Defensive Documentation for the LTC Professional

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What do you mean by "is"?

Importance of Documentation

Since the introduction of case-mix & its diagnosis- related groups, documentation has become increasingly important:

- **Validates the care we are providing**
- **Supports reimbursement we are receiving**
- **Utilized to defend actions taken by a facility**

Importance of Documentation

If your facility has not yet experienced a lawsuit…

"If it wasn't documented, it didn't happen…."

Priority reasons to document:

- **Written support of the care and services that is actually provided to the resident.**
- **A means of communication among the professionals who are providing services and care to the resident.**

If documentation is intended to provide a complete picture of the care and the services provided to the resident, the nurse's note can no longer be the only source of information for completing a picture of the resident's clinical condition.

The Organized Approach to Documentation

- **Documentation Order**
- **Documentation Format**

Problem-oriented Formats

SOAP – quick, to the point and easily remembered.

- **S:** Subjective data, what the resident says
- **O:** Objective data, what you as a healthcare provider actually see, touch, or feel
- **A:** Assessment, your conclusion based on subjective and objective data
- **P:** Plan of action, your proposed intervention(s) to solve the problem/issue

Problem-oriented Formats

APIER – starts with the assessment and combines both subjective and objective findings

- **A:** Assessment
- **P:** Plan
- **I:** Implementation
- **E:** Evaluation
- **R:** Revision

Problem-oriented Formats

PIE – starts with the assessment, identifying the problem and the nursing diagnosis.

- **P:** Problem, nursing diagnosis
- **I:** Interventions, actions taken
- **E:** Evaluations of interventions, success or failure

Problem-oriented Formats

- **Caution should be used with these formats.**
- **Often a clinician will use much subjective inf and produces conflicting care plans.**
- **(The medical record plan may well differ with the comprehensive care plan.)**

Focus Charting

- **Is based on resident-centered problems, i.e., behavioral issues or a significant change;**
- **Tends to rely only on individual occurrences or significant changes;**
- **Often eliminates the positive notes that support "well-being" that are so necessary in an outcome-oriented process.**

Charting by Exception

- **Forces documentation of only abnormal findings, significant changes, and unusual occurrences. Reduces time and effort, but intimates that care is only provided from "bad event to bad event."**
- **Can become a "red flag" during an audit or survey, and doesn't give the facility recognition for good resident care that is provided on a daily basis.**
- **Attorneys reviewing this format do not find the evolving development of a situation/occurrence. There is no documented evidence of the care team's interventions and interactions that preceded the situation/occurrence.**
- **And, of course, this type of documentation does not reflect positive interactions or events.**

Narrative Notes

The most commonly used format. When done properly, this process combines:

- **Assessment information**
- **Care team interventions**
- **Resident responses**
- **Appropriate notifications**
- **Follow-up information**

Narrative Notes

- **Follow-up can be a challenge when pertinent information is "lost" in lengthy narratives and does not surface with a "quick glance."**
- **Some facilities utilize a "check-off list" for their routine documentation; however, in most cases narrative documentation continues to be used for emergencies and adverse events.**

Poor Narrative Summar

Date: 12/08/03

Time: 3:00p.m.

Clinician Entry:

Resident up and OOB to therapy. Eats well. No c/o pain, appears OK today. Wanted to go home on LOA yesterday, but it was too cold. I told her it was too cold, maybe she could go another day. POD in to see resident, no orders.

J. Doe, R.N.

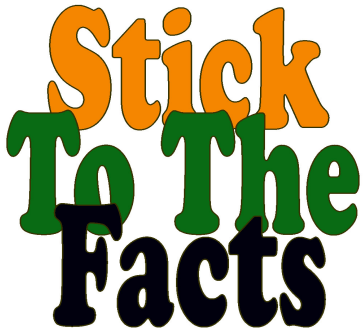
Good Narrative Summary

Date: 12/10/03
Time: 2:00p.m.
Clinician entry:
Resident continues with her therapy sessions. Has full weight-bearing on left lower extremity. Able to ambulate from room to nurses' station with therapist assistance. Ate 75% of breakfast, offered 150cc of juice with medication pass, accepted by resident. Resident stated she wanted to go home to visit. Call placed to physician regarding LOA. Notified daughter Jane of her request.

