Breakout Session:
Nursing and Treatment Documentation
Patient Assessment

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Documentation and Assessment

Objectives – To review and discuss each of the following:

- Patient history form
- Patient education checklist
- Treatment record
- Flow sheet
- Progress note
- Billing units

Hyperbaric Medicine Service
Patient History Form

Name_____ Date _____ Diagnosis_____

PATIENT TO COMPLETE WHITE SECTION			Nursing Staff to complete grey section; follow-up questions
Allergies			Latex? ☐ Iodine? ☐ Tape? ☐ Reactions?
Do you have: Advanced Directives, Medical Power of Attorney, Living Will?	Yes☐	No ☐	Ask for chart copies of medical- legal documentation **DNR** ☐
Have you had a chest x-ray?	Yes☐	No ☐	Date of last one _____
Have you had an EKG?	Yes☐	No ☐	Date of last one _____
Seizure/stroke/neurological problems?	Yes☐	No ☐	Epilepsy☐ multiple sclerosis☐ paralysis ☐ **s**wallowing difficulty ☐
Asthma/ COPD/ emphysema?	Yes☐	No ☐	Home oxygen ☐ liters/min _____ Sleep apnea ☐
Active tuberculosis?	Yes☐	No ☐	Productive cough ☐ last PPD: _____ Tx:_____
Previous pneumothorax?	Yes☐	No ☐	When?
Smoke now or in the past?	Yes☐	No ☐	Number of years _____ packs/day_____ when quit____
E-Cig/Vap use? Nicotine?	Yes☐	No ☐	Number of years_____
Chest Pain? Cardiac surgery?	Yes☐	No ☐	History of heart attack ☐ irregular heart beat ☐ palpitations ☐ pacemaker ☐ defibrillator ☐
Problems with your blood flow?	Yes☐	No ☐	Leg edema ☐ phlebitis ☐ stroke ☐ PVD ☐
Problems with your blood pressure?	Yes☐	No ☐	Chronic HTN ☐
Take blood thinners? Aspirin? Bleed easily?	Yes☐	No ☐	Anemia ☐ blood transfusions ☐ blood disorder☐
Arthritis? Any steroid use?	Yes☐	No ☐	Prednisone ☐
Objection to blood products?	Yes☐	No ☐	
Hearing problems? Able to clear ears?	Yes☐	No ☐	Hearing aids ☐ PE tube referral ☐
Chronic sinus problems?	Yes☐	No ☐	
Eye or vision problems?	Yes☐	No ☐	Cataracts☐ contacts☐ glasses☐ implants☐ glaucoma☐
Dentures, capped teeth, retainers?	Yes☐	No ☐	
History of alcohol or drug use or abuse?	Yes☐	No ☐	Type? Last use?
Claustrophobia?	Yes☐	No ☐	Anti-anxiety medication ☐
Cancer? type?	Yes☐	No ☐	Chemotherapy ☐ radiation☐ type and amount
Hyperthyroid	Yes☐	No ☐	Medication? Dose?
Sickle cell disease or trait?	Yes☐	No ☐	Last time in crisis? _____
Hernia, ulcers, heartburn, bloody stool?	Yes☐	No ☐	
Kidney, bladder problems?	Yes☐	No ☐	Dysuria/frequency☐ dialysis☐ schedule_____
Diabetes?	Yes☐	No ☐	Type? _____ Controlled by insulin ☐ diet ☐
Pregnant?	Yes☐	No ☐	LMP_____
Medication patches?	Yes☐	No ☐	Type? Change Frequency?
Do you have any special needs? (i.e. VAC, implanted pumps, prosthesis, colostomy, drains, central lines, Foley catheter, bladder irrigation)			List special needs: Call manufacturer for implanted devices

Nursing Comments, History of Present Condition, Barriers:

LIST ALL DOCTORS INVOLVED WITH MEDICAL CARE

Doctor	Specialty	Office Number		Doctor	Specialty	Office Number

LIST HOME HEALTH CARE COMPANY AND ANCILLARY MEDICAL CARE RECEIVING

Home Health Care Company	Phone Number		Ancillary Health Care	Specialty	Office Number

