TRAIN FOR SUCCESS INC.
DOCUMENTATION AND LEGAL ASPECTS
10 Hours

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DOCUMENTATION AND LEGAL ASPECTS 10 Hr

Purpose:

The purpose of this course is to review documentation guidelines that are required in the clinical settings: long term care, home health agency, assisted living settings, hospital, physician's office as well as clinics and other sites where patient care is being done. This course focuses on accuracy, legal requirements for nursing and CNA/HHA documentation within the patient's medical record, appropriate documentation in patient's Medical records and review of various formats for documentation.

Objectives/ Goals

After successful completion of this course the students will be able to:

1. Describe the importance of completing accurate and complete documentation within the patient's medical record.
2.Explain the purposes for documentation.
3.Discuss the Health Insurance Portability and Accountability Act, Privacy Rule.
4.Explain how to appropriately document errors.
5.Explain how to document continuations.
6.Explain how to document late entries.
7.Discuss the NANDA nursing diagnoses.
8.Describe the Nursing Interventions Classification (NIC).
9.Discuss the Nursing Outcomes Classification (NOC).
10.Describe various factors to consider in documentation.
11.Discuss characteristics of different formats for documentation.
12.Discuss various components of computerized documentation systems.
13. Discuss the Resident Assessment Instrument (RAI).

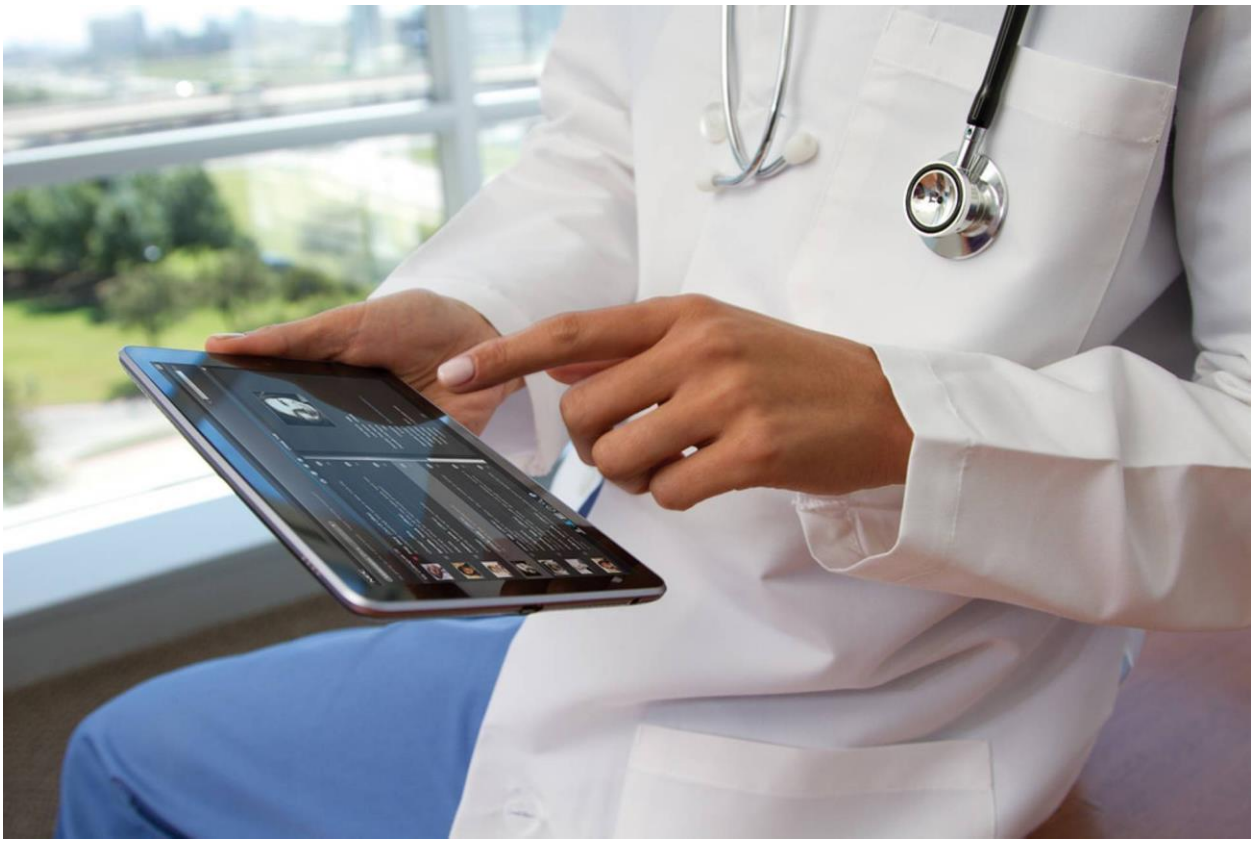
Introduction

Documentation is a set of documents that is used as a form of communication. Documentation can be provided on paper, online or on digital or analog media such as audio tape or CDs. It is becoming less common to see paper (hard-copy) documentation. Documentation can be distributed via the website, software products, and other on-line applications. Within the health care setting, documentation is a form of communication that provides information about the healthcare that the patient receives. Accurate and complete documentation of patient care is required by the facilities/institutions providing services to patients/residents, accreditation agencies, reimbursement agencies, federal and state governments; Medicare and Medicaid.

Some of the purposes of documentation include:

- Fulfilling professional responsibility and establishing accountability,
- Legal standards,
- Compliance with standard of practice,
- Communication among the health care team and providing education to Staff,
- To provide continuity of care,
- Providing information for research,
- For reimbursement.

A COMPLETE MEDICAL RECORD



A complete medical record must have an accurate and complete representation of the actual care/experience of the resident/patient in the facility.

A complete medical record needs to have enough information to demonstrate that the institution knows the status of the resident/patient, has care plans identified to meet the resident's/patient's conditions, and provides enough documentation of the effects of the care provided.

Documentation should provide a picture of the resident /patient and the results of treatment and the resident's/ patient's response to the treatment.

Documentation should also show the changes in status or condition of the resident/patient and any changes in orders or treatments.

Confidentiality is defined as a set of rules or a promise that limits access or place restrictions on certain types of information. Within the health care setting, confidentiality is a major issue in patient/resident care. Healthcare workers, nurses; LPN, RN, ARNP, Physicians, Physical, Occupational, Speech Therapist, Certified nursing assistants as well as everyone who works with the patient has to maintain confidentiality of patient information. For example: you cannot talk about the patient with others who are not working with the patient and you cannot leave patient's chart at the bedside for unauthorized personnel to view. Legally, you can be fined or imprisoned; if you talk about the patient or share patient information. HIPAA laws must be followed and maintained.

Health Insurance Portability and Accountability Act (HIPAA)

Confidentiality of patients' information

Health Insurance Portability and Accountability Act (HIPAA) violations involves both civil and criminal penalties which include fines and imprisonment. The fines can range from $100 for each violation of the law to a limit of $25,000 per year for multiple violations. For misusing or disclosing any of the patient's information, criminal sanctions carry fines of 50,000 to 250,000 and one to ten years imprisonment.

Always maintain confidentiality of patients' information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules:

The Office for Civil Rights enforces the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; the HIPAA Breach Notification Rule, which requires covered entities and business associates to provide notification following a breach of unsecured protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

The HIPAA Privacy Rule provides Federal protections for individually identifiable health information held by covered entities and their business associates and give the patient an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it allows the disclosure of health information needed for patient care and other important purposes.

Protected Health Information (PHI)

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule protects most “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form; electronic, on paper, or oral. The Privacy Rule calls this information protected health information (PHI).

Protected health information is information, including demographic information, which relates to:

 the person’s present, past, or future physical, mental health or condition,
 the provision of health care to the individual, or

 the present, past, or future payment for the provision of health care to the individual, and that identifies the person, or for which can be used to identify the individual.

Protected health information includes many common identifiers such as name, address, Social Security Number, date of birth when they can be associated with the health information.

A medical record, hospital bill or laboratory report, would be Protected health information because each document would contain a patient’s name and the other identifying information associated with the health data content.

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THE CERTIFIED NURSING ASSISTANT (CNA)

THE SCOPE OF PRACTICE FOR THE CERTIFIED NURSING ASSISTANT (CNA)

Check with your state to detail your role as a CNA/HHA. The Florida Statutes describe below, provides specific guidelines regarding the role of the nursing assistant within the long term and home health care settings.