J. Doe, R.N.

Narrative Notes

- **Stick to the facts**
- **Don't opinionate**
- **Don't rationalize**
- **Don't project**
- **Make certain that is written can supported**



Standards That Must Be Met

Two types of standards:

- **Internal standards can be met by knowing your facility's policies and procedures and your own job description.**
- **External standards involve the facility's level of care license, state and federal regulations, state professional licensing agency requirements and/or practice acts.**

Things to Do…

1. **Make sure you have the correct chart BEFORE you begin documenting your entries.**

Things to Do…

2. **Write legibly and neatly. Date & time your entries, & sign them correctly: first name or initial, last name, professional**

Things to Do…

3. **Avoid grammatical and spelling errors**

Things to Do…

4. **Be factual & descriptive**

Things to Do…

5. **Make sure entries are accurately dated and timed.**

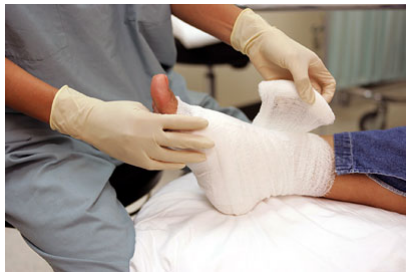
5. If you forgot to chart during a shift, make a "late entry" by writing the current date and time in the next available space and writing, "Late entry for (date & shift missed)."
6. To add information to an existing entry, write the date & time of the new entry on the next available space & include: "Addendum to note of (date and time of prior note)."
7. Sign the entries as usual.

Things to Do…

6. **Always document with a jury in mind!**

Things to Do…

7. **Chart procedures, tests & treatments only AFTER they are done – NOT in advance.**



Things to Do…

8. **Record the resident's symptoms and what you did in response**

   a. how did the resident respond to the interventions

   b. documentation should accurately reflect the resident's condition

Things to Do…

9. **Note communication among all health care team members.**

   a. Always document date, time and information conveyed, name of person notified, and his/her response.

Things to Do…

10. **Chart all instances of resident noncompliance or refusal or recommended treatment.**
11. **Document enough to convince a reader that a resident was adequately treated and cared for.**

Things NOT to Do…

1. **Do not guess, generalize or write personal opinions or statements.**
2. **Do not document for other caregivers.** Protect your signature. Your signature certifies that you actually assessed, observed, and delivered the care and/or services.

Things NOT to Do…

3. **Do not use the medical record to assign blame or settle disputes.**
4. **If there is a problem or question of staff competence, it is your responsibility to address the issue.** Chain of command should be involved in this situation.

Things NOT to Do…

5. **Do not refer to risk management efforts in the medical record.** For example, don't include such phrases as "Incident report completed."
6. **Do not use "unapproved" abbreviations.** In fact, be extremely cautious when using ANY abbreviation.

Things NOT to Do…

7. **Do not try to change the chart with the intent to deceive.**
   - ✓ Attorneys state that there are no secrets, just undiscovered truths.
   - ✓ Even if there are other mitigating circumstances, one piece of falsified documentation casts doubt on the complete record.

Things NOT to Do…

8. **Do not leave blanks in your notes to fill in later.**
9. **Do not leave space for someone else to put his or her note in.**

Things NOT to Do…

10. **Do not erase, write over, or obliterate any entries in a chart.**

    10. This is illegal!
    11. When incorrect information is written, draw a single line through the entry, date it, initial it, and then enter the correct information.

Things NOT to Do…

11. **Do not backdate.**
12. **Do not add to previously written notes.**
13. **Do not write over dates.**

Things NOT to Do…

14. Do not wait until the end of the shift or the end of day when everything has to be from

Two Pertinent Points

- **The medical record should be complete and consistent.**
- **All caregivers should know how and where care or services should be documented.**

"Red Flag" Words/Phrases

- **Will monitor.**
- **Will observe.**
- **Will follow-up.**
- **Notified physician.**
- **Physician called.**
- **7-3 or 3-11 will call MD/DR.**

"Red Flag" Words/Phrases

- **Appears.**
  If you are going to use this word, further describe the appearance.
- **Reassured.**
  This is a definitive word meaning "to state confidently…to make certain." Ask yourself whether you are offering support in a situation or assuring an outcome.
- **Routine, Same, Common.**
  Qualify what you mean by these words.

