Long-Term Care Survey Alert

Quality Assurance: These Dos and Don'ts Can Prevent Documentation From Becoming Your Facility's Undoing

The basis for F tags or worse are often found in the medical record.

Documentation should back you up during the survey or an investigation -- not back you into a corner. And anything from omitting basic information from the record to venting to panic-driven changes can be a roadmap to problems.

Put the risks to rest: The following documentation guidelines help you steer clear of the major pitfalls known to come back and haunt staff and facilities.

Start With These 3 Do Not Dos

• **Don't present a skewed picture of the resident.** "The record should tell a story - the good, bad and the ugly," says attorney **Donna Senft**, with Ober/Kaler in Baltimore. Yes, you want to include the important events, she adds, "but documentation should also describe what's going well based on the treatment plan."

The threat: Suppose a resident progresses well for a couple of weeks but then suddenly declines. If the facility has no "proof" through its documentation that the sudden change came out of the blue, watch out.

Instead: "When nurses do daily charting, they can focus on different aspects of the patient's response throughout the week," says Senft. And over the week, "you paint a picture of a person who is doing well in various areas," she adds.

Tip: Make sure to document how stable a patient is on Coumadin and his baseline INR if he's been on the medication a long time, advises attorney **Christopher Puri** in Nashville, Tenn. He handled a case where a patient had been stable for many years on Coumadin and had been getting quarterly INR testing before admission to the nursing facility. The facility got hit with IJ and a hefty CMP, however, because the resident had one high INR reading in the facility although he was asymptomatic for bleeding problems. "Surveyors combined that lab value with the allegation that an [INR] test was done late ..."

• **Don't overstep practice and charting bounds.** A bedside nurse should document objectively and not include opinions or diagnoses, advises **Mardy Chizek**, a long-term care nurse legal consultant and principal of Chizek Consulting in Westmont, Ill. For example, Chizek has seen nurses chart that a wound with drainage "smells like Pseudomonas." That might be OK for an infectious disease doctor to document, she says, but not a bedside nurse.

Check your state practice act: "In some states, LPNs cannot assess," advises **Robin Bleier, RN, LHRM-FACDONA**, principal of RB Health Partners Inc. in Tarpon Springs, Fla. Yet, an LPN in Florida and most states where Bleier has reviewed practice acts can gather data, make observations and report and record those observations. By contrast, an assessment involves using the data to draw a conclusion, says Bleier.

• **Don't use the chart to complain about staff or care.** You don't want to see comments, such as, "This is the third time I've been up here and there are still no weights on this resident," Chizek advises. Instead, encourage staff, including attending physicians, to use QA processes and incident reports to address complaints, she suggests.

What can help: Develop processes for staff to confront each other or report issues to management. Atlanta consultant **Darlene Greenhill** believes staff should address a safety issue immediately, even with a peer. The facility should also have a policy about what a staff person should report to managers ��" and give examples, she adds.

Follow These 4 Must-Dos

• **Always document resident and family education and care planning.** Chizek encourages having the family sign in to a care plan meeting. "Or if the staff has a meeting with the family by phone or sends written correspondence, always document that," she adds.

If caring for high-risk residents, send the family a copy of the resident's care plan with return-receipt requested -- if the resident agrees and/or the family person has authority to receive the care plan, suggests Chizek. She is handling a case now, for example, where a resident's husband claims that even though he was in the nursing facility eight hours a day with his wife who was on hospice, no one talked to him about the plan of care. In Chizek's view, that claim is "hard to believe." But without documentation to prove otherwise, the facility's in a tough spot.

• **Create a documentation trail when a resident declines recommended care.** If you don't, you'll be empty handed when regulators blame the facility for a huge pressure ulcer or choking death caused by a resident's noncompliance with the care plan. For example, a patient with a swallowing disorder may refuse dietary recommendations or compensatory mechanisms, observes **Joanne Wisely**, a speech language pathologist and director of clinical services for Genesis Rehabilitation Services in Kennett Square, Pa. At that point, the professional educates the patient or his responsible party about the consequences of his decision, Wisely says. And document that you keep trying and offer alternatives to the recommended care.

• **Follow the professional standard for making a late entry.** The golden rule is that you never change the original transcription in a medical record. "You can make an entry after the fact to clarify a previous entry," says Chicago attorney **John Durso.** "But don't write that the previous entry was wrong, which would undercut the credibility of all the documentation."

Example: A CNA documented something as fact about an incident when she really heard the information third hand from someone who wasn't present when it occurred. The person making the late entry might write that upon further investigation, the facility has determined that the CNA reported something she'd heard from a person who wasn't on the unit or shift where the incident occurred, Durso advises. And "the person in charge on the unit during the time the incident occurred reported the following facts ..."

• Always stress honesty as the best policy. "Documentation falsification of any kind can lead to major repercussions," cautions attorney **Paula Sanders**, partner with Post & Schell in Harrisburg, Pa. How do people tend to get in trouble in that way? "They panic and try to cover up their error rather than being straightforward and reporting it," she says. Or sometimes they rewrite or falsify progress notes in an "honest but poorly conceived attempt to 'correct' the record without following standard medical record documentation procedures."

One way to view it: More and more families nationwide are placing hidden cameras in residents' rooms, and New York is reportedly putting more "granny cams" in residents rooms, cautions Sanders. So "at the end of the day, the best approach is to provide care and document it as if there's a camera on you at all times."