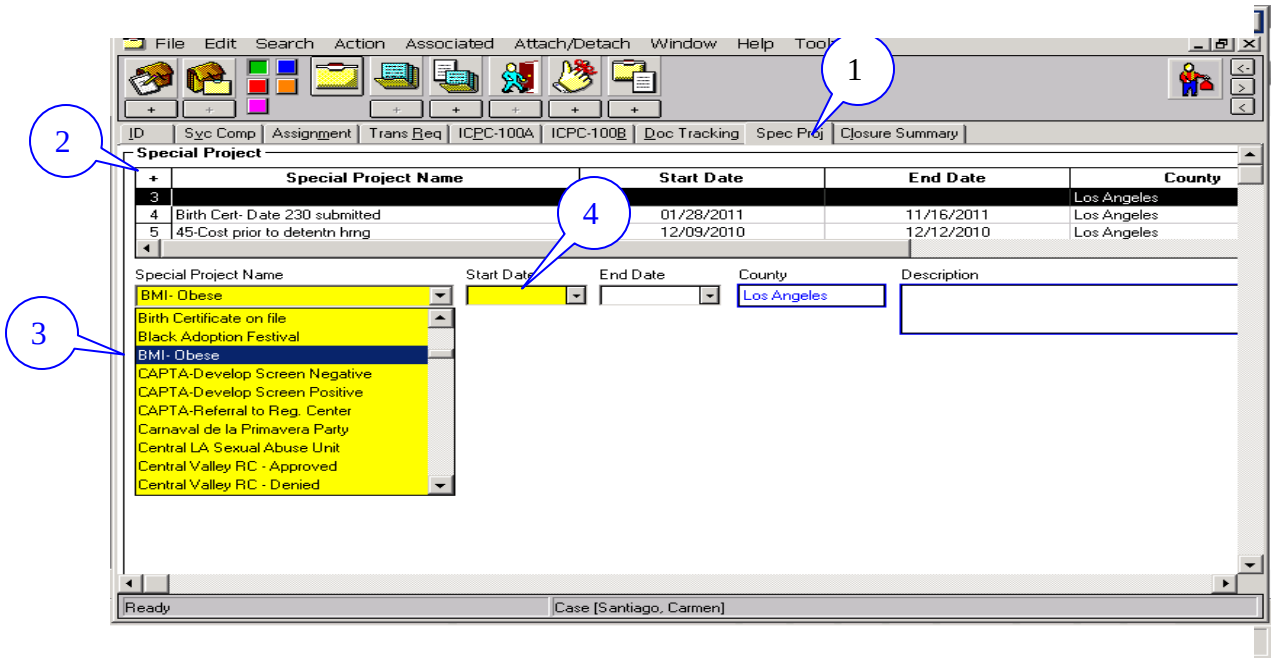
9. The PHN will conduct a home visit when appropriate.

Obesity Example 1

How to enter BMI in the Special Project section in CWS/CMS:

