Long-Term Care Survey Alert

Risk Management: Stay On The Right Side Of Documentation

4 ways to ensure your nursing notes make the grade.

A few nursing documentation strategies can spell the difference between F tags and a clean survey slate.

1. Tailor your documentation method to residents' acuity levels and needs, suggests **Mardi Chizek, RN, BSN, FNP, MBA, AAS**, of **Chizek Consulting Inc**. in Westmont, IL. "The standard for documentation is different for residents with long-term stays who are relatively stable," says Chizek. In her view, charting by exception -- in which you only document where there is an issue or exception to normal findings -- should be the standard for that population. So, for example, instead of writing over and over that a resident slept well, you'd only document your assessment and intervention when the person had insomnia.

"The exceptions most frequently occur where there is a change of condition or an exacerbation of an existing condition," says Chizek.

Must-do: Charting by exception will work best if staff has received training on how to use the method, says Chizek. And the facility needs a policy for the documentation approach. Otherwise, you'll see inconsistencies among documenters and with the facility's own policy and procedure, she cautions.

Not for Part A: For Medicare Part A residents, charting by exception is not the standard, says Chizek. Those residents have an acute condition, she notes. And for residents receiving skilled care, you have to document assessment and interventions "specific to the admission criteria, which demonstrate the existing level of skilled care for [continuing] stay purposes."

2. Consider implementing documentation protocols for high-risk issues, such as pressure ulcers, falls and infections, suggests Chizek.

"You can use a check sheet that includes the data elements that the licensed nurse should assess and document," she says. For a wound, you'd want to document staging, peri-wound tissue, wound measurements, exudate, color, pain, odor, etc., advises Chizek.

Key point: Chizek says her advice about charting by exception and flow sheets applies to licensed nursing staff only. "CNAs or nursing assistant flow sheets for documentation have an entirely different set of issues ... ," she says.

3. If you use a problem list, document each of the active problems. Chizek sees instances where the clinical record has documentation on one problem "over and over." But you don't see anything documented on the other ones, she notes. "If they aren't a problem any longer,document how they are resolved and take them off the problem list."

4. Develop a way to monitor the quality of documentation in real time. One shortcoming Chizek sees in nursing homes "is that no one really does quality monitoring of documentation." Yet the facility needs "a check and balance where someone reviews the documentation" preferably each shift to address shortfalls by adding extra assessment, etc.

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