LIST ALL MEDICATIONS CURRENTLY TAKING *(Include Non-Prescription Medicines, Vitamins, Minerals, and Herbs)*

Medication	Dose	Frequency		Medication	Dose	Frequency

LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS

Date	Surgery or hospitalization		Date	Surgery or hospitalization

PHYSICAL ASSESSMENT

T_____	**BP**_____	**P**_____	**R**_____	**%O2 SAT**_____ **liters on O2**_____	**Pain** _____ **out of 10**

Height Weight *Estimated* or *Actual*	Abuse/Neglect Issues
Lung Sounds	Neuro
Cardiovascular	GI
Psychiatric	Skin

NEW HBO PATIENT CHECKLIST

Teaching Instructions Given? ☐	Insurance Information/Authorization Obtained? ☐
Orientation Done? ☐	Photo Taken/Consent Signed? ☐
Consent Signed? ☐	New Patient Packet Given? ☐

Clinician Signature:

Date/Time:

Fall Risk Assessment Score: _____

Impaired judgment/lack of safety awareness	3
History of falls: past 3 months prior to admission/during hospitalization	3
Agitation	2
Impaired gait; shuffle/wide base; unsteady walk, amputation	2
Wets/soils self on way to bathroom	2
Dizziness/vertigo	1
Prosthesis	1

Patient Label

Hyperbaric Medicine Service
Patient Education Checklist

Patient Label:

All teaching is age and education level appropriate. Each time teaching is performed, the staff member documents: Date/Time/Initials in one box followed by learning code as indicated below. Mark N/A for items not applicable.

Patient and/or Family Educated on:				
GENERAL	**Date/Time/init**	**Code(s)**	**Date/Time/Init**	**Code(s)**
Introduction/Hours of Operation/Scheduling: ED priority				
Unit Orientation: Chambers/Dressing/Exam room				
Billing/Pre-Authorization: Medicare; Commercial				
Wound Care: Specific to Patient				
Nutrition Education: Pamphlet/Dietitian referral				
Diabetic Teaching: Diet/Blood sugar mgmt				
Anxiety: Patient is in charge!; offer meds				
Infection Control: Hand Washing/Precautions				
Patient Education: Indication handout				
Visitor Policy: limited for privacy; waiting room				
"HBO and You" Video				
HYPERBARIC TREATMENT				
Purpose:				
HBO therapy is mostly adjunctive				
Increases O2 levels in affected areas; systemically				
Referring physicians will confer regularly				
Treatment Procedure:				
Prohibited items/Fire safety: minimize fuel				
Patient preparation - 100% cotton, VS, ECG, BS, grounded, mask check, sippy cup				
Compression:				
Approx rate (1-3 psi/min) according to patient equalizing capability: Valsalva/Toynbee/PE tubes				
Compressing molecules cause warming, humid climate. Rapid, deeper descent = warmer; Gay Lussac's Law				
At Pressure:				
90 minute O2 treatment at pressure				
O2 is a medication (drug)				
Signs and symptoms of oxygen toxicity				
Air-breaks; acute mask use				
Decompression:				
Decompression is easier; approx 5-15 minutes				
Chamber temperature decreases;				
Never hold breath; avoid Valsalva				
Effects of Smoking on Healing:				
Nicotine constricts blood vessels, decreases flow				
Smoking should be stopped during HBO series				
Smoking cessation referral				
Can't stop: No Smoking 2 hr pre & 2-4 hrs post tx				
Side Effects/Risks				
Visual changes may exist up to 4 months post tx				
Cataracts may mature sooner				
Contraindicated in pregnancy unless CO				
Barotrauma: ear, sinus, tooth squeeze, pulmonary				
Claustrophobia; confinement anxiety				
Hypoglycemia in diabetes				

Code Legend

Learner	**Readiness**	**Method**	**Response**
P-Patient	A-Acceptance	D-Demonstration	DU-Demonstrates Understanding
F-Family	E-Eager	E-Explanation	VU-Verbalizes Understanding
O-Other	N-Non-acceptance	H-Handout	NR-Needs Reinforcement

Hyperbaric Medicine Service
Informed Consent for Elective Treatment

I, _____, hereby grant consent to and authorize the Hyperbaric Medicine Service, its physicians, employees, and agents to treat me with HYPERBARIC OXYGEN THERAPY for the condition of: _____.
Further, I understand that hyperbaric oxygen therapy might call for more than one treatment and I hereby authorize the Hyperbaric Medicine Service physicians to determine the number of treatments necessary to treat my condition.

