Health Information Practice and Documentation Guidelines

If it’s not documented, it didn’t happen!

Objectives

- Participants will be able to explain why documentation is important.
- Participants will be able to identify the basic information that is required when documenting in the clinical record.
- Participants will be able to describe particular issues that require documentation in the clinical record.
- Participants will be able to determine documentation “Do’s and Don’ts”.
F514: Records

- Facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized
- Interpretive Guidelines advise surveyors to "be more concerned with whether the staff has sufficient progress information to work with the resident and less with how often the information is gathered"
- "A complete clinical record contains an accurate and functional representation of the actual experience of the individual in the facility"
- Record should document change toward the resident’s ability to achieve care plan goals
- Documentation must demonstrate facility:
  - Knows the status of the resident
  - Has an adequate plan of care for the resident
  - Understands the resident’s progress, response to treatment or change in condition
  - Adjusts treatment based on the resident’s status and/or response to treatment

Electronic Medical Records Systems

- If electronic medical records are used, safeguards to prevent unauthorized access and reconstruction of information must be in place
- Written policy at facility describing the attestation policy(ies) in force at facility
- Computer has built-in safeguards to minimize possibility of fraud
- Each person responsible for an attestation has an individualized identifier
- Date and time is recorded from the computer’s internal clock at the time of each individual entry
- An entry is not to be changed after it has been recorded
- Computer program controls what sections/areas any individual can access or enter data, based on individual’s personal identifier, therefore level of professional qualifications
Documents Required in Clinical Record per F514

- Sufficient information to identify the resident
- Record of resident’s assessments
- Plan of care and services provided
- Results of any pre-admission screening conducted by State
- Progress notes
- Designation of attending physician
- Admitting information: medical history, physical exam & diagnosis
- Physician orders
  - All medication
  - Treatments
  - Diet
  - Restorative and special medical procedures required
- Nurses notes in chronological order and signed by the individual making the entry
- All symptoms and other indications of illness or injury including date, time and action taken on each shift
- Medication and treatment record including all medications, treatments and special procedures performed
- Copies of radiology, laboratory and other consultant reports
- Discharge summary
F514 Interpretive Guidelines

- “How is the clinical record used in managing the resident’s progress and maintaining or improving functional abilities in mental and psychosocial status?”
- “Is there enough record documentation for staff to conduct care programs and to revise the program, as necessary, to respond to the changing status of the resident as a result of interventions?”

Documentation Content

- Admission Record
  - Face sheet with demographic information, responsible party and contacts, financial & insurance information, contact information for outside professionals involved in resident’s care
  - SHOULD BE KEPT UP TO DATE AS CHANGES OCCUR
- Assessments
  - Completion of an assessment form OR documentation of an assessment using narrative description
  - “Assessments” collect data or identify a condition but should also include conclusions, recommendations & interventions
    - Evaluation: data relevant to issue
    - Conclusion: Interpretation & documentation of conclusion based on data
    - Plan: Recommendations and follow-up plans
Integrating Assessments with RAI Process: Interdisciplinary Assessment Process

- Required by regulation AND standard of practice
  - Preadmission Assessment: determine needs and assure facility has adequate resources & expertise to provide care
  - Admission Assessment: collect baseline information on resident & assist with initiating initial care plan until MDS, CAAs and care plan process complete
  - Fall Assessment: ID risks and develop INDIVIDUALIZED preventative plan
  - Skin Assessment: current skin status as baseline on admission, then weekly
  - Bowel & Bladder Assessment: prevent UTIs & restore function as possible
  - Physical or Pharmacologic Restraint Assessment: prior to initiation, then LEAST restrictive: bed mobility, ability to transfer between positions, bed transfers, chair transfers, standing
  - Self-Administration of Medication(s) Assessment: Interdisciplinary Team decision along with elder/family: ID med, indication, side effects, able to store in locked container & open & close container
  - Pain Assessment: Nature, intensity, frequency, duration, character, location, previous effective interventions, history, meds, elder’s goal, impact of pain, cultural impact, accompanying factors

Integrating Assessments with RAI Process: Interdisciplinary Assessment Process (cont)

- Nutrition Assessment: Address risk factors along with individual preferences and goals
- Activities/Recreation/Leisure Interest Assessment: Individual history, interests & preferences
- Social Service Assessment: ID of social service needs to address needs & link social supports, physical care & physical environment with needs & individuality and Advance Directives
- Mental & Psychosocial Function Assessment: Mental or psychosocial adjustment difficulty, decreased social interaction, increased withdrawal, anger, depressive behaviors, cognitive functionality, display of behaviors with or without pharmacologic interventions
- Restorative/Rehab Nursing Assessment: ROM, physical functioning, assistive devices
Care Plans

- Interim/Temporary: Based on conclusions for assessments, address primary reason for admission and treatments for needs including: clinical, psychosocial needs, behavioral needs, rehab/restorative needs & nutritional needs: MUST BE INDIVIDUALIZED & revised as needed until comprehensive care plan is completed
- Comprehensive Care Plan based on CAA analysis and summary
  - Timely
  - Integrate acute problems into care plan as they occur: must follow documentation guidelines & authenticate & date entry including new entry, changing or discontinuing an entry

