PRIVATE DUTY NURSING ACUITY GRID

Instructions:

The Private Duty Nursing Acuity Grid indicates the average amount of skilled nursing treatment or services as documented by concurrent health records for each of the services listed below:

- For the first certification period, these skilled nursing services are estimated by the nurse per shift.
- For recertification period(s), the **average** amount of skilled nursing services performed by the nurse per shift.

ASSESSMENT NEEDS

This is based on the severity of illness and the stability of the patient's condition(s).

(Choose one)		**Points**	**Score**
○	Initial physical assessment per shift	0.0	
○	Second documented complete physical assessment per shift	2.0	
○	Three or more complete physical assessments per shift	3.0	

(Choose one if at least 2 of the 4 assessment types are ordered and documented as medically necessary)
(Note: These assessments are incorporated in the physical assessment above. Select only if completed in addition to the physical assessment.)

○	VS/GLU/NEURO/Resp (Assess less often than daily)	0.0	
○	VS/GLU/NEURO/Resp (Assess less often than Q4, at least once per shift)	1.0	
○	VS/GLU/NEURO/Resp (Assess Q 4 hr or more often per shift)	2.0	
○	VS/GLU/NEURO/Resp (Assess Q 2 hr or more often per shift)	3.0	
		TOTAL:	

MEDICATION/IVDELIVERY NEEDS

(Choose one describing the medications provided by the nurse - Oral, Inhaler, Rectal, NJ, NG or G Tube. Does not include nebulizer or over-the-counter medications)		**Points**	**Score**
○	Documented medication delivery less than 1 dose per shift	0.0	
○	Documented medication delivery 1 to 3 doses per shift	1.0	
○	Documented medication delivery 4 to 6 doses per shift	2.0	
○	Documented medication delivery 7 or more doses per shift	4.0	

(Choose one)			
○	No IV access	0.0	
○	Peripheral IV Access	1.0	
○	Central Line of port, PICC Line, Hickman	2.5	

(Choose one)			
○	No IV Medication Delivery	0.0	
○	Transfusion or IV medication less than daily but at least weekly	2.5	
○	IV medication less often than Q 4 hrs (does not include hep flush)	4.5	
○	IV medication Q 4 or more often	6.0	

(Choose one)			
○	No regular blood draws, or regular blood draws less than twice per week	0.0	
○	Reg blood draws / IV Peripheral Site - at least twice per week	4.5	
○	Reg blood draws / IV Central line - at least twice per week	6.0	

(Choose one)			
○	No parenteral nutrition	0.0	
○	Partial parenteral nutrition	3.0	
○	Total patenteral nutrition (TPN)	6.0	
		TOTAL:	

FEEDING NEEDS

(Choose one)		**Points**	**Score**
○	Routine oral feeding or no tube-feeding required	0.0	
○	Documented difficult prolonged oral feeding by nurse	2.0	
○	Tube feeding (routine bolus **or** continuous)	2.0	
○	Tube feeding (combination bolus **and** continuous, does not include clearing tubing)	2.5	
○	Complicated tube feeding (Complications must be documented)	3.0	

(Choose any that apply)			
☐	Documented occasional reflux and / or aspiration precautions by nurse	0.5	
☐	G-Tube, J-Tube or Mic-key button	0.5	
		TOTAL:	

RESPIRATORY NEEDS

	Points	Score
(Choose one)		
○ No trach, patent airway	0.0	
○ No trach, unstable airway with desaturations, and Airway clearance issues	1.0	
○ Trach (routine care)	1.0	
○ Trach special care (wound or breakdown treatment; pull-out or replacement) at least two documented events during shift	2.5	
(Choose one- Instilling normal saline and resuctioning to break up secretions count as one suctioning session)		
○ No suctioning	0.0	
○ Nasal and oral pharyngeal suctioning by nurse > 10 times per shift	0.5	
○ Infrequent tracheal suctioning by nurse during shift, less than Q 3 hrs but at least daily	0.5	
○ Tracheal suctioning session by nurse during shift, Q 3 hrs	1.5	
○ Tracheal suctioning session by nurse during shift, Q 2 hrs or more frequently	2.5	
(Choose one)		
○ None of the following three options apply	0.0	
○ Oxygen - daily use	0.5	
○ Oxygen PRN based on pulse oximetry, oxygen needed at least weekly	1.0	
○ Humidification and oxygen - direct (via tracheostomy tube but not with ventilator)	1.5	
(Choose one - ventilator points include all ventilator related care and humidification)		
○ No ventilator, BiPap, or CPAP	0.0	
○ Ventilator; rehab transition / active weaning; documented	9.0	
○ Ventilator; weaning achieved, required monitoring; documented	6.0	
○ Ventilator; at night, 1-6 hours during shift; documented	8.0	
○ Ventilator; 7-12 hours per day; documented	10.0	
○ Ventilator; ≥ 12 hrs per day but not continuous; documented	12.0	
○ Ventilator; no respiratory effort or 24 hr/day in assist mode; documented	14.0	
○ BiPAP or CPAP by nurse during shift, up to 8 hrs per day	4.0	
○ BiPAP or CPAP by nurse during shift, greater than 8 hrs per day	6.0	
○ BiPAP ST by nurse during shift, spontaneous timed with rate used to ventilate at night	7.0	
(Choose one describing documented care by the nurse; excludes inhalers and normal saline)		
○ No Nebulizer treatments	0.0	
○ Nebulizer treatments by nurse during shift, less than daily but at least Q week	1.0	
○ Nebulizer treatments by nurse during shift, Q 4 hrs or less frequently but at least daily	1.5	
○ Nebulizer treatments by nurse during shift, Q 3 hrs	2.0	
○ Nebulizer treatments by nurse during shift, Q 2 hrs or more frequently	3.0	
(Choose one - must be physician ordered, medically necessary, by nurse during shift, and documented)		
○ No Chest PT (Physical Therapy), HFCWO (High Frequency Chest Wall Oscillation) vest, or Cough Assist Device	0.0	
○ Chest PT, HFCWO vest or Cough Assist Device at least q week	0.5	
○ Chest PT, HFCWO vest or Cough Assist Device / Q 4 hrs or less, but at least daily	1.5	
○ Chest PT, HFCWO vest or Cough Assist Device / Q 3 hrs	2.0	
○ Chest PT, HFCWO vest or Cough Assist Device / Q 2 hrs or more	3.0	
	TOTAL:	