Risks of Hyperbaric Oxygen Therapy

1. Oxygen toxicity-central nervous system/lung (seizure/fits)
2. Ear drum discomfort/rupture; sinus pain; dental pain
3. Myopia, vision change (reversible after HBO)
4. Increased cataracts growth rate (thickening of lens/change in vision)
5. Increase risk of fire
6. Over pressurized lung; embolism; pneumothorax; emphysema (collapsed lung/bubbles in bloodstream)
7. If you are diabetic, your blood sugar may drop while in chamber
8. Pulmonary edema (lung fluid accumulation)

The nature and purpose of hyperbaric oxygen therapy has been explained to me by _____ and I hereby acknowledge that I know and understand the nature and the purpose of the treatments. Additionally, the physician has explained to me the consequences, risks and alternatives to receiving hyperbaric oxygen treatment. I have been given the opportunity to ask questions and have them answered so that I can form my own decision.

Patient	**Date/Time**
Relationship if not Patient	**Witness**

I have explained the nature, purpose, prognosis and possible consequences of diagnostic and/or treatment procedures, and the risks involved, possible associated complications and alternative treatments of diagnostic and/or treatment procedures.

Physician Signature: _____ **Date/Time:** _____

Hyperbaric Medicine Service

Patient Assessment & Treatment Checklist

Patient Identication

Patient Name: JOHN SMITH **HBO#** 123456

General				Pre Tx Vital Signs (Post Tx PRN)					Pre Tx Assessment (Post Tx PRN)						Safety					Verification	
Date	Treatment #	Patient Status O/P or I/P	Wound Photo? Y/N	Blood Sugar for Diabetics	Temperature	Respiration	Pulse	Blood Pressure	Lung Sounds Left	Lung Sounds Right	FallRisk? Y/N	Pain Level (0-10)	TM Right	TM Left	ECG Alarm Settings	Patient Ground Confirmed? Y/N	Fire Risks Assessed? Y/N	Prohibited Items Authorization Form Completed?	PT/Family Education? Y/N	Supervising	Clinician (RN Co-Sign) Physician
1/29/24	3	O/P	Y	140	98.7	20	88	140/80	CE / CE	CE / CE	Y	0	T-0 / T-2	T-0 / T-0	90-50	Y	Y	Y	Y	Cone	Handley

SN=See Notes
NA=Not Assessed

Photos: inital tx. then q 5 txs & upon D/C
Label with date, MR# and # of completed treatments

Pain Level
0 (none) - 10 (intense)
Chart how pain is managed in progress note

Draw a diagonal line / thru the box if post tx value obtained.
Record value below line.

Lung Scale
CE=Clear/Equal thru ou
DT=Diminished thru ou
DB=Diminished @ bas
DU=Diminshed upper
CRT=Crackles thru out
CRB=Crackles @ bases
CRU=Crackles upper
WT=Wheezes thru out
WB=Wheezes @ bases
WU=Wheezes upper
O=Other (see progress note)

Teed Scale
T0= Teed 0
T1=Teed 1
T2=Teed 2
T3= Teed 3
T4=Teed 4
T5=Teed 5

Fall Risk Assessment

Impaired judgement/lack of safety awareness	3
History of falls; past 3 months prior to admission/during hospitalization	3
Agitation	2
Impaired gait; shuffle/wide base; unsteady walk, amputation	2
Wets/soils self on way to bathroom	2
Dizziness/vertigo	1
Prosthesis	1

