Long-Term Care Survey Alert

Medical Record Documentation: 8 Things You Never Want To Chart

Read this before you next put pen to paper or fingers to keyboard.

They say the devil is in the details, but as far as F tags are concerned, it's more often in the medical record documentation.

So avoid these eight common documentation gaffes that can get your facility in hot water in the survey, compliance and malpractice arenas.

1. Documenting a scenario that creates the impression that the facility allowed a potentially dangerous situation to occur without intervention. Here's a real-life example: "Son assisting mother down the hall who has unsteady gait." The staff person doing the charting thought she was documenting information about the resident's unsteady gait and the fact that her son had visited and helped his mother. But the notation left out the fact that the nurse recognized a fall waiting to happen and went to assist, and that the nursing staff instructed the resident's family not to ambulate the resident without assistance.

Since none of that information appeared in the chart, the note simply created liability for the facility, especially if that resident later fell while walking with a family member.

2. "Fudging" flow sheets or other care records. Examples include "filling in holes" on treatment administration records to document care that was not provided -- or documenting care when the resident was actually in the hospital or on leave on that date, cautions **Howard Sollins**, attorney with **Ober/Kaler** in Baltimore.

Sometimes such entries represent honest mistakes (someone charts in the wrong record). Or staff may be waiting to document too long after they do an assessment or administer a treatment, so their recollections are off the mark, notes **Beth Klitch**, principal of **Survey Solutions** in Columbus, OH.

The cure: Implement policies/procedures to encourage and facilitate contemporaneous charting.

Another essential step: Routinely check to see how well direct-care staff are performing vital assessments and care recorded on flow sheets.

Real life example: In one facility, the skin care assessment flow sheet showed CNAs had been checking a resident's skin for breakdown with no problems noted in the nursing notes. The family called the DON to ask if the resident had a wound on his foot because they noticed his sock foot was bloody when they did his laundry. The DON discovered a large, necrotic, draining pressure ulcer on the resident's heel.

'Big Brother' is watching: One consultant reports working with a number of facilities lately where staff have been charged criminally with neglect (and led away in handcuffs from the facility) after government agents compared the facility's internal video camera footage with documentation of care (flow sheets, etc.).

Compliance tip: If the therapist doesn't complete all of a therapy treatment protocol during a session (because the resident was tired or became ill, etc.), he should document that's the case, advises **Garry Woessner**, principal of **Woessner Healthcare Consulting Group** in Edina, MN.

3. Jumping to conclusions in writing about the cause of what's observed. Staff should chart just what they see, hear, etc., without speculating about the cause. And in that regard, "a fall is not a fall unless it's witnessed," emphasizes

Gene Larrabee, a consultant with **Primus Care Inc.** in Valpariso, IN. You would, however, document your assessment of a resident found lying on the floor, including any follow-up to detect potential fall-related injuries, Larrabee advises.

4. Injecting negative opinions about residents. Peggy Voitik, RN, LNHA, recently saw an entry where someone charted "the resident is as mean as a snake." "Such charting is viewed as violating resident's rights," cautions Voitik, who is principal of **VP Circle of Quality Inc.** in Minonk, IL. "Sometimes you do have to chart things that put the resident in a negative light, but do so factually -- for example, quote what the resident actually said or did."

5. Charting that doesn't convey exactly what you tell physicians when you call them about changes in patients' conditions. Voitik recalls how one facility got sued when a resident lost his vision because an eye infection didn't respond to treatment. "Even though the nurses had called the doctor several times about the resident's eye infection, they never described in the notes how the eye looked and what exactly they had told the physician." Then the doctor testified that if he'd known how bad the eye looked, he would have come to see the resident. **Lesson learned:** Document in the nursing notes exactly what you told the doctor and why you called him. Ditto for discussions with families about a resident's change of condition or problem.

6. Notations that point blame at another health care discipline or provider. You see this more often than you might think -- and it's fodder for F tags and civil liability. "For example, a dietitian's note shouldn't complain that the chart contains no resident weights or labs for her to review," cautions **Kathy Locke, MSN, RN, LNC**, with **Locke LTC Consulting Ltd**. in Columbus, OH. **Solution:** Teach staff -- including physicians -- about the liability involved in that kind of charting. Encourage staff to resolve their differences with each other at staff meetings.

7. Including statements that could be construed as fraud and abuse. Real life example: A nurse wrote: "Public assistance won't pay for this medication so we have called the doctor to get another medication." Sounds innocent enough, but the note was written in a state that required facilities to pay for non-formulary drugs required by Medicaid residents, notes **Marilyn Mines, RN**, a consultant with **FR&R Healthcare Consulting** in Deerfield, IL. "And the nurse's notation may sound like staff are trying to get around the regulation, even when that's not really the case," Mines cautions.

8. Charting entries that cause surveyors to question staff's common sense. For example, one charting entry for a resident on tube feedings read: "Give resident lollipops orally." Another real-life example: "Resident's right leg caught in bed rail. Removed it. Patient no longer in pain."

While humorous, too many such notations may not be too funny to a surveyor or jury second-guessing why a resident suffered a very bad outcome.