According to the 2018 Florida Statutes 400.211, Persons employed as nursing assistants; certification requirement:

(1) To serve as a nursing assistant in any nursing home, a person must be certified as a nursing assistant under part II of chapter 464, unless the person is a registered nurse or practical nurse licensed in accordance with part I of chapter 464 or an applicant for such licensure who is permitted to practice nursing in accordance with rules adopted by the Board of Nursing pursuant to part I of chapter 464.

(2) The following categories of persons who are not certified as nursing assistants under part II of chapter 464 may be employed by a nursing facility for a period of 4 months:

(a) Persons who are enrolled in, or have completed, a state-approved nursing assistant program;

(b) Persons who have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state; or

(c) Persons who have preliminarily passed the state's certification exam.

The certification requirement must be met within 4 months after initial employment as a nursing assistant in a licensed nursing facility.

(3) Nursing homes shall require persons seeking employment as a certified nursing assistant to submit an employment history to the facility. The facility shall verify the employment history unless, through diligent efforts, such verification is not possible. There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, a

former employer who reasonably and in good faith communicates his or her honest opinion about a former employee's job performance.

(4) When employed by a nursing home facility for a 12-month period or longer, a nursing assistant, to maintain certification, shall submit to a performance review every 12 months and must receive regular inservice education based on the outcome of such reviews. The inservice training must:

(a) Be sufficient to ensure the continuing competence of nursing assistants and must meet the standard specified in s. 464.203(7);

(b) Include, at a minimum:

1. Techniques for assisting with eating and proper feeding;

2. Principles of adequate nutrition and hydration;

3. Techniques for assisting and responding to the cognitively impaired resident or the resident with difficult behaviors;

4. Techniques for caring for the resident at the end-of-life; and

5. Recognizing changes that place a resident at risk for pressure ulcers and falls; and

(c) Address areas of weakness as determined in nursing assistant performance reviews and may address the special needs of residents as determined by the nursing home facility staff.

Costs associated with this training may not be reimbursed from additional Medicaid funding through interim rate adjustments (F.S. 400.211 2018).

According to the Chapter 464 of the Florida Statues CERTIFIED NURSING ASSISTANTS 464.201 (5)

“Practice of a certified nursing assistant” means providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with:

- Personal care,
- maintaining mobility,
- nutrition and hydration,
- toileting and elimination,
- assistive devices,
- safety and cleanliness,
- data gathering,
- reporting abnormal signs and symptoms,
- postmortem care,
- patient socialization and reality orientation,
- end-of-life care,
- cardiopulmonary resuscitation and emergency care,
- residents’ or patients’ rights,
- documentation of nursing-assistant services, and
- other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of

competence in that skill by a registered nurse. This subsection does not restrict the ability of any person who is otherwise trained and educated from performing such tasks.

Certified Nursing Assistant (CNA)

Legal documentation involves:

 Careful and accurate charting, never document a task if it was not done, this too is illegal (always notify the nurse for assistance as needed),

 Never document for another CNA, this is illegal,

 Always document the facts,

 Do not place personal feelings in the chart

 If you observe something abnormal with the patient, do not just write it down; make sure the charge nurse is notified so that the patient can be assessed,

 only document care when it is given,

 Avoid using abbreviations, Potential for errors (refer to the Do not use list)

 Make sure hand writing is clear and can be read by others of the health care team, everything that you document, or chart can be used in court and the lawyers and everyone involved in the legal team must be able to read it.

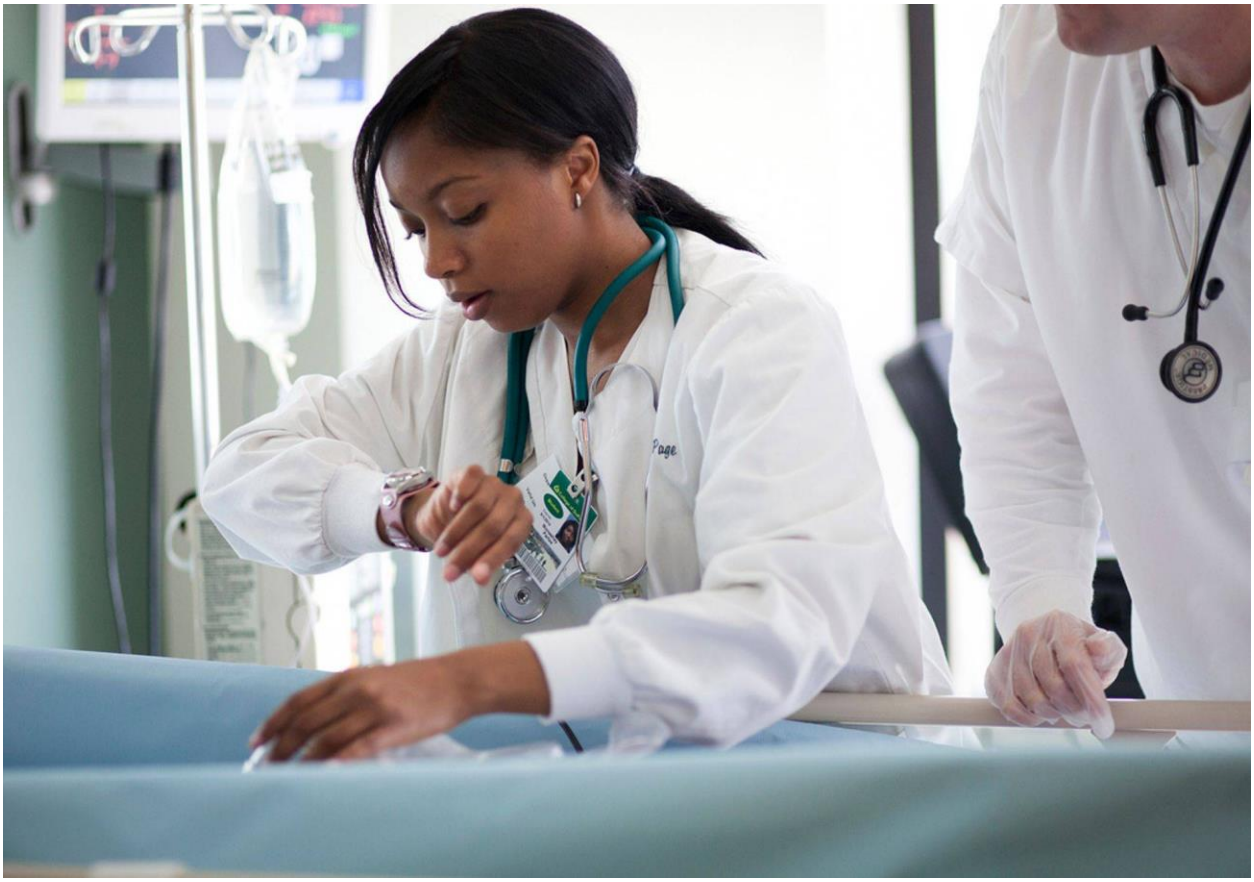
Nursing

For more information regarding the NURSE PRACTICE ACT, click on link:

Florida Statutes CHAPTER 464 NURSING; PART I NURSE PRACTICE ACT (ss. 464.001-464.027)

NURSE

Nurses need to know the state law, the policies and the professional standards that relates to the specialty in which they are practicing. If there is any doubt or lack of knowledge consult with a supervisor or an expert to assist.



Members of the Health care Team

As previously mentioned, it is very important to complete appropriate documentation within the patient's medical record because other members of the healthcare team will also be reviewing and reading the document. Therefore, always provide information about the patient that is current, accurate, factual, complete, and it reflects a picture of the resident/patient while under the care of each health care worker (nurse, CNA, physician etc.).

Goal of Documentation

The overall goal of the nursing documentation is to:

 Ensure that there is documented timeline for the care that the patient receives. Every entry that is completed by each nursing staff or members of the healthcare team has to be coordinated.

This coordinated documentation will allow members of the health care team and other who need to review the chart, to see the patient's status at specific times and assist the health care team in determining if changes have occurred within the patient and at what time the changes were observed, reported and documented.

 Always remember that documentation is considered a legal document which reflects the care the patient received and should reflect that patient care was given in accordance with appropriate standards of care.

Personnel completing the documentation

As a health care worker, you are also documenting for your own purpose. When you have appropriately documented, this documentation will be available for you to access as needed, if you need to recall complete details of what did for the patients.

If there is a lawsuit or claim filed within a year or more, you might not remember all the details of care given to that patient or even the time that care or medications were administered therefore your complete and accurate documentation will be useful at that time.

