Long-Term Care Survey Alert

Document Management: Ditch These Potential Pitfalls to Electronic Records and MDSs

If you don't have policies for these 2 critical practices, now's the time to write them.

Electronic records can speed up your care and documentation. But they can also put you on the fast track for F tags and even fraud allegations if you don't address key vulnerabilities associated with this technology in nursing homes.

Case in point: Attorney **Paula Sanders** has seen surveyors watch a supervisor correct something in the electronic record. Then the surveyors claim the supervisor made a false entry in the patient's medical record because she didn't actually provide the documented care. "The supervisor may have been sitting next to the person providing care but that caregiver didn't have the HIPAA security clearance to modify the record," says Sanders, with Post & Schell in Harrisburg, Pa.

Proactive strategy: Make sure your facility has a policy and procedure "delineating" how staff should correct electronic records, Sanders stresses. The policy should identify "who has the authority to make the changes and under what circumstances." Implementing and following such policies can help the facility defend against potential allegations or citations claiming staff made false entriesin the EMR, she adds.

Example: If a facility maintains ADL flow sheets, those should be part of the paper or electronic record, advises **Pam Campbell, RN, C,** with LTC Solutions in Camdenton, Mo. The facility should have a policy addressing how those are changed -- and who can change them, she adds.

Campbell says that if she were making a change in the electronic record as a supervisor, she'd make sure to follow the correct facility policy and industry standard for doing so. And she'd document the circumstances surrounding the need to make the modification.

Important: "Anytime you make a change to the electronic health record (or any clinical record), there should be a quality assurance component," Campbell advises. "You look at why the change was needed or an error made, and how to prevent a similar problem."

2 More Must-Dos for Electronic Records

1. Beware shortcuts. Facilities that have EMRs should beware cutting and pasting documentation, Sanders cautions. Doing so for demographic information is OK, if it's still accurate. "But you don't want to have rote repetition where every note looks the same and there's no indication that you provided care differently than you did before."In other words, "it's the cookie cutter repetition that could be a red flag" for surveyors and other auditors, Sanders cautions.

Another trap: Sanders has been seeing facilities cited when surveyors watch nurses give med pass and then check the CareTracker or similar electronic record and find that the nurse documented medication administration before actually giving the meds. Due to the electronic time stamp in electronic records, you have an easier time discovering that practice than you do in a paper MAR, she points out.

2. Follow the rules for maintaining MDSs

electronically. Facilities have to maintain 15 months' worth of MDSs, noted CMS' **Christina Stillwell**-**Deaner** during a Nov. 9 agency-sponsored webinar on the MDS 3.0 and RUG-IV. And even if your facility hasn't gone entirely electronic with its records, you can still maintain MDSs in an electronic format, she said.

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The catch: If the facility doesn't have electronic signatures, you have to print out and sign all of the signature pages for an MDS assessment, Stillwell-Deaner reminded listeners. You can maintain the rest of the assessment data electronically, but it has to be "readily accessible and available for surveyors" and anyone caring for the resident. "Facilities should have policies in place for how that's handled."

Specifically: The MDS 3.0 RAI User's Manual notes that when facilities maintain the MDS electronically without using electronic signatures, they "must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record."

The RAI manual allows you to use electronic signatures for the MDS, if state and local law permit their use, says **Joan Brundick, RN, BSN,** state RAI coordinator for Missouri. If you aren't sure, check with your state RAI coordinator, she advises.

In addition, the nursing home's policies must authorize electronic signatures, Brundick counsels. The facility must also have a written policy and security measures designed to protect the electronic signature from being used by anyone except its owner, she adds.

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