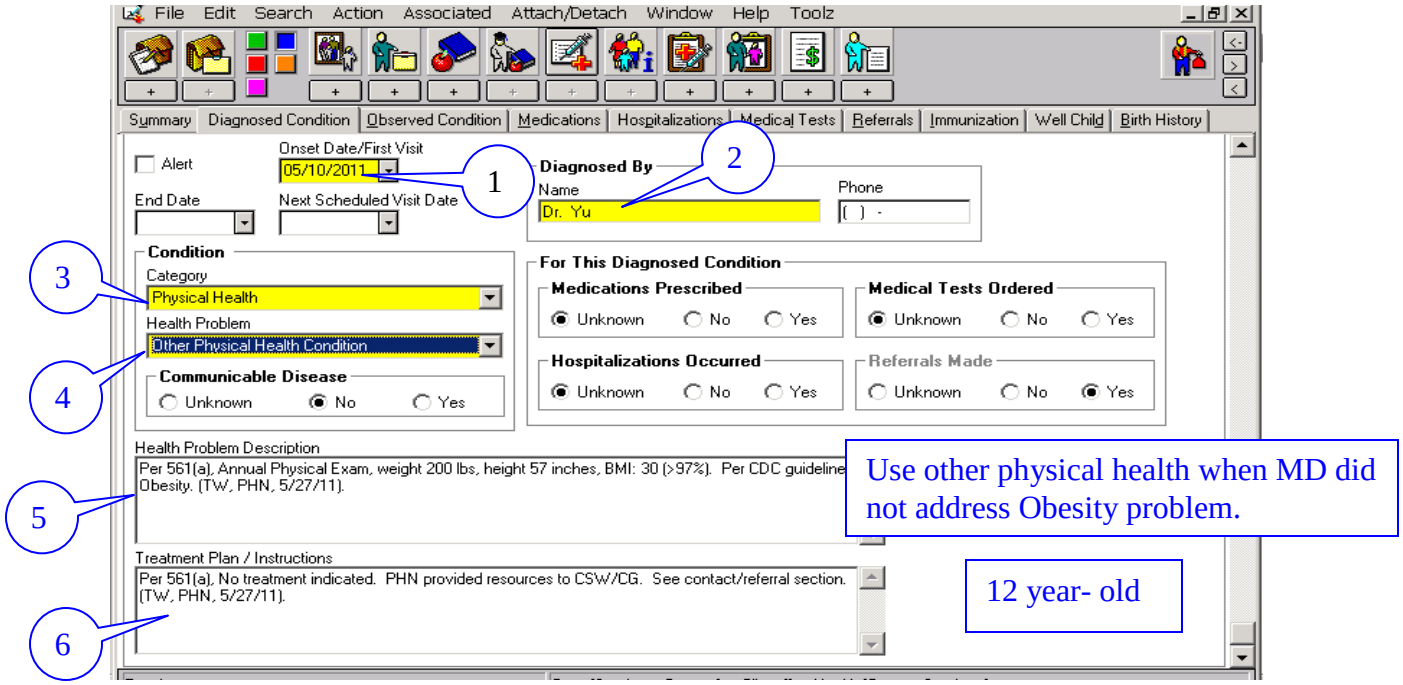


After you click the Special Project, this screen will appear:

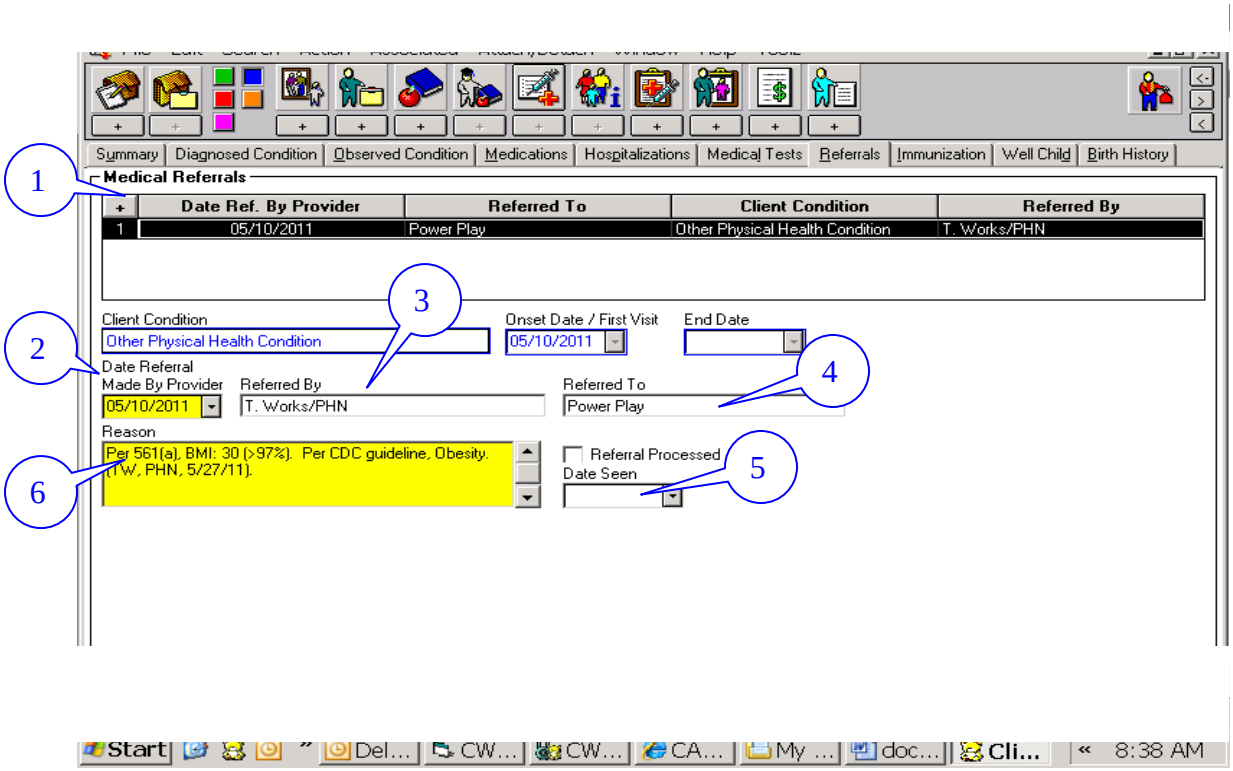


Obesity and Overweight Example 2

When the provider did not address the plan of care:



Obesity and Overweight Example 3: Refer to the appropriate agency:



XVIII. PREGNANCY and STD:

1) **A child who is pregnant and under DCFS jurisdiction.**

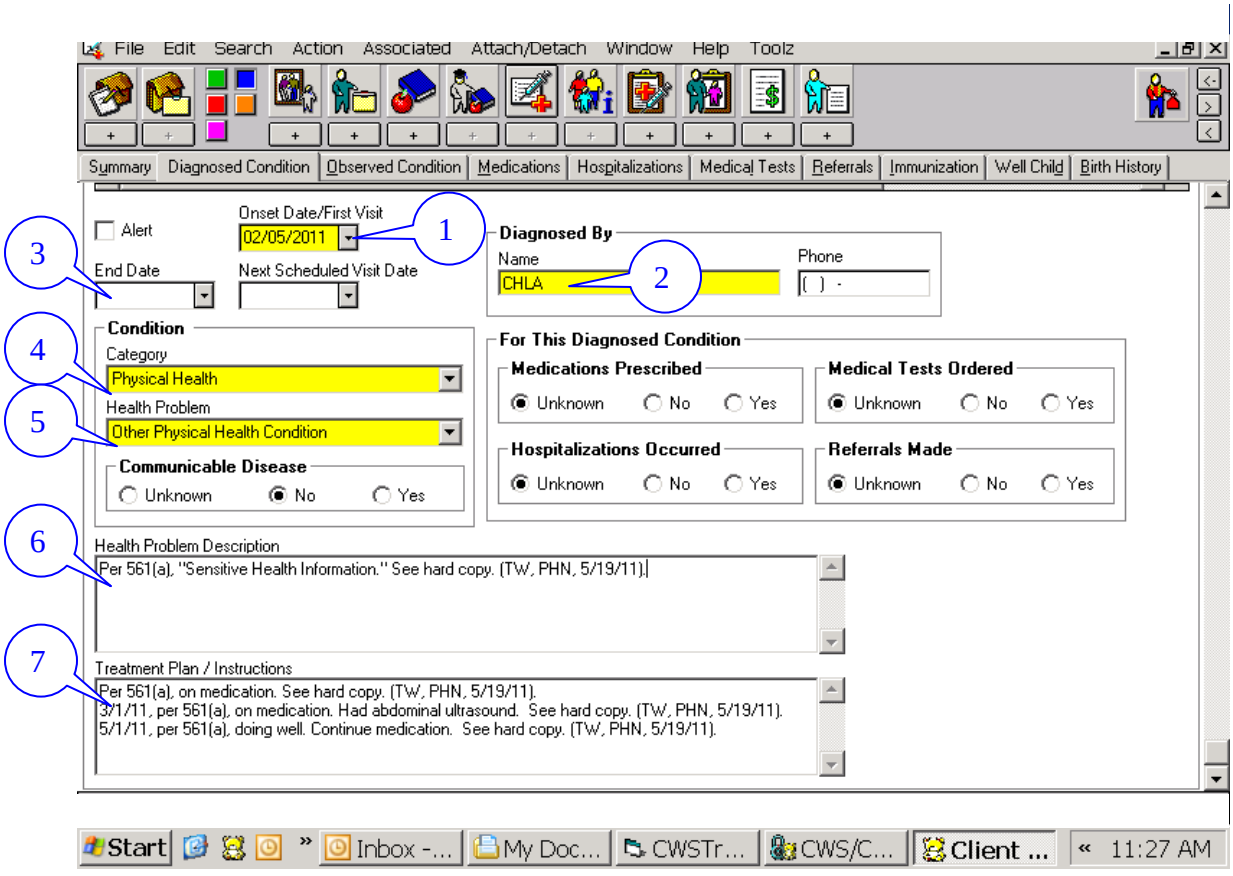
2) **A child who has STD.**

3) **Health Problem: choose "Other Physical Condition"**

4) **Health Problem Description box, PHN input: "Sensitive Health Information," for STD and Pregnancy.**