See your state for the statute of limitation (time frame); within some states, the statute of limitations allows lawsuits within 2 years or more of the date of the event resulting in a claim. The timeframe may be extended as much as 20 years if the patient involved is a minor.

Everyone within the health care team must document and the documentation should be at the time of patient care so that the information is accurate and complete. Never leave your shift without documenting; never say “I will come back in the morning and document.”

Lawyers, consultants, Judge and Jury

When there is a lawsuit, all of the documentation of the patient's medical record will be reviewed by the lawyers, consultants, nurses and other experts involved. The team will look for what was not done per standard of care, what could have been done better, what was not accurately done, what was not done that should have been completed etc. The documentation will be read by the jurors involved in the case.

Follow the nursing process.

The nursing process should always be followed. The nursing process requires:

- Assessment,
- Nursing diagnosis,
- Planning,
- Implementation, and
- Evaluation.

Assessment

Assessment is the first step in delivering nursing care. Nursing assessment is defined as the gathering and analyzing of information about a patient's physiological, economic, psychological, sociological, cultural and spiritual status.

Nursing Diagnosis

The nursing diagnosis is the nurse's clinical judgment about the patient's response to actual or potential health status/conditions.

Planning

Based on the assessment and diagnosis, the nurse establishes measurable and achievable short- and long-term goals and expected outcomes for the patient. The information is placed in the plan of care.

Implementation

Implementation involves carrying out the nursing care according to the plan of care.

Evaluation

Ongoing evaluation is completed to check the patient's status and the effectiveness of the nursing care. The care plan is then modified as needed.

Accurate and Complete Documentation

State nurse practice acts may vary from state to state so follow the established guidelines for documentation. Some tips for accurate and complete documentation are listed below:

 Always write clearly (legibly), everyone within the health care team needs to be able to read what you have documented. This is vital to accurate and continuity of care for the patient. It is good to use block printing if your handwriting is illegible.

 Avoid charting in advance, this too is illegal and can lead to devastating errors.

 Always complete your documented entry using a chronological documentation format. This will provide separate entries for each narrated item because you want to provide a clear picture of the events and times surrounding the care that was provided for that patient.

 Document timely; charting should be done every 1-2 hours for routine care. Medication administration and other interventions or changes in condition should be documented immediately. If medications are not recorded in a timely manner, there is a possibility that the patient may receive that medication again.

 When standard time is used, always include AM or PM with notations. Some healthcare facilities use military time to reduce errors.

 Your Signature is very important. The healthcare worker must always sign for every notation in the patient's medical record.

 If you are to assess the patient's baseline mental status, document it because if there is a change or deviation noted from baseline this could indicate an injury or an acute illness.

 If you completed a task or an intervention, always document the intervention followed by an evaluation; did the intervention help the patient, was it effective? If intervention was not effective, what was done? Was the physician updated, all basis covered? Patient's needs met?

 Also document any complaints of the patient and/ or family and ensure follow up is done with the supervisor, with timely resolution and documentation.

 If you document a body system abnormality, always note the details because over a period of time the abnormality may become worse.

 Always accurately document how your assessment was done. For example, if you watch the chest of the patient rise and fall, you cannot document that the patient has normal breath sounds unless you have used the stethoscope to listen to the lungs.

 Do not use abbreviations unless they are approved, acceptable and included in your facility's policy and procedure. Therefore, if you are unable to complete an entry on that page, do not shorten the word (do not make up your own word) move to the next page; follow your facility's policy and procedure for continuing an entry on the next page.

 Do not use slangs within the patient's medical record. As mentioned before the patient's medical record is a legal document. All documentation should be in Standard English with accurate grammar. Accurate spelling is also required because misspelled words may lead to different interpretations.

 Writing must be done using permanent ink pen (dark ink, blue or black) and writing needs to be neat and legible. Do not use pencil or pen that can be erased. Check your facility policy, some only allow black ink.

 Always assess the patient at the time of admission, transfer and discharge. You need to know the status of a patient when he/she enters your care and before he/she leaves.

 Avoid leaving spaces in charting. If blank spaces are left, this will allow others to make additions to the patient's medical record, to your notation. Make a straight line through any empty space.

 Make sure if you have to complete a late entry, always follow your facility's policy. Late entries must indicate the date and time they were actually entered into the patient's medical record, and you have to include the notation -Late entry; followed by the date and time of the event.

 When medications or treatments are delayed, the healthcare worker must document in the patient's medical records, noting the reason for the delay. For example, the patient may be completing a diagnostic examination and has not yet returned to the unit. If aware that the patient is scheduled for the examination, prioritize and make plans to complete the treatment before the patient leaves for the examination; if possible.

 When you have to continue notes from one page to another, make a notation that the entry is continued on the next page, this is to indicate that the note is not complete. Then document also on the next page to indicate that it is a continuation. Both of the pages have to contain your signature (Follow your facility's Policy).

 When making corrections in the medical record, the error cannot be white-out, erased, scratched out to make illegible. The error can be corrected by drawing a line through the text and writing the word "error." sign your name and date the cross off. Follow your facility policy.

Always remember !!

• Writing has to be legible –clear for others to read and understand

• Use dark ink pen on the patient's medical records

• Whenever you make an error, use your pen and cross it off with one thin line. Write error, sign your name and date the cross off.

Do not try to cover up the mistake with marker or scribble.

Do not rewrite over the error; just one straight line through the error.

White out cannot be used when you make a mistake.

Documentation Variations among health care institutions

Healthcare workers often work in various settings. Physicians, nurses, CNAs and other healthcare personnel often work in more than one facility at the same time. Therefore, it is very important to understand the basic formats for effective documentation.

Appropriate and accurate documentation requires the nurse to have an understanding of the nursing process and nursing diagnosis.

NANDA International (formerly the North American Nursing Diagnosis Association) is a professional organization of nurses standardized nursing terminology that develops, researches, disseminates, refines the nomenclature, criteria, and taxonomy of nursing diagnoses.

NANDA International sets the standards for nursing diagnoses with a taxonomy that includes domains, classes, diagnoses, based on health patterns; domains such as:

Activity/Rest

Comfort

Coping/Stress

Tolerance

Elimination

Growth/Development

Health Promotion

Life Principles

Nutrition

Perception/Cognition

Role Relationships

Safety/Protection

Self-perception

Sexuality.

Nursing Interventions Classification (NIC) and Nursing Outcomes Classification (NOC)

Nursing Interventions Classification; a standardized list of several of different interventions and activities needed to implement the interventions. The patient outcomes related to the nursing interventions classification are detailed in the Nursing Outcomes Classification (NOC), which contains several outcomes, each with measures to determine if outcomes are met.

Computerized documentation systems

Computerized documentation systems often incorporate nursing diagnoses into the system, which produces lists of interventions and expected outcomes. More institutions are utilizing computerized systems for documentation.

These computerized systems vary from one facility to another; however, security is a common factor for all systems. Training has to be provided for the staff, which usually include securing patient information from unauthorized persons whether the computer is at the nurses' station or at the bedside, security of password information; no one is allowed to share their password with their co-worker etc.

Computer systems usually track the use of the system; therefore, it is documented who is logged on and time and date. There has to be training regarding how to correct errors when an entry error is made.

Computerized documentation systems have many advantages, including but not limited to:

- Eliminates handwritten orders,
- The records are legible; no need to worry about unclear handwriting,
- Enters signatures automatically,
- Security of patient information; need password to log in to access patient information,

 Orders can be automatically transmitted to pharmacy and medication is ordered quickly,

 Reduction in errors,

 Prevents tampering of the medical record,

 Difficult to delete information from the record.

Computerized documentation systems may include:

Electronic medical record (EMR)

Electronic medical record is the computerized patient medical record. With the use of the computerized documentation system, computer terminals may be located in the patient's room, therefore healthcare providers / workers, professionals have to be educated/ trained regarding the importance of logging off the computer system so that persons who are not authorized will not be able to access and view the patient's information.

The computerized documentation system usually has computerized physician order entry, clinical decision support system; therefore, the notes can be entered electronically.

Clinical decision support system (CDSS)

Clinical decision support system refers to the interactive software systems which has evidence based medical information. Clinical decision support system can be used for different purposes such as providing diagnosis and treatment options when the symptoms are imputed into the computer system. Clinical decision support system may also monitor the orders and the treatments to prevent repetitions or duplications.

