

# Long-Term Care Survey Alert

## Quality Assurance: Audit Charts For These 4 Survey Hot Spots

Ask these key questions before surveyors beat you to the draw.

Use this checklist of questions to detect the kind of documentation that's an F tag waiting to be written:

### 1. Is the documentation objective and does it report situations accurately, completely and concisely?

Without getting picky, do you have additional basic questions about "the rest of the story" when you read a medical record note?

**Example:** A nursing note states the resident is complaining of right shoulder pain with no further explanation. "This leads the person reviewing the documentation to believe that the documentation is incomplete," says **Kathy Locke, MSN, RN, LNC**, with **Locke LTC Consulting Ltd.** in Columbus, OH. "For example, were the doctor and family notified? What were the results of the nursing assessment? Did the resident suffer an injury?"

**2. Do entries provide rationale or justification for a problem being unavoidable, if that's the case?** "The documentation should contain justification as to why a pressure ulcer was unavoidable" at the time it was discovered, says **Gene Larrabee**, a consultant in Valpariso, IN. Then you'll have something to point to if surveyors start reading you the riot act about the pressure ulcer. "The documentation should also include measures staff tried to prevent the condition," says Larrabee.

**3. Are there any signs that residents' records appear to have been altered without following facility policies and procedures? Real-life scenario:** A resident receiving offsite dialysis suffers a cardiac arrest and dies in the nursing facility. There's a clear trail of lab results showing the resident had potassium levels inching toward the danger zone. The vital sign flow chart also shows significant deviations from the resident's baseline consistent with hyperkalemia. The nursing notes include an entry indicating that the staff called the physician about the problem, but the physician's answering service denies receiving the call. And the notation is written in slightly lighter blue ink and squeezed in between the lines.

**Documentation heads up:** When making a late entry into the medical record, date the entry when it's written and indicate that it's a late entry, advises **Jill Burrington-Brown, MS, RHIA**, professional practice manager with the **American Health Information Management Association**. "Of course, if the patient has had a bad outcome, a late entry will look suspect," she counsels. In such a case, it's a good idea to meet with the patient's family and other staff and start a file of their recollections about the care, she advises. "But keep that information separate from the medical record."

**4. Are there significant discrepancies about the resident's condition or care?** "For example, if nursing care plans call for a restorative program, and the activities or social work staff documents that the resident is too cognitively impaired to participate, the surveyors can cite the facility for failure to do an appropriate assessment," warns **Peggy Voitik, RN, NHA**, a consultant in Minonk, IL.