5) **In the Treatment Plan/Instruction box, PHN input: on medication(s) (not the name of medication), and follow up visit. See hard copy.**

Pregnancy and STD Example:



XIX. HIV:

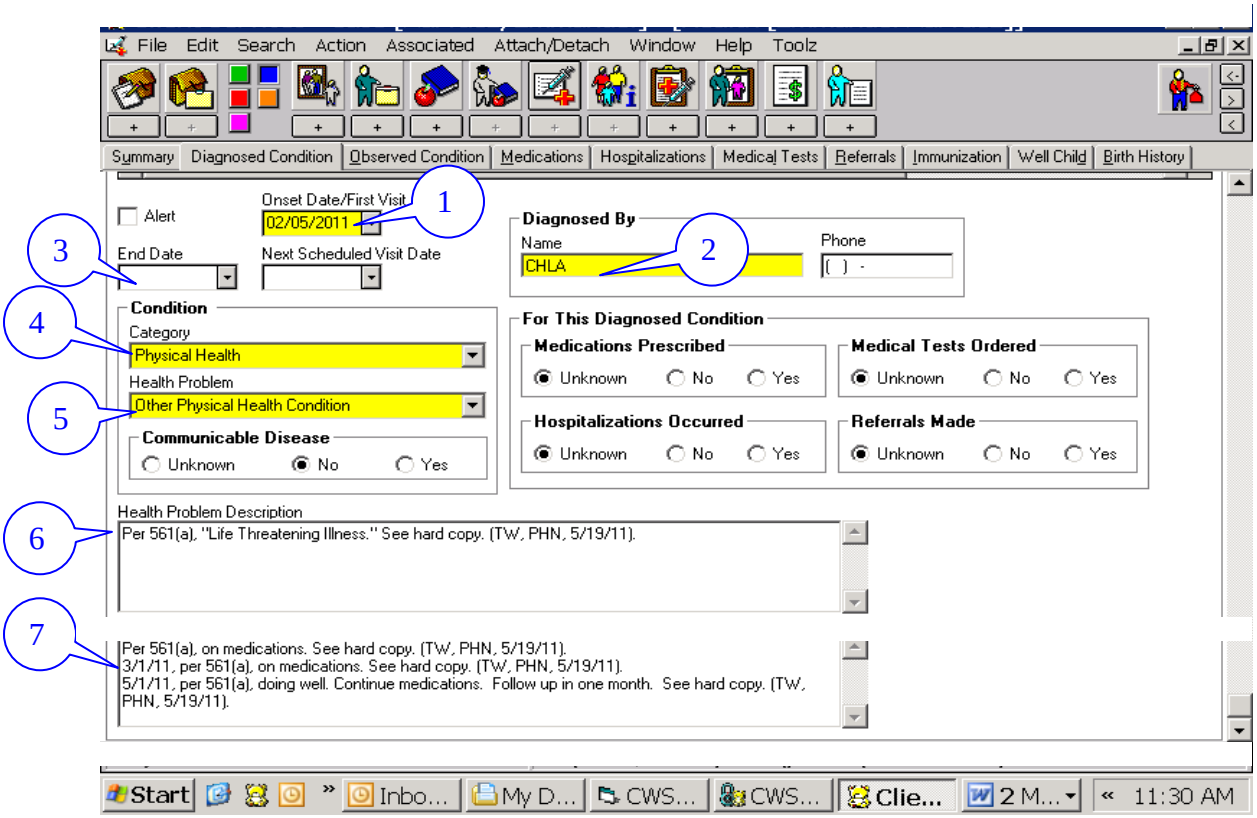
1) A child who has HIV.

