Course Objectives

• Explain why accurate documentation is so important from a legal standpoint

• Define the following – HIPAA, Confidentiality, Malpractice, & Unusual Occurrence Reports

• List the most common types of documenting mistakes and sources of inaccuracy

• Describe strategies to preserve resident confidentiality at all times

Course Objectives (continued)

• Explain how to address issues related to resident’s noncompliance, refusal of care & services and Unusual Occurrence Reports

• Define the facility’s frequency of charting and charting responsibilities for the following: skilled, non-skilled, post I&A, significant change in resident’s condition and new treatment

• Briefly describe and understand the importance of accurate, complete medical record during the survey process and for the nurse’s own protection against liability if the nurse is a defendant in a malpractice suit
Terms - Defined

- **Charting** is defined as the recording and documentation of a resident’s condition, treatment and response to treatment.

- **HIPAA** – The Health Insurance Portability and Accountability Act of 1996 and modified in 2001 & 2002 established standards and safeguards for documentation and transmission of health records to assure privacy and security of data.

- **Confidentiality** is the foundation of trust in the resident/caregiver relationship. As a healthcare professional, it is expected that any information you learn while providing care will remain confidential unless authorized by the resident, or ordered by law to reveal it.

Terms - Defined (continued)

- **Malpractice** – A dereliction from professional duty or a failure to exercise an accepted degree of professional skill or practice by a practitioner rendering professional services which results in injury, loss or damage. Negligence can result from a lack of knowledge or skill, or from failure to exercise reasonable judgment in the application of professional knowledge or skill.

  NOTE: Lack of failure is determined by comparing the action in question with what a similar practitioner would reasonably be expected to do in the same circumstances.

- **Unusual Occurrence Report** – Documentation of an incident that does not meet safety standards or the standard of care, or routine operations or established procedures.

  - **Sentinel Event** – an unexpected occurrence involving death or serious physical or psychological injury, or risk thereof
  - **Serious Reportable Event/Never Event** – an error in medical care that is clearly identifiable, preventable, and serious in its consequences for residents; include surgical events, product or device events, resident protection events, environmental events and criminal events.

Common Mistakes

- Illegible handwriting on written charts
- Generalizations
- Spelling errors
- Incorrect or unacceptable use of abbreviations
- Recording assumptions
- Omissions
- Misfiled and/or not filed timely resulting in delay in treatment(s)
- Poor quality photocopy / missing pages
Will your clinical record stand the “test of time”?

- Illegible handwriting – ambiguity or misinterpretation
- Generalizations – “vital signs normal”

Nurse’s Notes need to be specific:
- Temperature: 98.6
- Pulse: 80
- Respiration: 20
- Blood pressure: 120/80

- Spelling errors – Misspelled words reduce your credibility in the courtroom

Abbreviations should be used sparingly and then only those approved by the Joint Commission and your facility.

Assumptions – For example, if you find a resident lying on the floor, you can document: “Resident found lying on the floor,” but to record “Resident fell out of bed onto the floor” is an assumption that may not be accurate.

Omissions – A line of reasoning that the plaintiff’s attorney will use is that, “If it wasn’t recorded, it didn’t happen, or it didn’t happen in a timely manner.”

NOTE: Frequent omissions may be evident on MARs, TARs, ADLs, Food Consumption Records, Weights, Behavior/Side Effect Flow Records, Census checks with residents deemed elopement risk and documenting a resident’s response to medications; i.e., especially true of pain medications, psychoactive medications, date, time and resident’s name.

- Misfiled records may bring in additional plaintiffs in a filed suit and information not filed timely especially laboratory and diagnostic studies may result in delay in treatment.
Fundamentals

• "If you didn’t document it, you didn’t do it!"

• Poor documentation often implies poor nursing care to a jury

• American Nurses Association estimates that there are one million health care errors in the United States hospitals per year!

• ANA further states as of 2001, nurses and other allied health professionals are being named with increasing frequency as defendants in lawsuits

• "Do Not be a part of those statistics!"