Computerized physician or provider order entry (CPOE)

Computerized physician or provider order entry (CPOE) refers to the interactive software application that automates ordering for medications or treatments. Orders must be entered in a prompted format that eliminates many errors. These systems usually include Clinical decision support system to provide alerts if there is an inaccurate dose or duplication order. Computerized physician or provider order entry eliminates handwritten orders and the information is automatically transmitted to the pharmacy, reducing errors and medication is ordered quickly.

Documentation Formats

Many institutions utilize the narrative format when documenting in the clinical record. Healthcare workers must utilize the system that is in place / follow the policy and procedures of the facility that they work in.

Some of the formats that are available include:

- Narrative format
- Focus
- Charting by exception (CBE)
- Problem Oriented medical record (POMR)
- Flow Sheet, Assessment, Concise, Timely (FACT)
- Problem/ intervention/ Evaluation (PIE)
- Core.

Narrative format

Narrative format is used in most of the institutions. Narrative charting involves recording data using progress notes, with the flow sheets supplementing the notes. Narrative charting does not follow a specific outline and follows the thought process of the healthcare worker who is documenting. Focus Organized into patient centered topics, the Focus system encourages integrating assessment data to evaluate the patient's condition on an ongoing basis. The Focus system is best used where the procedures are repetitive and is utilized primarily in acute care settings. Progress notes are written utilizing the DAR (Data, Action, and Response) format.

Charting by exception (CBE)

Charting by exception requires the development and use of practice standards or protocols for each body system. The forms utilized in the documentation are developed following specific guidelines. Developing the standards and forms eliminates the need to document in narrative format standard nursing care. The healthcare worker check off the areas on the flow sheet through which the patient has met the established standard, then writes a narrative note when the patient's condition deviates from the established standard.

Problem Oriented medical record (POMR)

Problem oriented medical record (POMR) is utilized in many health care institutions. The POMR system follows a problem list format, identifying all areas (both positive and negative) that are impacting the patient. The notes and all the documentation refer back to the problem list, using the

Subjective, Objective, Assessment, Plan (SOAP), the Intervention, Evaluation (SOAPIE) and/or SOAPIER (Revision) format.

Flow Sheet, Assessment, Concise, Timely (FACT)

Flow Sheet, Assessment, Concise, Timely (FACT) developed to help eliminate repetitive notes, irrelevant data, inconsistency and to reduce amount of time required to complete documentation. Flow sheets are designed to address the redundant activities in caring for a resident. The narrative documentation utilizes the Data, Action, Response (DAR) format of the Focus charting system.

Problem/ intervention/ Evaluation (PIE)

Problem/ intervention/ Evaluation (PIE) organize information according to the patient's problems to simplify the documentation system. Problem/ intervention/ Evaluation (PIE) utilize flow sheets which have been developed for daily documentation supplemented with structured narrative documentation. This system also integrates the care plan into the daily documentation.

Core

Core focuses on the nursing process. The Core framework utilizes the data base, flow sheets, care plan, progress notes, discharge summary to chart the patient's needs and progress. Progress notes follow the data, action, evaluation/response (DAE) for each of the problems.

Abbreviations

Use of abbreviations

Abbreviation is a shortened form of a word or phrase. Abbreviations can lead to some serious or life-threatening errors, therefore there are guidelines in place.

Some abbreviations and their meanings are listed below.

ABBREVIATION and MEANING
a.c. =Before meals
ACL =Anterior cruciate ligament
ad lib= Freely
a/g ratio = Albumin to globulin ratio
AKA = Above the knee amputation
a.m. =Morning
ASA =Aspirin
b.i.d =Twice a day
BM =Bowel movement
BMP= Basic metabolic panel
BP =Blood pressure
BS =Blood sugar
Ĉ= with
CC= cubic centimeters
Cap =Capsule
C&S = Culture and sensitivity
CVA =Cerebrovascular accident
D.C. =Discontinue
Disp= dispense
DNR =Do not resuscitate
DVT= Deep venous thrombosis
ec = enteric coated

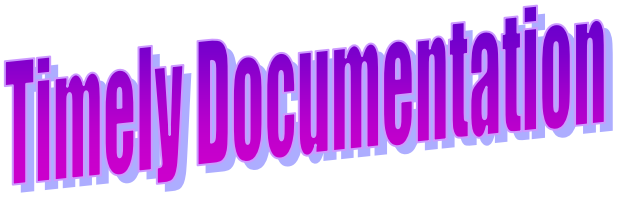
elix = elixir
ETOH =Alcohol
Ext =Extract
fl or fld =Fluid
g. or Gm. or g =Gram
Gr =Grain
gtt. =Drop
h. or hr. =Hour
H&H: = Hemoglobin and Hematocrit
H&P = History and physical examination
hs = At hour of sleep, bedtime
HTN= hypertension /high blood pressure
IM = Intramuscular
I.V. = Intravenous
L = liter
MAR = medication administration record
MEq =Milliequivalent
Min =Minute
Mg =Milligram
ML =Milliliters
NPO =Nothing by mouth
N/V = Nausea or vomiting
NTG =Nitroglycerin
O&P = Ova and parasites
O2 = oxygen
O.D.= Right eye
O.S.= Left eye
O.U.= Both eyes
Oz = ounce
ORIF = Open reduction and internal fixation
P= Pulse
p.c. =After meals
PERRLA = Pupils equal, round, and reactive to light and accommodation
p.m. =Evening
p.o. =By mouth
Post = after
prn =as needed
Pre = before
prn= as needed
q am= every morning

qh= every hour
q2h= every 2 hours
q3h=every 3 hours
q4h= every 4 hours
qid = four times daily
qhs=every night or at bedtime
qpm= each evening
R= respirations
R/O = Rule out
RLQ = Right lower quadrant
RUQ = Right upper quadrant
Š= without
SL = sublingual
SOB =Shortness of breath
Sol =Solution
ss. =One half
Stat =Immediately
SQ = Subcutaneous
Supp= suppository
susp. =Suspension
Syr. =Syrup
T= temperature
tab. =Tablet
Tbsp =Tablespoonful
Tsp = teaspoon
Tid =Three times a day
Tinc =Tincture
TPR= temperature /pulse /respirations
Top =Topically
tsp. =Teaspoon
UA or **u/a**= urinalysis
ung. =Ointment
VS = vital signs
Wt= weight

The Joint Commission has set guidelines and rules; all healthcare settings have to standardize abbreviations, acronyms and symbols that they are using. They are also required to adhere to a Do Not Use list.

The Do Not Use List includes some of the following:

Do Not Use u, or for unit. Mistaken sometimes for zero. You must write "unit" Do Not use iu for international unit. Mistaken for IV. Write "international unit" Do Not Use Q.D., QD, q.d., qd (Daily). Mistaken for each other. Write "Daily". Do Not Use Q.O.D. QOD, q.o.d., qod (every other day). Write "every other day" See the complete Do Not Use List (The Joint Commission http://www.jointcommission.org/assets/1/18/Do_Not_Use_List.pdf)



Time is a very crucial factor within the nursing process. Healthcare workers; Physicians, Nurses, CNA have to document the time of all interventions and notations. For example, the patient complains of severe pain to the fractured extremity, the nurse administered the pain medication prior to leaving the shift; no notation was completed.

The patient reports pain to the oncoming nurse, who is aware that patient has a fracture and will experience pain, therefore administers the pain medication; within the hour the patient has received pain medication twice. Another scenario; the CNA obtained vital signs at 7am; at 2:30pm the patient reports feeling ill, flushed and experiencing severe headache; the CNA gives the nurse the results of the vital signs assessment which was documented as completed 2:30pm this may lead to inappropriate interventions and inaccurate reporting to physician regarding patient's status.

Documentation /Physician orders

Telephone order and Verbal order

Always follow the institution's Policy when noting orders on the physician order sheet. When the nurse receives a telephone order (the physician telephones and gives an order) then it has to be documented as a Telephone Order (T.O.) The telephone order should indicate a telephone

order with the time, date, physician's name and that the order has been repeated to the physician, also Verbal orders, must be documented as V.O. and must be written exactly as dictated and then verified.

Vital Information

Some information such as allergies/ sensitivities, Patient's identification; name and other identifying information should be on every page of every document in the patient's medical record.

Notation of Medications and treatments

When medications and treatments are administered, the healthcare worker has to document in the patient's medical record. Also, If the wrong medication or treatment is administered, this also has to be documented. The nursing note has to indicate all treatments and medications given to the patient, even if it was the wrong medication or treatment.

The individual who administers the wrong medication or treatment has to document the:

- Name of the medication,
- the dose of medication,
- Name of physician notified,
- time the physician was notified,
- Nursing interventions or physician orders to prevent or treat adverse effects,
- Patient's response to treatment.