Documentation “Best Practices”

- “Real-time charting”: Chart as close to the time the interventions occur & avoid falling into habit of charting at the end of the shift
- Key principles
  - Factual, concise & accurate: NOT include editorial comments, speculation or meaningless phrases
  - Written from first-hand knowledge except in emergency when 1 practitioner is designated as “recorder”
- “Double-documenting”: Reduce redundancy in record
  - Leads to omissions
  - Increases chance of discrepancies in documenting same information
  - If charting requires more than one place to record same information, consider revising p/p’s
- “Holes”: Take steps to ensure MAR/TAR documentation is completed prior to end of each shift
  - After staff leaves, difficult to justify complete recall of meds administered
Documentation “Best Practices” (cont)

- Medication orders
  - Name
  - Dose
  - Frequency
  - Route
  - Indication (diagnosis, signs/symptoms)
  - NN discussion of resident assessment or condition warranting new med order and documentation of discussion with physician &/or resident’s responsible party

- Notifications
  - Use caution with communication books & fax communications
    - Physician is not considered notified until physician receives fax or reads communication book

- Each page (both sides) labeled with resident’s name
- Every entry must be authenticated by author
  - Signature should include author’s first initial, full last name & title
  - For MAR/TAR initials, record should always include a mechanism to identify with author’s full signature
- For incidents that occur in facility, record should include:
  - Pertinent facts of what happened
  - Pertinent medical status of resident
  - Medical care rendered in response
  - Who notified and time of notifications
  - Investigation MUST include:
    - When was elder last seen by staff?
    - What was elder doing when last seen?
    - When was elder last toileted or used toilet?
    - What does elder say happened?
- Never leave “loose ends” in record
  - If NN must be continued, nurse should sign bottom of page & write “continued” then next page write “continued from previous page” with date & time of previous note & sign completion of the note
Narrative Charting & Summaries

- Admission/Readmission Note
  - Date & time
  - How transported & who accompanied
  - Reason for admission/readmission
  - Clinical condition
- Narrative Documentation
  - Accurate & functional representation of actual experience of resident in facility
  - Enough info to show facility knows status of resident, has plans of care & documents effects of care provided; resident’s response to treatment, all changes in condition and changes in treatment
- Monthly Summaries: not required
  - Based on care plan
  - If flowsheets used, should include a summary for narrative documentation to supplement check boxes but care plan should still be basis for summary

Consent, Acknowledgements, Notices

- Informed consent for use of restraint (pharmacologic or physical)
- Release of Records
- Bedhold policy
- Notice of Legal Rights
- Notice prior to transfer
- Notice prior to change in room or roommate
- Demand letter when considering discontinuation of Medicare services
- Notice of change in condition
Verbal Orders

- Should have policy on how to document verbal orders in record
  - Specific process and timeframe for documenting verbal orders
  - Identify which individuals in facility are authorized to accept verbal orders
  - Identify how quickly verbal orders must be countersigned

Rubber Stamp Signatures

- F386 allows physicians to use rubber stamp signatures in certain situations, Medicare reimbursement rules bar use of rubber stamp signatures
  - CMS MLN Matters Article (SE0829) stated, "physicians and other providers who bill Medicare Contractors may not use stamp signatures"
Correcting Errors in the Clinical Record

- Documentation mistakes are inevitable
- Single line drawn through erroneous documentation and correction noted
- Correction made only by person who made the original entry
- Correction should be initialed and dated
- NEVER, NEVER, NEVER use “white out” in the clinical record or destroy erroneous documentation
- Late entries
  - Document as soon as possible
  - Always document date & time entry is made to clinical record to provide additional information in conjunction with previous entry
  - Addendum should always include date & time that addendum was made & reason for addendum

Accessibility of Records

- Must appropriately store and maintain clinical records to ensure record is accessible to providers, resident’s authorized representatives & surveyors
- If facility has transitioned from paper-based records to EMR system, must provide surveyors access to EMR system and any printouts of records that are requested
Systematic Organization of Clinical Records

- Must be completed using forms, methods, and systems that are consistent with state & federal requirements & facility policies
- Should renew licensure requirements requiring written policies & procedures in place that specify what goes into clinical record & how record is completed
- Must have policies for record retention
  - Medicare required facility records retained for
    - Period of time required by State law or
    - 5 years from date of discharge when no State requirement or
    - For a minor, 3 years after resident reaches legal age under State law

Clinical Record Audits

- Internal consistency across all record entries
- Transcription errors
- Legibility
- Time entries
- Chronological entries
- Record unaltered and truthful
- Acceptable abbreviations and techniques
- Proper spelling/grammar
- Entries with consistent time documentation (military)
- Appropriate signatures
Direct Care Staff Documentation

- "Real time" documentation
  - Vital signs
  - Medication administration
  - ADLs
  - Skin observations
  - Urinary output
  - Meal & fluid intake
  - Bowel elimination patterns
  - Weights & height
  - Restorative exercises & treatments & response to treatments
  - 15-, 30-minute, 1-hour checks
  - Repositioning schedules
  - Assistive device use & application
  - STOP and WATCH!!!!!

Thanks Again

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