ELIMINATION NEEDS

	Points	Score
(Choose one that best applies to care nurse provided during the previous 60- days).		
○ Continent of bowel and bladder	0.0	
○ Uncontrolled incontinence < 3 yrs of age	0.0	
○ Uncontrolled incontinence, **either** bowel or bladder, ≥ 3 yr of age	1.0	
○ Uncontrolled incontinence, **both** bowel and bladder, ≥ 3 yr of age	2.0	
○ Incontinence and intermittent straight catheterization, indwelling, suprapubic,or condom catheter	3.5	
Bowel or Bladder		
☐ Ostomy Care - at least daily	3.0	
	TOTAL:	

SEIZURES

(Choose one)	Points	Score
○ No seizure activity	0.0	
○ Mild seizures - at least daily, no intervention	0.0	
○ Mild seizures - at least 4 per week, each requiring minimal intervention	1.0	
○ Mod seizures - at least daily, each requiring minimal intervention	2.0	
○ Mod seizures - 2 to 4 times per day, each requiring minimal intervention	4.0	
○ Mod seizures - at least 5 times per day, each requiring minimal intervention	4.5	
○ Severe seizures - up to 10 per month, each requiring intervention	4.5	
○ Severe seizures (req IM/IV/Rectal med administration - at least daily)	5.0	
○ Severe seizures (req IM/IV/Rectal med administration - 2 to 4 times per day)	5.5	
	TOTAL:	

THERAPIES/ORTHOTICS/CASTING

(Choose one)	Points	Score
☐ Fractured or casted limb	2.0	
☐ Passive ROM (at least Q shift)	2.0	
☐ Torso Cast, torso splint, or torso brace	2.0	

(Choose one)	Points	Score
○ No splinting schedule, or splint removed and replaced less frequently than once per shift	0.0	
○ Splinting schedule requires nurse to remove and replace at least once during shift	1.0	
○ Splinting schedule requires nurse to remove and replace at least twice during shift	2.0	
	TOTAL:	

WOUND CARE

(Choose one)	Points	Score
○ None of the options below apply	0.0	
○ Wound Vac	2.0	
○ Stage 1-2, wound care at least daily (does not include trach, PEG, IV site, J-tube, G-tube)	2.0	
○ Stage 3-4, multiple wound sites	3.0	
	TOTAL:	

ISSUES THAT INTERFER WITH CARE

(Choose one)	Points	Score
○ None of the issues below interfere with care	0.0	
○ Unwilling or unable to cooperate	1.0	
○ Weight ≥ 100 pounds or immobility increases care difficulty	1.0	
○ Unable to express needs and wants creating a safety issue	1.0	
	TOTAL:	

OTHER ISSUES

	Points	Score
☐ Requires isolation for infectious disease (i.e. tuberculosis, wound drainage) or protective isolation (Nursing care activities for creating and maintaining isolation must be documented.)	3.0	
	TOTAL:	

GRAND TOTAL FOR ALL CATEGORIES ON NURSING ACUITY GRID :

CERTIFICATION

I HEREBY CERTIFY that by signing and submitting this report to Health Care Financing (HCF) that the information may be relied upon for the accurate determination of Nursing Acuity.

I certify that all submitted data on this grid and on any supporting information with it, is true, accurate, and completed and prepared from the case notes and obervations of the case worker / RN in accordance with all applicable rules, regulations instructions, and requirements.

I further certify and represent that I have personally reviewed this report and that all representations are true and accurate according to the best available information and records.

I hereby agree to keep such records as are necessary to disclose fully the information contained herein for a period of no less that five (5) years from the date of submission and further agree to make all said records and information available as original documentation or as copies as designated by the request of authorized state personnel, including, but not limited to, agents of the Department of Health and the Bureau of Program Integrity.

I UNDERSTAND AND INTEND THAT THE DEPARTMENT WILL RELY UPON MY STATEMENTS HEREIN TO DETERMINE THE NURSING ACUITY AND ANY MISREPRESENTATION, FALSIFICATION, CONCEALMENT, OR OMISSION OF MATERIAL FACTS CONSTITUTES FRAUD AND I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

_____

Signature of Registered Nurse or LPN caring for patient

Title: _____

Date: _____