Follow the facility policy and procedure regarding with medication and treatment errors. An incident report will also be completed.

LONG TERM CARE DOCUMENTATION

Within the long-term care setting the individuals who residents and receives care are often referred to as residents, clients, patients and some facility "customers". Follow the institution policy and ensure that your documentation includes the appropriate name.

Complete and accurate documentation within the long-term care setting is also very vital due to several factors such as:

- Regulations
- Surveys conducted by The Agency For Health Care Administration (AHCA)
- Litigations (laws suits)
- Documentation based on reimbursement/ payment systems
- Increased legal challenges
- Complex clinical needs
- Complex patient decision making.

Federal Regulations and Clinical Record guidelines

Long-term care facilities such as Skilled Nursing Facilities (SNF), rehab. centers often review their documentation policies and procedures/ guidelines.

They frequently have to incorporate accreditation requirements, payer requirements (for reimbursement purposes) and state regulations into the documentation systems.

Federal regulation requires that the facility has to maintain clinical records on each resident/patient in accordance with accepted professional standards and practices that are:

- Accurately documented,
- Complete,
- Readily accessible and
- Systematically organized.

LONG TERM CARE RECORD

Certified Nurse Assistant (CNA)

The certified nurse assistant may perform tasks associated with:

- personal care,
- maintaining mobility,
- nutrition and hydration,
- toileting and elimination,
- assistive devices,
- safety and cleanliness,
- data gathering,

 reporting abnormal signs and symptoms,

 postmortem care,

 patient socialization and reality orientation,

 end-of-life care,

 cardiopulmonary resuscitation and emergency care,

 residents' or patients' rights,

 documentation of nursing-assistant services, and other tasks.

The certified nursing assistant is also required to perform accurate and complete documentation within this setting.

NURSING DOCUMENTATION IN THE LONG-TERM CARE SETTING

Admission Record

Every clinical record needs to have an admission record or face sheet or that provides the demographic information, diagnosis, financial, insurance information, patient's/ resident's responsible party and contact(s) and other contact information for other professionals involved in the patient's/ resident's care outside of the facility for example, attending physician etc. The face sheet has to be revised and updated with changes as they occur.

Long Term care and other facilities have designated individuals who are responsible for this task. Sometimes a nurse, Unit Manager or nursing supervisor may be responsible for adding new information when changes occur after regular business hours; then the designated medical records personnel is updated and log the changes. The old face sheet is kept in another designated section of the chart. Nothing is thrown out from the medical record even after several changes or updates are made.

Admission Assessment: An admission or readmission assessment usually incorporates data that would be considered a nursing assessment and the physical examination. Although there is no Federal regulation to perform the admission assessment, professional practice standards for the healthcare industry indicates that an admission assessment should be completed so that there will be baseline information and better awareness of the client/ resident needs so that appropriate and accurate care plan can be initiated. State regulations may provide specific details on information to collect such as vital signs, pain assessment, a review of systems, skin integrity etc.

Assessments within Long Term Care

There are several assessments that are used within the long term care environment. Some include:

- Resident Assessment Instrument (RAI)
- Nursing Assessment,
- Pain Assessment,

- Fall Risk Assessment,
- Pressure ulcer risk assessment
- Dietary assessments
- Elopement Assessment,
- Bowel and Bladder assessment
- Social Service Assessment,
- Smoking assessment etc.

Assessments can be documented in various ways. Documentation of an assessment may be simple as completing an assessment form or writing a narrative assessment.

The Resident Assessment Instrument (RAI)

The Resident Assessment Instrument (RAI) is the mandated assessment tool under the Federal Omnibus Budget Reconciliation Act of 1987 (OBRA) that is required in Long term care settings. Click on link below for October 2018 manual:

Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual October 2018 For Use Effective October 1, 2018

Completion of the Resident Assessment Instrument (RAI)

The MDS; its primary purpose as an assessment tool is to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents (cms.gov 2018).

• Medicare and Medicaid Payment Systems.

The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups). The RUG classification system is used in SNF PPS for skilled nursing facilities, non-critical access hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. More detailed

information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing.

• Monitoring the Quality of Care.

MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality measures (QMs) were developed by researchers to assist: (1) State Survey and Certification staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the usefulness of the QMs, which may be modified in the future to enhance their effectiveness (cms.gov 2018).

• Consumer Access to Nursing Home Information. Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The Nursing Home Compare tool (www.medicare.gov/nursinghomecompare) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes (cms.gov 2018).

The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that

(1) the assessment accurately reflects the resident's status

(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals

(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

The completion of the RAI can be conceptualized using the nursing process as follows:

a. **Assessment**—Taking stock of all observations, information, and knowledge about a resident from all available sources (e.g., medical records, the resident, resident's family, and/or guardian or other legally authorized representative (cms.gov 2018).

b. **Decision Making**—Determining with the resident (resident's family and/or guardian or other legally authorized representative), the resident's physician and the interdisciplinary team, the severity, functional impact, and scope of a resident's clinical issues and needs. Decision making should be guided by a review of the assessment information, in-depth understanding of the resident's diagnoses and co-morbidities, and the careful consideration of the triggered areas in the CAA process. Understanding the causes and relationships between a resident's clinical issues and needs and discovering the "whats" and "whys" of the resident's clinical issues and needs; finding out who the resident is and consideration for incorporating his or her needs, interests, and lifestyle choices into the delivery of care, is key to this step of the process (cms.gov 2018).

c. **Identification of Outcomes**—Determining the expected outcomes forms the basis for evaluating resident-specific goals and interventions that are designed to help residents achieve those goals. This also assists the interdisciplinary team in determining who needs to be involved to support the expected resident outcomes. Outcomes identification reinforces individualized care tenets by promoting the resident's active participation in the process (cms.gov 2018) .

d. Care Planning—Establishing a course of action with input from the resident (resident's physician and interdisciplinary team that moves a

resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise; crafting the “how” of resident care.

e. Implementation—Putting that course of action (specific interventions derived through interdisciplinary individualized care planning) into motion by staff knowledgeable about the resident’s care goals and approaches; carrying out the “how” and “when” of resident care (cms.gov 2018).

f. Evaluation—Critically reviewing individualized care plan goals, interventions and implementation in terms of achieved resident outcomes as identified and assessing the need to modify the care plan (i.e., change interventions) to adjust to changes in the resident’s status, goals, or improvement or decline (cms.gov 2018).

Types of Assessments and Requirements:

Some of the following assessments are required by Federal regulation and others are standard practice within the healthcare industry. The assessments may be completed on separate forms; the format may be manual or electronic or may be documented in narrative notes.

Preadmission Assessment and Admission Assessment

Completion of a preadmission assessment is not required by Federal regulation but is commonly completed to obtain information and determine the needs of the resident/ client and ensure that the institution /facility has adequate resources to provide care for that resident.

Fall Assessment Documentation

The facility/ institution has to identify each client/ resident who is at risk for accidents/incidents and/or falls and appropriately document, care plan and implement measures/ procedures to prevent accidents. Due to the time allowed to complete the Resident Assessment Instrument (RAI), it is recommended that the risk for falls assessment be completed on admission and readmission.

Some of the risk factors may include:

 AGE,

 Medications that the resident is taking may have side effects such as dizziness, hypotension etc.

 sedation,

 Patient has a history of falls,

 Diagnosis that increase risk for falls,

 Infection,

 sensory impairments,

 sleep disorders,

 confusion,

 Patient has unsteady gait,

 Poor balance,

 Patient requires assistance with walking,

 Patient may require assistance for transfer,

 History of wandering,

 orthostatic hypotension,

 poor judgment,

 Pain,

 urinary frequency,

 urinary incontinence

 weakness

The healthcare worker / nurse has to document /include the risk factors in the care plan should include the risk factors and the interventions to be implemented to try to prevent falls or other accidents.

Based on the Fall risk assessment findings interventions may include:

 Monitoring for side effects of medications,

 Ensure patient has assistive devices; such as cane, walker or wheelchair to assist with mobility,

 Assistance with ambulation,

 Ensure non-skid footwear,

 Referral to Physical Therapy for Eval /strength building exercises,

 Provide a clutter free environment,

 Ensure patient has eyeglasses in place prior to ambulation,

 Pain management,

 Adequate nutrition and fluids,

 Toileting schedule,

 Remove objects in walkway,

 Ensuring adequate lighting etc.