Confidentiality

• Foundation for trust in the resident/caregiver relationship

• As a healthcare provider, it is expected that any information you learn while rendering of care will remain confidential unless authorized by the resident, or ordered by law to reveal

• Laws vary from state to state and institution

• Depending on State law, some institutions may even require that the physician be present when resident or responsible party views the medical record

Confidentiality (continued)

• Know your facility’s P&P for viewing the medical record both as an active resident and/or when discharged

• Locate and position screens so a person passing by is not given inadvertent access

• Never share computer access codes with unauthorized individuals

• Photographic documentation of a resident without the expressed written permission is a breach in confidentiality
Confidentiality (continued)

- Use of cell phones and broadcasting of information
- Use of blogs, and/or diaries regarding residents and other healthcare providers
- Use in research – resident maintains the right of control of access to the medical record
- HIPAA rules and regulations govern paper, oral and electronic communication

Confidentiality (continued)

- HIPAA provides both civil and criminal penalties for violations that can range up to fines of $250,000 and ten years in prison
- Even if a name is not given, as long as the particular patient is identifiable from the stored information, the HIPAA rules & regulations still apply

Noncompliance and/or Refusal of Care

- Need to take particular care with documentation of informed refusals and/or refusal of care and services
- Consequences must be clearly explained
- Informed refusal must be clearly documented and must include, but not necessarily limited to the following: who did the explaining, consequences and resident’s response to the explanation
**Noncompliance and/or Refusal of Care**

- Equally you must document carefully and CAREPLAN any form of noncompliance with the resident’s treatment plan; i.e., refusals for treatment/dressing change, medications, refusing to allow blood sugar monitoring etc. Again, explain the consequences and document the explanation completely, response of the resident, MD notification and notification of the resident’s responsible party and/or significant other.

**Unusual Occurrences / Incident & Accident Reporting**

**Do's and Don'ts**

**DO** document the following:
- Date & time of the occurrence
- Details of the incident to include only what you observed and/or what the resident stated happened
- Resident’s physical & mental assessment including vital signs, pain, neurological observations for falls with head injuries and unwitnessed falls
- Severity of the outcome
- Names of physicians, nurse managers, responsible party(ies) and witnesses
- Date and time you notified the above, information provided, instructions received, first aid rendered
- Follow-up and response to interventions
- Name and title

**DON'T**

- Do not include the actual report within the medical record unless mandated by State law
- Do not write that an error was made, or that an incident report was filed
- Avoid using words indicating errors such as mistake, accidentally, miscalculated, inadvertently or unintentionally
- Do not write the full name of any other resident involved in an incident indicate resident’s room number and initials only
Documentation – Fall Event within the medical record

- Date & time of the occurrence
- Details of the incident to include only what you observed and/or what the resident stated happened
- Resident’s physical & mental assessment including vital signs, active/passive ROM, pain, neurological observations for falls with head injuries and un-witnessed falls
- Severity of the outcome; i.e., transfer to ER/hospital
- Names of physicians, nurse managers, responsible party(ies)
- Date and time you notified the above information provided, instructions received, first aid rendered
- Follow-up on any laboratory and/or diagnostic studies
- Review of fall risk assessment to determine if a significant change has occurred and update accordingly.

NOTE: Residents with no prior history of falling who have now experienced 2 or more in a given month may not be an MDS “Significant Change”, but may have an underlying condition such as UTI, anemia, and/or recent medication changes/adjustment

- Name and title

Documentation – Pressure Ulcer/Other Skin Conditions Target Focus Areas

- PURA upon admission for the 1st four weeks, quarterly, and with a significant change
- Pressure relieving/reducing devices for both bed & chair
- Weekly skin checks to include lower leg extremity evaluation
- Wound assessments by RN with wound onset, degeneration and weekly thereafter includes both pressure and non-pressure; i.e., non-healing skin tears, VSU, arterial, diabetic, surgical, etc.

Documentation – Pressure Ulcer/Other Skin Conditions Target Focus Areas (continued)

- MD progress notes reflect review of wound/skin conditions present
- Wound Consultant’s data and in-house data accurately reflect current wound status week by week
- RD/DM address current wound status and interventions recommended
- Documentation of nutritional supplements, Vit C, Zinc
- Documentation of meal %’s and with food consumption < 75%, snacks/supplements offered
- Weights monitored as clinical condition denotes
- Careplan addresses resident’s potential for pressure ulcer/skin condition and updated accordingly with wound onset/degeneration/resolved
Physician’s order to include each wound listed singly, location, type of wound, cleansing product, treatment/dressing, and duration of treatment; i.e., “Cleanse pressure ulcer right trochanter with normal saline, apply hydrogel to wound bed and cover with 4x4’s and secure with tape. Change q day and prn for 14 days.”