Fall Precautions for a score of >2

Revised 1/2024

Hyperbaric Medicine Service
Treatment Record

Patient's Name: ___JJon Smith_____ **HBO#:** 123456

Diagnosis: ___ Late Effects of Radiation_____ **ICD Code:** _____

Patient Preparation Preferences:

Bottle of drinking water, cotton wash cloth;moistened, elevate head of bed 45 degrees

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Medical Details: **Allergies:** _____ **Status:** **Full Code** ☐ **DNR** ☐

Blood Sugar Pre___ **Post**___ **PE Tubes** ___ **Slow Descent**___ **Air Break** 1__ 2__ **DCI Table 5** ___ **DCI Table 6** __

Myringotomy: Date/ Time: **PreTreatment Meds:**

DATE	RX #	ATA	Mins of O2	Rate	LS	AP	LP	AS	Total Mins/ Units	~~Wellness Check~~ every 15 mins Time/Initials	Air Break(s) 1	Air Break(s) 2	Equipment Involved	Initials/ Co-sign
5/1/2022	3	2.5	90	1-2 / 2	0805	0819	1009	1020	135 / 4u	840 855 910 / 925 940 955	849-859	929-939	NRB	SH

Rate= psi/min of compression/decompression **LS** = left surface **AP** = at pressure **LP** = left pressure **AS** = at surface

Hyperbaric Medicine Service
Progress Notes

Patient Name: John Smith

Date & Time	Tx #	Notes
5/1/22 0800	3	Patient prepped for HBO tx. Pre tx Safety Check performed.
		Vital Signs & Blood sugar WNL. Physician present to assess.
		Orders confirmed for 2.5 ATA x 90 min ☐ two 10 min airbreaks SH
5/1/22 0805	3	Compression starts @ 2 psi/min rate SH
5/1/22 0806	3	Pt c/o ear pain 4/10 ☐ chamber held at 5psi - then
		decreased to 4psi to allow pt time to clear ears; drinking
		water & Valsalva. SH
5/1/22 0807	3	Pt reports ears cleared. Restart Compression at 1psi/min SH
5/1/22 0812	3	Pt at 9psi "ears feel fine". Compression rate increased to 2psi/min SH
5/1/22 0819	3	Pt at 2.5 ATA, timer started for 30 mins. TV volume adjusted. Purge flow
		valve decreased to warm chamber per Pt. request. SH
5/1/22 0849	3	Airbreak #1 started via NRB mask SH
5/1/22 0859	3	Airbreak #1 completed ☐ difficulty SH
5/1/22 0929	3	Airbreak #2 started SH
5/1/22 0939	3	Airbreak #2 completed ☐ difficulty SH
5/1/22 1009	3	Pt informed to prepare for decompression. Rate 2psi/min SH
5/1/22 1020	3	Pt. @ surface, removed from chamber ☐ complaints. Lungs
		clear. Ears examined by physician; (R) ear teed 2, (L) ear
5/1/22 1035	3	teed Ø. Plan: Pt return for tx tomorrow - reinspect ears SH

* Left surface @ 805
At surface @ 1020
135 mins total (4 units)

Hyperbaric Medicine Service

Medicare Billing for 30-minute HBO Treatment Units

HCPCS Code G0277

Medicare reimburses for the time from when the chamber door is closed until the chamber door is opened again.

This includes **compression time, air-breaks** and **decompression time** in addition to the prescribed oxygen **treatment time**.

The 16-minute rule:

Medicare pays in 30-minute units. Medicare mandates that there must be at least 16 minutes into each 30-minute unit in order to bill for that unit as shown in the chart below.

Example:

So, if a patient started compression at **8 am**, reached pressure at **8:10 am**, had **two 10-minute** air breaks and completed **90 minutes** of oxygen treatment. Then began decompression at **10 am** and reached surface at **10:15 am**. The total treatment time was **135 minutes** or **4 units**.

Minutes	Units
0 - 15	0
16 - 45	1
46 - 75	2
76 - 105	**3**
106 - 135	**4**
136 -165	**5**
166 - 195	6
196 - 225	7
226 - 255	8
256 - 285	9
286 - 315	10
316 - 345	11
346 - 375	12
376 - 405	13
406 - 435	14