Within the long-term care setting the fall risk should be reassessed with each Resident Assessment Instrument (the MDS), with change in the resident condition, and after every fall. The plan of care should also be

reviewed after each fall and revised to include a different intervention to try to prevent another fall from occurring.

The Minimum Data Set (MDS) is part of the U.S. Federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. The Minimum Data Set (MDS) provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staffs identify and treat health problems.

The Minimum Data Set is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes. MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings.

Documentation regarding the resident’s skin integrity is very important. Based on the comprehensive assessment the facility must make sure that a resident who is admitted to the facility without a pressure injury (ulcer) or skin impairment, does not develop pressure injury (ulcer) or skin breakdown unless the resident’s clinical condition indicates that they are unavoidable.

If the residents develop pressure injury /ulcer or skin impairment, they must receive the necessary treatment and services that will;

- promote healing,
- prevent infection,
- prevent new pressure injuries /ulcers and
- prevent increasing size/ stage of pressure injuries/ulcers from developing.

The nurse has to document progress with each treatment, whether there are signs or symptoms (s/s) of infections noted and follow up with the physician for change in treatment as needed. The resident's skin condition must be reviewed for each MDS including the discharge assessment. Although it is not a requirement, it is advisable that documentation regarding the resident's skin condition be provided when the resident departs and returns from a leave of absence, for example out with the family, or other events away from the facility.

This will provide information regarding the presence or absence of bruises that may be determined to be facility acquired if it is not documented that the injury was sustained while the resident was out of the facility.

The documentation has to support:

 The promotion of the prevention of pressure injury/ulcer development,

 The promotion of the healing of pressure ulcers and infections, and

 The prevention of the development of additional pressure ulcers.

Documents for the identification and documentation of resident's at risk or with existing pressure ulcers include:

 Skin Assessment; the nurse has completed a visual examination of the skin on admission,

 History & Physical (H&P) and Discharge Summary medical findings,

 Dietician Evaluation,

 Laboratory Work/ blood work,

 the use of a standardized skin at risk assessment for example the Braden scale,

 Intake and Output Totals (I &O),

 Resident Assessment Instrument

When there is early identification of the risk areas, this helps to facilitate prompt implementation of the plan of care; which documents the interventions needed to stabilize, decrease, or remove the risk factors.

Some of the Risk Factors include:

 Impaired mobility /decreased mobility,

 weight loss, medical diagnoses,

 decreased functional ability,

 co-morbid conditions, for example, diabetes mellitus, end stage renal disease or thyroid disease,

 medications such as steroids that may affect wound healing,

 history of healed ulcers,

 decline in appetite,

 impaired blood flow, such as arterial insufficiency,

 resident refusal of care and / or treatment,

 skin exposed to urinary and fecal incontinence due to B&B incontinence,

 cognitive impairment,

 malnutrition, and hydration deficit,

 devices that may cause pressure.

Risk Factor and Interventions

The care plan documentation should include the risk factors and the interventions to be implemented to try to reduce or eliminate risk factors related to skin at risk and/or pressure injury (ulcer).

Based on the assessment findings the interventions may include:

 Preventative Skin Care,

 Turning and positioning,

 Pressure relieving devices on beds and chairs,

 Management of pain,

 Encouraging ambulation,

 Encouraging movement,

 Encouraging time out of bed,

 Placement of supportive surfaces to reduce pressure in bed and chair,

 Nutritional approaches that have been designed for adequate nutritional support,

 Adequate nutrition and fluid intake etc.

Accurate and complete documentation must be completed on admission and should include the skin assessment. A complete review of the resident's skin, from head to toe must be completed to establish a baseline.

There should also be ongoing documentation of the skin integrity so that change in skin integrity can be addressed and treated promptly. Long term care facility usually has an on-going system in place to assess the

condition of the skin such as routine monitoring for skin conditions which could occur at the time of the resident's bath or shower.

The Certified Nursing Assistants (CNA) documents and if abnormal findings are observed the CNA reports the findings/ observations to the nurse, the charge nurse or nursing supervisor who would then check the resident and follow up with physician and others of the health care team as needed.

The documentation of Assessment and Treatment of Pressure Injury (Ulcer) include:

Identification of the skin's condition while admitting resident,

Measurements,

monitor on an on-going basis throughout the resident's stay,

potential for development of additional pressure ulcers,

Characteristics of pressure injury (ulcer),

Factors that influence the development of the pressure ulcer,

Potential for deterioration of existing pressure injury (ulcer),

Stage of pressure injury (ulcer) including if it is not stageable,

Description of pressure injury (ulcer),

Color of skin surrounding pressure injury (ulcer)

Signs /symptoms of infection,

Potential complications,

Presence of pain,

Change in the level of pain,

Progress toward healing,

Dressings and treatments,

Description of the skin surrounding dressing,

when dressing is due to be changed,

Monitor for the presence of complications.

Documentation must be completed according to the policy and procedures of the facility. Documentation is usually done with each dressing change and assessment and can be noted:

 In a narrative format in the progress notes,

 On a specific flow sheet or,

 On the reverse side of the Treatment Record.

Charting should include:

 Date and time of documentation,

 Stage of the pressure (document if it is unstageable) Document the location,

 Measurement /Dimensions and presence of undermining / tunneling

 Drainage/ exudates,

 If drainage is present is it (serous, serosanguineous, sanguineous, what color is it, presence of odor, purulent, and approximate amount of drainage)

 Document if resident reports pain,

 if pain is present; document the nature of the pain, frequency, continuous or intermittent and treatment provided,

 Does resident report relief after treatment or increase pain,

 Document the wound bed; color, characteristic of tissues; necrosis or granulation,

 Describe the wound edges and the surrounding tissues; any redness, rolled edges, hardness or maceration (softening),

 Document whether there are signs / symptoms of infection,

 Document response to treatment also is the resident compliant with treatment plan or non-compliant,

 Update physician if there is lack of healing or increase deterioration and all abnormalities including resident non-compliance if applicable and document.

Whenever the documentation reflects that an intervention was either not applicable or not feasible, there has to be adequate documentation from the healthcare worker and the practitioner of clinically valid reasons why the interventions were not implemented.

Re-Evaluation and Documentation

If the pressure injury (ulcer) does not show some evidence of healing within two to four weeks, the pressure injury (ulcer) and the resident's overall clinical status needs to be reassessed. The healthcare team needs to re-evaluate the treatment plan and determine whether to continue the treatment or change the current interventions.

If the healthcare team decides to keep the current treatment regimen, there has to be documentation regarding the reasons for continuing the present treatment when there has been no progress towards healing.

Skin ulcers or abnormalities are documented in the resident's Care Plan. The interventions and the implementation of these interventions are critical and should include preventative measures.

Interventions to treat pressure injuries (ulcers) may include, but not limited to:

- Turning and positioning
- Protective skin care
- Using pressure relieving devices on beds and chairs
- Effective pain management
- Ensuring nutritional supplements
- Adequate fluids
- Treatments as ordered by physician.

Documentation regarding Bowel and Bladder

On admission to the facility, the Admission Nursing Assessment identifies the status of the resident such as:

- Continence status as described by resident,
- Continence status by observation,
- Risks or conditions that may affect continence,
- Environmental factors that may affect the ability to access the toilet, ambulatory devices or status,
- If catheter is present; documentation of medical justification for the catheter, type and size of catheter, color of urine, flow of urine, potential for removal of catheter,
- The use of medications that may affect continence, etc

Documentation /progress notes for bladder and bowel retraining programs are usually recorded weekly until the resident has reached the goal or the program is discontinued.

Documentation regarding Self-Administration of Medication

If the resident requests to self-administer medications, the interdisciplinary team needs to determine that it is safe for the resident to self-administer medications before the resident is allowed to do so.

The assessment may include cognitive status, vision and manual dexterity. If it is determined that the resident is capable and is a suitable candidate for a self-medication program, the physician is updated, and an order is obtained.

Documentation within the plan of care needs to reflect the self-medication program and goals. Narrative notes or flow sheets will reflect the resident's progress in the program.

Documentation regarding Nutrition

The institution needs to make sure that the residents maintain acceptable nutritional status, for example ideal body weight and albumin/protein levels; unless the resident's clinical condition demonstrates that it is not possible.

The facility needs to ensure that the resident receives adequate nutritional and fluid intake. When a nutritional problem is identified the institution needs to make sure that the residents receive a therapeutic diet.

Adequate documentation must be maintained. The resident also needs to be interviewed to determine food allergies and food preferences to ensure that the residents' needs are being met.