Wound Assessment to include date of onset, location, stage, length, width, depth, presence of eschar/necrotic tissue/slough, undermining and tunneling including location and depth, drainage, wound edges, type of tissue present (i.e., granulation, epithelization, etc.), S&S of infection, peri-ulcer skin condition and presence or absence of pain and PRD currently in use

Notification of physician and responsible party with wound onset, degeneration/resolved

MDS accurately reflects current wound/skin status

Screening for nutritional risk

Assess interventions and counseling needs

IDCP teams plan for nutritional care

Current POs for diet/therapeutic diet/supplements if applicable

Consistent documentation of resident’s response to nutritional care

Documentation of resident’s food preferences including religious and cultural request

Residents with swallowing difficulties have been referred to speech-language pathologist or ST/OT as appropriate

Weights monitored as clinical condition denotes

Monitoring of meal intake

Monitoring of I&O as appropriate

Laboratory/diagnostic evaluation (nutritional status)

Snack supplements documented with resident refusal or food consumption < 75%

Evidence of an evaluation of the resident’s physical, mental and psychosocial needs to identify risk factors to prevent unplanned weight loss and once identified, the nutritional interventions determined upon the resident’s admission and change in nutritional status occurred, were implemented timely

MO/RP notified of significant weight variance

Careplan reflects clinical conditions and risk factors identified specific to nutritional status as outlined in the assessment tool and interventions determined documented on the plan of care and implemented timely

MDS accurately reflects resident’s current nutritional status
Documentation – Overall Plan of Care

• The resident’s careplan reflects the clinical condition and risk factors specific to the resident’s needs, goals and recognized standards of practice
• Be developed by an interdisciplinary team that includes a registered nurse with responsibility for the resident, and other appropriate staff in disciplines determined by the resident’s needs
• Measurable objectives and timetables to meet the resident’s medical, nursing, mental and psychosocial needs
• Available to appropriate personnel providing care for the resident
• Initial careplan completed at the time of admission and individualized careplan within twenty-one days after admission
• Careplan reflects changes and/or revisions to resident needs, goals and recognized standard of practice
• The resident’s MDS is an accurate assessment by staff that are qualified to assess relevant care areas of the resident’s status, needs, strengths, and areas of decline

Federal Regulation – F842 Clinical Record Defined

§483.70(l)(1)(5) Clinical Records

1. The facility must maintain clinical records of each resident in accordance with accepted professional standards and practices that are:
   ✓ Complete
   ✓ Accurately documented
   ✓ Readily accessible and
   ✓ Systematically organized
§483.70(i)(1)(5) Clinical Records must contain:

✓ Sufficient information to identify the resident
✓ A record of the resident’s assessments
✓ The plan of care and services
✓ The results of any preadmission screening conducted by the State
✓ Progress notes

Federal Regulation – F842 Clinical Record Defined

F842 §483.70(i)(1)(5) Clinical records must be retained for:

✓ The period of time required by State law; or
✓ Five years from the date of discharge when there is no requirement in State law; or
✓ For a minor, three years after a resident reaches legal age under State law

Federal Regulation – F842 Clinical Record Defined

F842 §483.70(1)(4)(i)-(iii) Resident -identifiable information

✓ A facility may not release information that is resident-identifiable to the public
✓ The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so
Administrative Functions & Considerations

- Reimbursement by third-party payers
- Quality improvement and performance with target focus audits for “flagged indicators” utilizing CASPER reports
- Ongoing target focus review by nurse manager focusing on “HRE” (High Risk Exposure) areas such as Unusual Occurrence reports, I&As, new pressure ulcers and/or degenerating wounds, significant weight variance, elopement event, review for their accuracy, completeness and compliance with facility P&Ps
- Communication tools between shifts effectively utilized
- As well as communication both to and from outside provider services complete, accurate and timely; i.e., dialysis, physician visits, etc.
- Annual review of P&Ps and documentation tools

Think About It……..

Will your **clinical records** stand the “**test of time**”?

--- Thank You ---