2) Health Problem: choose "Other Physical Condition"

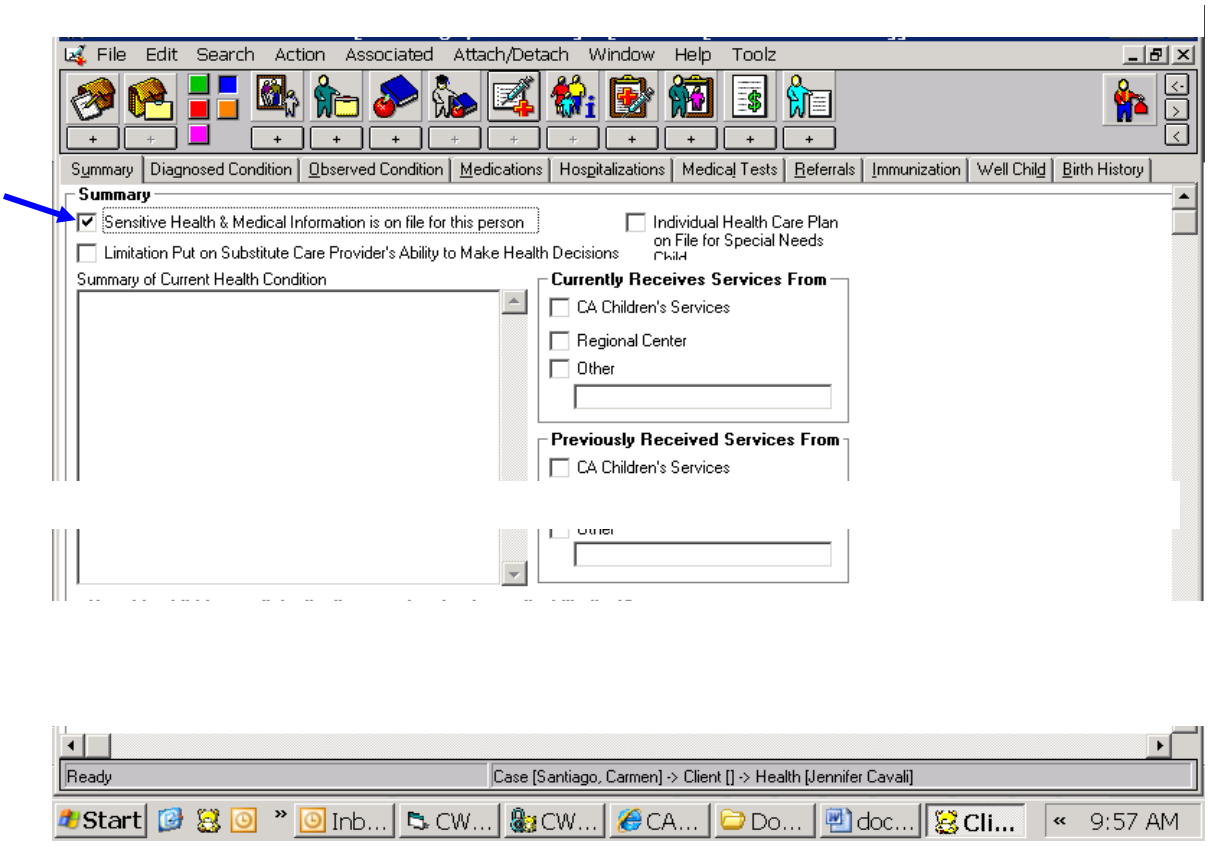
3) Health Problem Description box, PHN will input: "Life Threatening Illness."

4) Treatment Plan/Instruction box, PHN input: on medication(s), (not the name of medication) and follow up visit. See hard copy.

HIV Example 1:



HIV example 2
How to enter in the Summary Section for HIV:



REFERENCES:

1. PMA State Policy (03/26/08).
2. HCPCFC PMA Policy (draft 10/29/09).
3. HCPCFC PM160 Policy (draft 10/26/11).
4. DCFS policy: 0080-505.20-Health and Education Passport (HEP).
5. Health and Education Passport Training (May 20, 2009).
6. DCFS CWS/CMS for New Users. (11/2007).
7. DCFS policy: 0500-504.10 & 0600-502.20- HIV/AIDS confidential information.
8. Confidentiality issues + ICD-9 Code.
9. DCFS F-rate policy 0600-505.10 and 0900-522.11.
10. DCFS Healthy Lifestyle Plan 0600-506.00.
11. Obesity, Overweight, Underweight and Failure to Thrive Policy to follow
12. Nurse To Nurse Policy
13. Hospital Log Policy
14. HCPCFC Pregnancy to follow
15. Center for Disease Control and Prevention (CDC).