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MDS Alert

Survey Focus: Defensive Documentation: Improve Care -- And Survey Outcomes -- With Stellar Medical Records

Keep these 3 sources of information front and center.

If your facility has had one citation too many in recent surveys, consider that the culprit might be right in plain sight: your facility's medical records.

A majority of citations link back to problematic documentation, affirms **Karen Merk, R.**N.**, B.**S.**,** Clinical Risk Manager for **GuideOne Risk Resources for Health Care**, in Des Moines, Iowa.

Costly case in point: A nursing facility in Louisiana was slapped with immediate jeopardy citations under F309 and F490--with a per instance CMP of $10,000--for a shortcoming related to proper testing after a resident was prescribed Coumadin. The nursing facility argued that the resident refused to allow the recommended follow-up blood tests. The problem with that defense? The medical record showed no sign of the resident's refusal, reports **Jeannie** A**dams**, an attorney with **Hancock, Daniel, Johnson &** N**agle, P.C.**, in Glen Allen, Virginia.

To keep such omissions and missteps from leaving you open to survey citations and other types of liability, consider these best practices:

Get it Right From the Start-- in Writing

To fare well at survey time, set a goal of great documentation from Day One, starting with admission. When a new resident arrives, keep three sources of information in mind, coaches Merk: Your new resident, the party responsible for the resident (e.g., adult child or other family member), and any transfer records.

Great documentation at the admission stage is vital -- and these three sources will help you create a record that gives an accurate snapshot of the resident upon admission.

Agood starting point: Be sure to ask both resident and the resident's responsible party this essential question: What are your expectations of the facility? "If the answer is 24 hour a day nursing care, you know you'll need to ask some follow-up questions," advises Merk.

Asking questions related to a new resident's principal diagnosis can be particularly helpful in ensuring an accurate--and defensively fortified--medical record. In the case of a Parkinson's disease diagnosis, for example, ask if the resident ever held onto furniture at home to help herself get around; did she ever fall to her knees when walking; what was her routine like at home; was she incontinent?

Such a detailed assessment will let you to paint an accurate picture of the resident upon admission, a portrait that could be instrumental in battling unwarranted citations later on.

Bonus: The intake conversation can also set the stage for improved communication with the family throughout the resident's stay. You can even note the loved one's preferred method of contact in the event a concern comes up regarding care.

Questions are also key to ensuring you secure all of the information you need from a resident's transfer records.

Be forewarned: Even in the age of electronic medical records, you won't automatically be handed all of the information you may need--and the ability to ferret out missing information could be critical to staving off a survey citation in the not

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too distant future.

Example: One astute intake coordinator noticed that an incoming resident's medical record mentioned a medication commonly used to treat C. difficile. The record, however, failed to mention that diagnosis. By digging a little deeper, the intake coordinator was able to establish the diagnosis, ensuring accuracy in the nursing facility's medical record and her ability to protect the new residents and others at the facility.

Facilities can go on the offense with behavior problems by asking hospitals to provide initial medical records, which should accurately note any behavior problems evident upon the person's admission to the hospital. Later hospital records may mask these problems, particularly in cases when a patient has been sedated during the hospital stay.

Care plan example: Regardless of principle diagnosis, always go for a detailed account. "Resident admitted with Stage 1 wound, 2 cm x 2 cm on left heel. May progress to stage II, II, IV due to underlying tissue ischemia" would let surveyors know that you had taken seriously the assessment of existing wounds and would provide a detailed account of wound size and type.

Always Chart for Clarity

Charts laden with vague descriptions such as "respirations labored" and "some edema" leave you wide open for citations, cautions Merck. Consider these substitutions:

- Instead of "poor color" use appropriate descriptors, such as "color gray and cyanotic."
- Instead of "some edema," use such specifics as "has 2+ pitting edema from below knees to ankles, faint pedal pulse, cyanotic."
- Instead of "respirations labored," note what you have measured and observed, for example: "respiration's 32, shallow and irregular."

Think Like a Surveyor

Defensive documentation means always charting with objective accuracy and clarity. Take this example of poor documentation, which could be perceived as an admission of poor care, leading directly to a citation related to falls: "CNA dropped the resident while transferring her to bed."

Better approach: An accurate and improved note would be along these lines: "Resident fell during transfer to bed with staff assist x1."

Terms to avoid include the following:

Don't use "informed." Instead, note specific methods you have used to "educate" the resident and his family.

Don't use "will monitor / observe follow-up." The pitfall here: You are leaving the follow-up to someone else. Instead, note what the specific steps you have taken, on your shift. For example, in the case of a new pain medication, ask the resident to rate her pain at several intervals, and note those specific findings.

See "change in condition" as a medical record red flag. Avoid using the term, and, if you see it, be sure specifics are noted and appropriate notifications to family and physician have been made.

How to Lose Your Case

Conflicting documentation upon admission leaves you wide open for survey citations or other liability. Address such concerns immediately, urges Merk.

A careful inspection of transfer records, for example, might show conflicting assessments of a patient's weight upon admission. For optimum care, be sure your record reflects one accurate assessment"reinforced by your own clear entry.

Best practice: Be sure residents' weights are entered as a matter of routine in only one section of the medical record.

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Varying, and possible inaccurate, entries in various sections (e.g., nutrition versus nurses' notes) can open you up to citations and weaken your defense should a related citation come your way.

In cases involving refusal of care, take these extra defensive steps:

- Document conversation explaining risks and benefits and listing interventions
- Have resident or the resident's responsible party sign a form verifying that he or she received the information.
- Be sure record shows that physician is aware of the refusal by asking him or her to sign statement of awareness.

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