The certified nursing assistant needs to accurately document the resident's meal intake and update the nurse when there is a decrease noted in meal and fluid intake. The Nutrition Assessment should include identification of the factors that put the resident at risk for malnutrition. Important considerations should be taken for residents with dentures; are the dentures well fitted or are the dentures causing discomfort or pain?

The Nutritional Assessment may require a Registered Dietitian to assist. The healthcare team will need to review the factors that contributed to the decline, the potential for decline or the lack of improvement for residents who are at risk. The medically related conditions and the nutritional problems need to be documented in the resident's care plan.

Some interventions may include:

Therapeutic diet

Altered fluid consistency

Altered texture of diet

Periodic review by the dietitian

Review of laboratory results

Special dinning program that encourage meal / fluid intake such as restorative dining.

The problem and goals of the care plan is reviewed quarterly and with a significant change using the progress note or the reassessment form.

Documentation regarding Mental and Psychosocial Functioning

Based on the comprehensive assessment the facility must make sure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem.

Some assessments used to identify mental and psychosocial functioning include, but not limited to:

Resident Assessment Instrument

Social History and Evaluation

Mini Mental State Exam (MMSE)

Neuropsychiatric Inventory (NPI)

Neuropsychological Tests

Clock Draw Test

ADAS-Cog (Alzheimer Disease Assessment Scale-Cognitive)

Behavioral Pathology in Alzheimer's Disease Rating Scale (BEHAVE-AD)

Cornell Depression Assessment

CERAD (The Consortium to Establish a Registry for Alzheimer's Disease) Clinical and

Cornell Scale for Depression in Dementia (CSDD)

Geriatric Depression Scale (GDS)

The 7 Minute Screen.

Documentation regarding Restorative/Rehab Nursing Assessment

The long-term care facility has to provide care and services to maintain or attain the resident's highest level of independent function. Based on the assessment the facility has to make sure that a resident who enters the facility without limited range of motion (ROM), functional activities of daily living does not experience a decline in their functional status unless the resident's clinical condition shows that it is unavoidable.

Assessments may include but not limited to:

The Resident Assessment Instrument

ADL assessments; bathing, grooming, hygiene, toileting, dressing

Screens and recommendations by physical therapist, occupational therapist and speech therapist,

Range of motion (ROM)

Bed mobility,

ambulation and transfer

Self-feeding ability

Bladder and/ or bowel status

Communication.

Documentation within the Care Plan

Documentation within the care plan must include the functional deficit with measurable goals, and the restorative training program. The nurse who is in charge of the nursing restorative program needs to record progress notes that addresses the resident's progress toward goals.

Many facilities ensure that documentation of the resident's progress is completed at least quarterly and more frequently as needed, with changes in status.

Documentation within the resident's care plan is critical to the resident's condition, needs and progress. The care plan has to provide direction to the healthcare team regarding providing care and treatment to the resident.

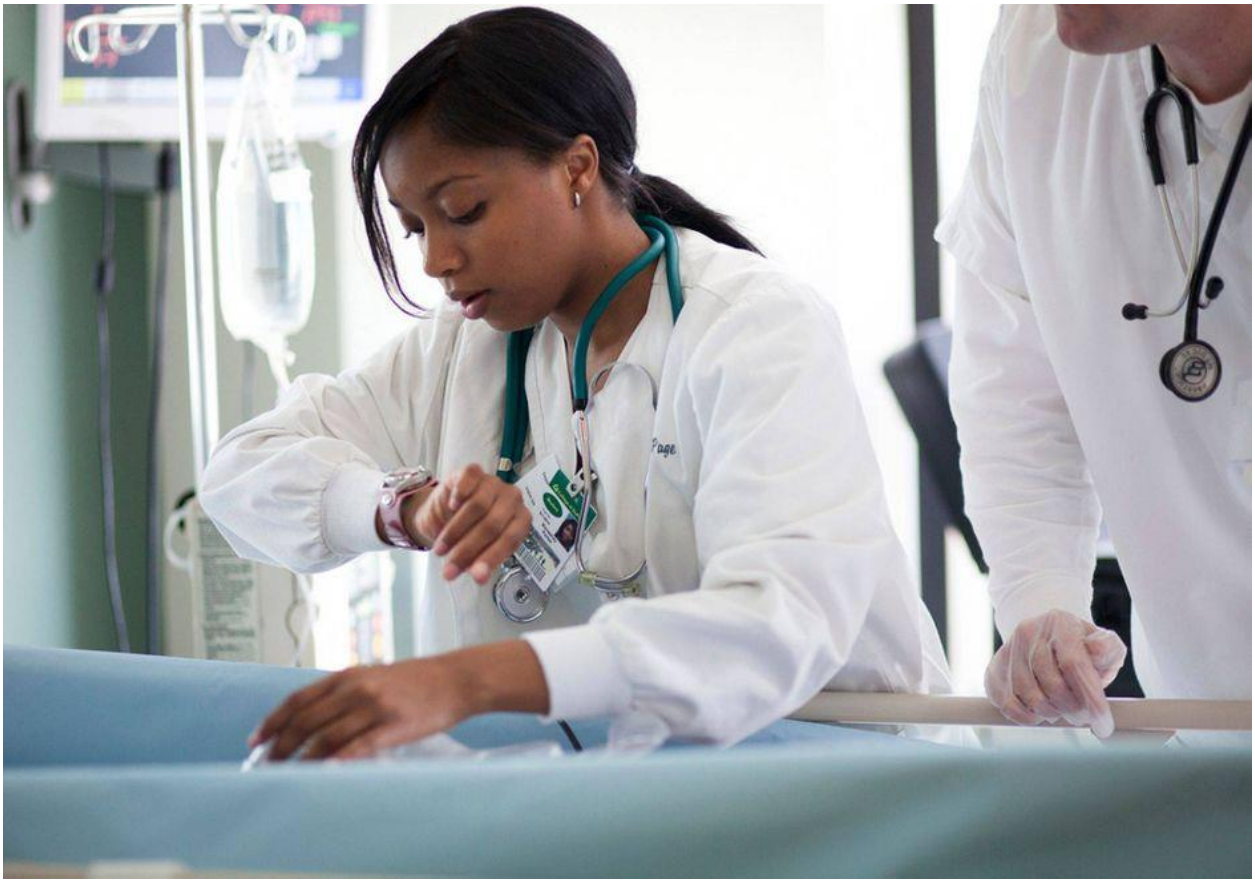
The facility has to develop a comprehensive care plan for every resident. The plan must include measurable objectives and time frames to meet the resident's nursing, medical, mental and psychosocial needs that have been identified in the comprehensive assessment.

The documentation within the care plan needs to describe the services that will be provided to maintain or attain the resident's highest possible physical, mental, psychosocial well-being; and any services that would otherwise be required but are not provided because the resident refused treatment or for other reasons.

The care plan must reflect steps for each outcome objectives if identification of those steps will enhance the resident's ability to meet his/her objectives. The healthcare team will use these objectives to monitor the resident's progress.

The care plan interventions need to be prioritized. This should be documented in the clinical record or on the plan of care. The care plan must be prepared by the interdisciplinary team which includes the physician, a nurse with the responsibility for the resident and other appropriate staff and disciplines as determined by the resident's needs, the participation of the resident, the resident's family or the resident's legal representative (if they would like to attend).

There should be evidence/ documentation that the care plan is reviewed periodically by a team of qualified persons after each assessment and as the resident's status changes.



Documenting Skilled Nursing and Therapy services

The resident's medical record must have proof that the resident needed and have received skilled services such as nursing and / therapy services on a daily basis. The residents who are receiving skilled services have to show evidence in the medical record documentation of the need for daily skilled services that is being given. The content of the documentation needs to be objective and measurable.

When the therapy services are justifying the Medicare coverage, the nursing documentation should be consistent with the therapy documentation and address how skills the resident learned in therapy are being applied on the nursing unit.

Documentation regarding Activities of Daily Living (ADL)

Activities of daily living (ADL) means functions and tasks for self-care, including ambulation, bathing, dressing, eating, grooming, toileting and other similar tasks. As the Certified Nursing Assistant (CNA) documents, the documentation in the medical record should provide support for the scoring on the MDS along with observation and interviews. The facility needs to utilize ADL charting to collect information from all three shifts during the 7-day observation period.

If the staff member assessing the ADL status and completing the MDS does not agree with the supporting documentation based on observations and / or interviews, a clarification note needs to be written documenting the reasons for the ADL scoring on the MDS.

ADL (Activities of Daily Living) Flow sheets and NAR (Nursing Assistant Record) Flow sheets.

