MDS Alert

MDS Best Practices: Keep Your Charts Accurate And Your Records Straight

What you can do to minimize copycat charting

The best way to provide the highest quality of care (and to code the MDS effectively) is to pay attention. Getting to know residents their names, their preferences, where they came from, who comes to visit and when, and generally treating them as individuals is crucial to the highest quality care and the patient-centered culture change sweeping the country. It's also very important for accurate documentation for both the clinical record and eventual coding for reimbursement.

Caution: With so many "moving parts" in the documentation of residents' care, accuracy is easily lost, especially when CNAs and others directly involved in care do not write their own notes during each shift but instead copy the previous shift's notes. This repetitious documentation does not reflect the nursing staff's daily quality of care, nor does it help you or a team member fill out the MDS.

Beware: Copycat or otherwise inaccurate charting could come back to haunt you in a big way.

In our current legal environment, individual nurses are being named in lawsuits, and their notes on a resident's clinical record are held to judicial standards, though the event in question could have happened three years ago. "Is that nurse who charted 'Called physician' and nothing more going to be able to state under oath exactly what he/she said, let alone what the physician responded? Probably not," **Jane Belt, Ms, Rn, RaC-Mt, QCP**, curriculum development specialist for the **american association of nurse assessment Coordination** (**AANAC**), says.

"I am not a huge proponent of scare tactics," Belt says. "But this is reality if a jury was reading your documentation what would be the verdict? In our current regulatory and legal environment, there is zero tolerance for inadequate, incomplete or the lack of documentation."

Remember Charting Basics

Charting is elementary and one of the things you learn in school and use all of the time. But it's also foundational: Ideally, a resident's record reflects every change, every diagnosis, and every treatment, meaning that every current and future decision is based on the availability of information in a resident's chart. Remind indifferent team members that their voice and participation in care matter; they may not be making decisions about the direction of a resident's care, but their work and recordkeeping are the basis upon which MDs, RNs, therapists, and even the resident and family members will plan the future.

"Documentation is the only written evidence of any interactions that occurred between the health professionals, families, and residents. In addition, documentation serves as evidence of the administration of any test or procedures, resident and/or family education and the effectiveness. Because of these immense responsibilities tied to documentation, it needs to contain the nursing process and the utilization of critical thinking," Belt says.

Teach Documentation Skills

Remember: Training matters at every step. Think about how much you've learned on the job. A new team member probably doesn't know your system or requirements, and if they do, they learned the knowledge wasn't intuitive. This is a great opportunity to build good charting habits or to change less desirable recordkeeping tendencies.

When you encounter or hear complaints about poor documentation, think about the concern as an opportunity to train.

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"What have you taught them about documentation requirements for long-term care? Just because a nurse walks through your doors does not mean he or she innately knows the requirements. Each setting along the healthcare continuum is different, so a new nurse or a nurse changing career paths needs help and guidance," Belt says.

Take a Team Approach

Make waves: How can you change your facility's charting culture? A good first step is thinking about providing and documenting care as an interdisciplinary, whole-team activity. CNAs, physical therapists, occupational therapists, speech therapists, and registered nurses all interact with the resident to provide care, and team members should document accordingly. Descriptions of care can and should be specific and different, but they shouldn't conflict.

Keep in mind: Imagine a surveyor or auditor reading a resident's chart. Are the notes legible? Are all parts completed? How accurate of a picture do the notes paint, especially for someone who has no context or knowledge about a particular resident?

If your facility uses electronic methods to chart, there are further options to promote best charting practices. Make sure, too, that you're using all features provided. "It is very easy to go through the screens and just click away; when there is space for comments, are you looking to see if there are comments? Check boxes really do not relate much about the resident; provide guidelines what to include in narrative notes what is expected needs to be spelled out," Belt says.

Don't forget to use features like automatic recording of the time that notes are entered to your advantage in evaluating your facility's charting protocols. With this feature, you have the data on hand to determine when and who adds notes.

"Timing is vital to the reliability of the notes since the computer documents the actual time that any data was entered into the system," Belt adds.

Caution: "Electronic medical records also can lead to cloned (copycat) charting, and the Medicare and Medicaid reviewers are well aware of it," Belt says. "Does your system allow the user to copy and paste? Is there a way to disable that feature?"

Put Yourselves and Your Methods to the Test

How can you improve documentation across the team? "Audit, audit, and then audit more" Belt suggests.

Look for excellent and not-so-good examples of charting, and use them to train staff as they try to figure out what to chart, Belt says. That way, any issue with charting becomes a learning opportunity you can take advantage of, she says.

Tailor your training: Learners do not all learn the same way, Belt points out. For example, some team members need to see good and bad examples in order to figure out how they could improve. "Listening to someone talk about charting can be somewhat dull. Getting the learners involved in the process will help them learn," she says.

Best practice: Ask team members to look for low-level changes and document them as they occur so the clinical record portrays a resident's status accurately. Obviously, neither your notes nor your team members' notes should be the same from morning shift to night shift or for days at a time, but up-to-date documentation is especially important for any change in function.

Here are some examples that illustrate the significance of all team members participating in a resident's clinical record and the importance of each team member's individual, timely contributions.

Example: A speech therapist sees Mrs. Thompson for a session and notices that she's having a little trouble swallowing. She exhibited no difficulty swallowing at last week's session, but the intensity of her difficulty inspires the therapist to check her chart to see how long it's been happening. The therapist wonders whether she's receiving assistance at mealtimes because the way she's swallowing puts her at risk for aspiration. Mrs. Thompson doesn't remember, and her chart doesn't say anything about how long Mrs. Thompson has been having difficulty, meaning Mrs. Thompson has been risking aspiration (and therefore pneumonia) for days by continuing to eat unassisted or unobserved.

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Example: Accurate, comprehensive notes provide necessary context for the clinical record. A CNA might write that Mr. Jackson, a stroke victim, needs assistance across all ADLs, especially with dressing and mobility. A therapist might note that Mr. Jackson struggles with bed transfer, dressing, and ambulation, though he only occasionally needs assistance eating, and is receiving therapy to strengthen his weak side and extend his range of motion. Besides featuring more detail, the therapist's notes more accurately reflect Mr. Jackson's partial paralysis, and comprehensive documentation is crucial for full reimbursement.

And remember, all of this documentation has a direct impact on filling out the MDS. "If the nursing note indicates that the nurse took action that's great, but what was the response of the resident to those actions? Nurses must use their assessment skills the documentation proves that the assessment was completed and that there was follow-up. As the saying goes, 'if it is not documented, it did not happen,'" Belt says.

Think about how hard you and your colleagues work to provide individualized care for your residents. Unless your CNA's hawk-like observation skills are documented if she sees the subtle changes in a resident's range of movement, but doesn't write down those observations neither she nor your colleagues will get the credit they deserve for their comprehensive care. Documentation is both the foundation and the cornerstone to individualized, high-quality care and duly deserved reimbursement.

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