"Red Flag" Words/Phrases

- **Good. Poor. Fair. Well.**
- **More. Less.**
- **Increase. Decrease.**
  Specify numbers, frequency, amount, etc.
- **Adequate. Inadequate.**

"Red Flag" Words/Phrases

- **Appropriate. Inappropriate.**
  Support these words with actual, specific, factual descriptions of what the resident is doing.
- **Forced fluids.**
- **Reassure all will be okay.**
  Use "comfort" instead.
- **Wandered.** If the resident does not meet the definition of "wanderer" as specified in the MDS/RAI Instructional Manual, use other words to describe the resident's movement.
- **Abusive. Combative.**

Computerized Charting

- **Process can help improve accuracy and keep information easily updated.**
- **It is more legible, thereby reducing errors in interpretation.**
- **Is there a back-up paper system for new employees who are unfamiliar with the system? And for the times when the computer is down?**
- **The system may be confusing to attorneys and other care professionals who are unfamiliar with your system and/or program.**
- **At times a facility may utilize both forms of documentation – hard copy and computers. This may give the appearance of being "out of sequence." A chronological order of events may seem to lack continuity.**
- **For regulatory agencies, the utilization of computerized care plans may indicate that plans have not been individualized per each resident's specific needs.**

Adverse event/change in condition or treatment

1. Date and time
2. All appropriate discipline observations/ assessment (i.e., nursing, dietary, activities, social services)
3. Location & description, if an incident
4. Actions taken
5. Persons notified, including physician and/or family members & their responses
6. Vital signs
7. State of resident (if possible)
8. Subsequent follow-up entries until situation is stable or resolved according to facility policy

Adverse Events

You need to know what should be documented, and what does NOT get charted in the medical chart.

1. "Rule of thumb" – if a resident makes a specific complaint, it should be documented.
2. If there is a medication error, a device malfunction, or resident is injured or involved in a situation with the potential for injury, an Incident Report is required.

Adverse Events

3. Clinical observations of only the resident are recorded in the resident's medical record.
4. Make NO mention of the "Incident Report" in the resident's medical record. The Incident Report is an administrative Risk Management document and not part of the resident's Medical Record.

Adverse Events

5. State ONLY the facts and NOT speculations. REMEMBER: NO assumptions!

Refusal of care/medication/food

1. Date & Time
2. Type of Refusal
3. Potential complications and adverse effects reviewed
4. Resident's cognitive status
5. Notification of family & physician, with time if necessary
6. Advance Directive status
7. Alternative treatment discussed
8. Chronic refusals identified in interdisciplinary care plan

Behavioral Issues

1. Date & Time
2. Appropriate disciplines' observations/ assessment (i.e., nursing, activities, dietary, social services)
3. Location, description and resident(s) involved, if incident
4. Actions taken
5. Persons notified, including physician and/or family members (if necessary) and their responses
6. State of resident
7. Subsequent follow-up entries

Prejudicial Labeling

- "Acting nutty."
- "Swearing like a sailor."
- "Cussing up a storm."
- "Crazy as a loon," "Crazy as he/she can be."
- "Just mean and hateful."

Likewise, negative statements about families should also be avoided.

Room Transfer

1. Date & Time
2. Old room number
3. New room number
4. Reason for move
5. Resident's reaction
6. Roommate's reaction
7. Follow-up entry
8. Physician order to transfer from certified to non-certified bed and reason
9. Notification of family member, with time

Elopement

- Many attorneys have used the medical record notation of a resident having "wandered" out of the building to make a case of unsafe practices and lack of supervision.
- Often, facilities use the words "wandered" and "elopement" interchangeably.
- Just because a resident walked out the door, even if he or she is identified with the potential to elope, this does not mean the resident is unsupervised or lost. That decision will depend on how the facility defines elopement and on the words that are used in the medical record.

Elopement

- A resident with dementia walks throughout the facility. If a caregiver goes to the resident's room, or a specific area in the facility to deliver care or service, but the resident is not there but is located in another area of the facility, is the resident wandering or exercising a choice of location?
- A resident who is identified as confused and wears an alert/alarm bracelet goes out the front door onto the porch and the alarm sounds, is that elopement? It often depends on your choice of words, or the parameters that the facility has set for elopement.

Elopement

The facility **should** define this term.

- Is elopement a matter of going out the door?
- Is it being out on the front porch? Parking lot? Yard?
- Does it consist of going out without signing out?