If the ADL flow sheets are used, it is best if they are tailored to the resident's care plan. ADL flow sheets can be either documented by nursing after consulting with direct care staff or by the certified nursing assistant providing the care. When the nursing assistant completes the flow sheets, there should be a system to monitor completion every shift. Unless you are using an electronic care tracking program, flow sheets are the easiest way to document amount of care rendered to the resident. ADL scores are very important to scoring the ADL section of the MDS correctly. Scoring on the ADL flow sheets should be consistent with the scoring on the MDS to increase consistency in data collection and assessment.

Rehabilitation Services are provided to improve the physical functioning of the resident, to allow them to return to the community. The Rehabilitation Services Assessment should be conducted within a reasonable timeframe after the physician's order is received. When the services have been started, a progress note needs to be documented within specific time lines; (some states within 14 days and then at least every 30 days as long as the resident is receiving therapy services).

The physician needs to certify the assessment and plan of care documented by the therapists. Within some facilities, the therapists utilize

a specific government generated form for this purpose. The form may include:

- assessment of the resident's functional condition / status,
- the plan of care going forward and
- location for the physician to sign, certifying the need for and approval of therapy services.

When the residents have reached their goal, a therapy discharge summary needs to be completed. The documentation must include the number of days and minutes of therapy. The clinical record needs to reflect the dates and times, usually documented in a flow record (electronic and /or hard copy). The therapists may include a notation regarding what the resident's performance level was for that therapy session and a weekly summary is often documented.

Physician Orders/ Admission Order

When a resident is admitted to the facility, the institution has to have physician orders for the resident's immediate care. These orders should include, at least, the resident's medications, diet and routine care to maintain or improve the resident's functional abilities until the healthcare worker/ staff can complete a comprehensive assessment and develop a comprehensive interdisciplinary plan of care. When the transfer orders are confirmed with the attending physician, the physician may add or delete some of the orders provided via the transfer document. These should be documented, as appropriate, following documentation standards.

Content of the Order

The physician's order should include the medication or treatment, the correlating reason or medical diagnosis. The medication order should also include dosage, strength, the route of administration, frequency, and reason for administration should be documented in the order.

Telephone Orders

All orders that were received by telephone should be countersigned by the physician in the required timeframe as defined by state law. The documentation should indicate that the verbal order was read back and was verified with the physician. Follow your facility's policy regarding the appropriate timeframe for countersignature.

Standing Order

Standing orders have to be used with caution. Standing orders should not be used in place of notification to the physician of a change in status; the nurse has to update the physician with changes in resident's status. Some states do not allow the use of standing orders.

Transcription of Orders and Noting Orders

Transcription of orders, for example telephone orders, is the responsibility of the professional nurses (RN, LPN/LVN per the scope of practice defined by State law/practice acts), can also be delegated to a trained individual if allowed by state law or practice acts. If the transcription of order was delegated, the nurse still has to sign off on the order and retain the responsibility for accurate transcription.

When the telephone order or fax order is transcribed into the resident's medical record, it should be transcribed/ documented "verbatim" as given from the physician.

Contacting the physician and obtaining the order

Nurses, Therapists and other professionals designated to take orders has to first contact the physician to obtain the order. Each resident's medical care has to be supervised by a licensed physician. Licensed nurses are not authorized to independently write the physician orders without first contacting the physician and receive direction of the physician. It is not acceptable to write the telephone order, implement the order and then send the order for signature without contacting the physician. The nurse

practitioner and physician assistant has the authority by law and scope of practice to write orders on behalf of a physician.

Documentation regarding discontinuing an order when
a new order is obtained

Accurate and complete documentation has to be complete when the physician changes a physician order that is currently in use. The original physician order must be discontinued first then the new order has to be written that reflects the change.

Accepting orders from a Nurse Practitioner (NP)/Physician Assistant (PA)

Orders should only be accepted from a nurse practitioner or physician assistant if the state practice acts allow the nurse practitioner or physician assistant to give orders or prescribe and the attending physician has given authorization through a scope of care agreement. Both the scope of care agreement with the attending physician and a copy of the nurse practitioner or physician assistant's license should be kept on file by the facility.

Medication administration record (MAR) and treatment administration record (TAR) are derived from the physician orders. Nurses are required to document the delivery of medications and treatments, by placing their initials in the blocks of the MAR and TAR form when the medication or treatment has been administered.

Some facility requires the initials to be circled if the medication or treatment was not administered / completed and to document the reason in the medical record, with appropriate update to the physician. There should be no spaces or gaps noted in the Medication administration record (MAR) and treatment administration record documentation.

The medical record may also contain a legend that matches staff initials with full signature and title. Any medications and / or treatments given on a as needed (PRN) basis must be initialed, and the information pertaining to the need for the PRN, documented either on the back of the Medication administration record and treatment administration record or elsewhere in the resident's medical record as required by the facility's policy.

For electronic records; the Medication and Treatment Records may only have the initials on the Medication administration record and treatment administration record, either on print or view. Some electronic medication administration records (eMARs) may be able to perform audit functions at the end of medication pass to make sure that all required documentation is in place.

Documentation regarding New Medication and Treatment Records on Readmission

Documentation of medications and treatments within the resident's medical record is crucial when the patient returns from another setting such as the hospital. To eliminate possible errors in transcription or administration of medications and treatments, new medication and treatment records should be initiated with a return from the hospital rather than continuing on the

previous record. The new medication and treatment records would be based on the new orders received after hospitalization.

Documentation regarding Consents, Acknowledgements and Notices

Documentation must include an Informed Consent for the use of restraints Check with your state regarding use of restraints. Within the long-term care facility, when a restraint is being considered for a resident, the facility needs to obtain informed consent from the resident or from the resident's legal surrogate/representative. The facility has to explain the potential risks and benefits of using the restraint, the risks and benefits of not using a restraint, and alternatives to restraint all within the context of the resident's condition.

The informed consent should include:

 Explanation of how the restraint will treat the resident's medical symptoms,

 An explanation of how the restraint will assist the resident in maintaining and /or attaining his or her highest possible level of physical and/ or psychological wellbeing,

 An explanation of the negative outcomes of restraint use.

If the resident is not capable of making a decision, the legal representative or surrogate may exercise the right based on the information that would have been provided to the resident.

Documentation regarding Advance Directives

The facility has to inform all residents and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive. A written description of the facility's policies to implement advanced directives and applicable state laws must be provided to the resident or the representative.

A copy of the advanced directive should be kept in the resident's medical record. Some states utilize the Physician Orders for Life Sustaining Treatment (POLST) or Medical Orders for Life Sustaining Treatment (MOLST) as the approved method for documenting the resident's wishes for treatment. The Physician Orders for Life Sustaining Treatment is an approach to improving end-of-life care in the United States, encouraging physicians to speak with patients and create specific medical orders to be honored by health care workers during a medical crisis. The form is to be accepted by all health care providers.

Discharge Information

Discharge order

First there has to be a discharge order, the resident's physician must document that a discharge or transfer is necessary. This documentation is usually obtained by a physician order prior to transfer or discharge.

Discharge Documentation

A discharge narrative note should be written at the time of the resident's discharge and should include:

- The date of discharge,
- The time of discharge,
- The condition of the resident at discharge,
- The resident's disposition,
- The instructions, education/ training provided,
- Information regarding where the resident was discharged to, and
- The individual taking responsibility for the resident.

Discharge Summary Documentation

For the planned discharge such as discharge to another facility or to home, federal regulations require that the facility complete the discharge summary that includes:

 A concise summary of the resident's stay

 A final summary of the resident's status based on the comprehensive assessment, and

 A post discharge plan of care.

The post discharge plan of care will serve as the discharge instructions for a resident who is going home or as the transfer form for a resident going to the hospital or to another health care facility.

Content for the post discharge plan of care includes:

 A description of the resident and family's preference for care,

 how the resident and family will access the services, and

 how care should be coordinated if continuing treatment involves multiple care givers.

 Specific resident needs after discharge, such as personal care, sterile dressings, and therapy, as well as a description of resident/care giver education needs to enable the resident/care giver to meet needs after discharge. Some facilities, depending on the policy will give a copy of the discharge summary to the resident when discharged from the facility.

Resources

Center for Medicare and Medicaid Services

Hospital - Center for Medicare and Medicaid Services

Ambulatory Surgery Centers

Home Health Providers

Outpatient Rehabilitation Providers

Rural Health Clinics

Nursing Homes

Psychiatric Hospitals

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