Elopement

- If parameters are set for elopement and if the "wandering" definition is followed more closely, the facility can document more effectively.
- All staff should KNOW the Centers for Medicare & Medicaid Services revised MDS/ RAI definition of wandering!

Elopement

For example:

- If a resident who is determined to be incompetent (incapable of making personal choice or decisions) leaves the grounds (grass/ yard/walkway as boundaries) without staff knowledge and an emergency search response is initiated, the event will be considered elopement.
- If a resident who regularly ambulates throughout the facility goes out the door with staff observation or after alerting staff, the event is not elopement.

Wandering – "Labeling"

Poor entries:

- 4/15/03; 12:00p.m.; Ms. Jones wandered out the front door, alarm sounded, brought back by CNA. J. Doe, RN
- 4/15/03; 1:00p.m.; Ms. Jones wandered to unit two, nurse returned her. J. Doe, RN

Improved entry:

- 4/15/03; 1:00p.m.; Ms Jones walked to porch, alarm alerted, staff joined Ms. Jones on porch. J. Doe, RN

Common Omissions in Documentation

- Failing to record pertinent health or drug information
- Failing to record nursing & other disciplines' actions
- Failing to record that have
- Recording on the chart

Common Omissions in Documentation

- Failing to document a discontinued medication
- Failing to record drug reactions or changes in resident's current condition
- Transcribing orders improperly or transcribing improper orders
- Writing illegible or incomplete records

Documentation Dilemmas and Problems

The Diagnosis Dilemma

- Often residents are admitted to an acute care facility with a preliminary diagnosis of dehydration.
- The problem begins when the hospital admitting diagnosis is transferred to the LTC facility and the facility does not question the diagnosis or recognize the potential for it to cause problems.
- Invalid diagnoses continue to appear month after month because the facility simply copied the hospital's diagnoses.
- Question it!

Documentation Dilemmas and Problems

No Initial Care Plan

- Although this is not a requirement, it is an important component for creating a defensible record.
- The plan directs the care. More importantly, it can provide protection for the facility by documenting efforts you have made to identify and meet the needs of the resident.

Documentation Dilemmas and Problems

Incomplete or Lack of Assessment Forms

- Assessment forms provide the clinician with a forced function system of reviews and problems identified in a simple check-off format.
- The problems lie with forms that are not completed, not signed or with forms that were to be used but were not. Many times, forms are initiated and an area calls for information not available to the professional/clinician.

Documentation Dilemmas and Problems

Care Plans That Do Not Capture the Problem

- Although regulations have mandated the development of care plans, they are not always relied upon as they should be when staff delivers care.
- If the care plan is only a paper process, you miss the opportunity to use it as it was intended.
- **The care plan should actually match the actions of direct care staff out on the floor.**

Documentation Dilemmas and Problems

Unrealistic Goals

- Goals should be measurable, all levels
- They should be something the resident can attain, taking into consideration the resident's multiple medical problems, personal choices and habits.

Documentation Dilemmas and Problems

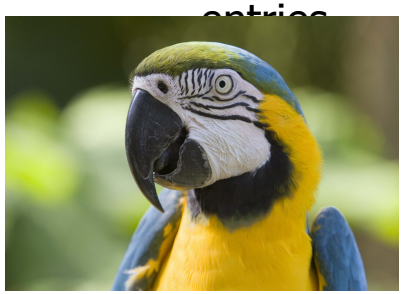
Overuse of Approaches/Interventions

- Should be simply stated, concise, and understood by all.
- Should also be supported in the individual discipline progress notes, if that discipline is involved with the intervention.
- Should be written specific assignments to someone.

Documentation Dilemmas and Problems

Repetition

- To avoid repetition, commonly referred to as "parrot charting" in litigation, use the care plan goals and approaches as the basis of your entries.



Documentation Dilemmas and Problems

Opposing Versions

- Often occurs when professionals make subjective entries about what occurred without reading the previous notes or assessing the entire situation.
- Be sure you have all the facts before you make an entry. Read back over several days. If unclear, ask questions.

Documentation Dilemmas and Problems

Value Judgments in Medical Records

- If the medical record contains a caregiver's professional opinion that another member of the health care team or the facility was negligent, that care-giver could be named as a co-defendant in a lawsuit and may have to stand by that opinion.

Teamwork

- Physician
- Nursing
- Dietary
- Social Services
- Activities
- CNAs
- Therapists

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