Did I Write That?

THE PITFALLS OF DOCUMENTATION

Lisa Pando, RN, BA CCRN, CLNC, CDONA, RAC-CT, INTERACT Educator

GPS Healthcare Consultants

OBJECTIVES

- EXAMINE INACCURATE NOTES THROUGH ACTUAL NURSING DOCUMENTATION REVIEW AND DETERMINE VIABILITY
- DISCUSS LEGAL IMPLICATIONS OF DOCUMENTATION THAT ARE CONSIDERED INSUFFICIENTLY EXPLANATORY
- PROVIDE TIPS FOR TRAINING AND EDUCATION TO NURSING STAFF

5 Pitfalls to Skilled Nursing

- Not using Federal definitions
- Not understanding inter-relatedness
- Not making it interdisciplinary
- Not matching it to billing
- Not training staff

DID I DO THAT?

MEDICAL RECORD

- A PATIENT'S MEDICAL RECORD SERVES A VARIETY OF PURPOSES:
  - COMMUNICATION BETWEEN PROVIDERS WITH RESPECT TO THE CARE THEY HAVE PROVIDED
  - JUSTIFICATION OF CARE TO INSURANCE COMPANIES FOR SERVICES RENDERED
  - LEGAL DOCUMENT USED TO EVALUATE A PATIENT'S CLAIM OF DISABILITY
  - SERVES AS A FOUNDATION FOR MEDICAL MALPRACTICE
  - THAT OF A BUSINESS RECORD

MEDICAL RECORD

- EACH RECORD SHOULD PROPERLY IDENTIFY:
  - THE PATIENT
  - THE PATIENT'S MEDICAL HISTORY
  - RESULTS OF ASSESSMENTS
  - DOCTOR'S ORDERS
  - OBSERVATIONS OF PATIENT'S CONDITION
  - REPORTS OF PROCEDURES
  - **PROPERLY EXECUTED CONSENT FORMS**

MEDICAL RECORD

- THE MEDICAL RECORD CAN BE YOUR BEST FRIEND OR YOUR WORST ENEMY.
- IN THE EVENT OF A LAWSUIT THE COURTS TAKE WHAT YOU HAVE WRITTEN LITERALLY

- LET'S TAKE A LOOK…….AND PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

EXAMPLE

*DATES CHANGED FOR HIPAA PURPOSES

- 2/1/13:0900 “PATIENT VERBALIZING WANTING TO DIE”
- 2/6/13:0900 “PATIENT VERBALIZING WANTING TO KILL SELF”
- 2/9/13:0900 “PATIENT ASLEEP UNABLE TO WAKE UP-WILL CONTINUE TO MONITOR”
- 0930 “PATIENT STILL ASLEEP STILL UNABLE TO WAKE UP-WILL CONTINUE TO MONITOR
- 1130 ”PATIENT CODE BLUE/PATIENT EXPIRED”

DISCUSSION

- THOSE WERE THE ONLY ENTRIES IN THE NURSES NOTES.
- WHAT IS MISSING FROM FIRST ENTRY?
- SECOND ENTRY?
- DO YOU THINK THESE ENTRIES COULD STAND UP IN COURT? WHY OR WHY NOT?
- WHAT ARE THE LEGAL IMPLICATIONS OF THIS PARTICULAR DOCUMENTATION?

MEDICAL RECORD

- NURSES NOTES SHOULD PROVIDE THE MOST DETAILED ACCOUNT OF THE PATIENT'S DAY TO DAY CARE AND CONDITION.

- HOW OFTEN ARE NURSES MISSING THE MARK ON WHAT IS DOCUMENTED?

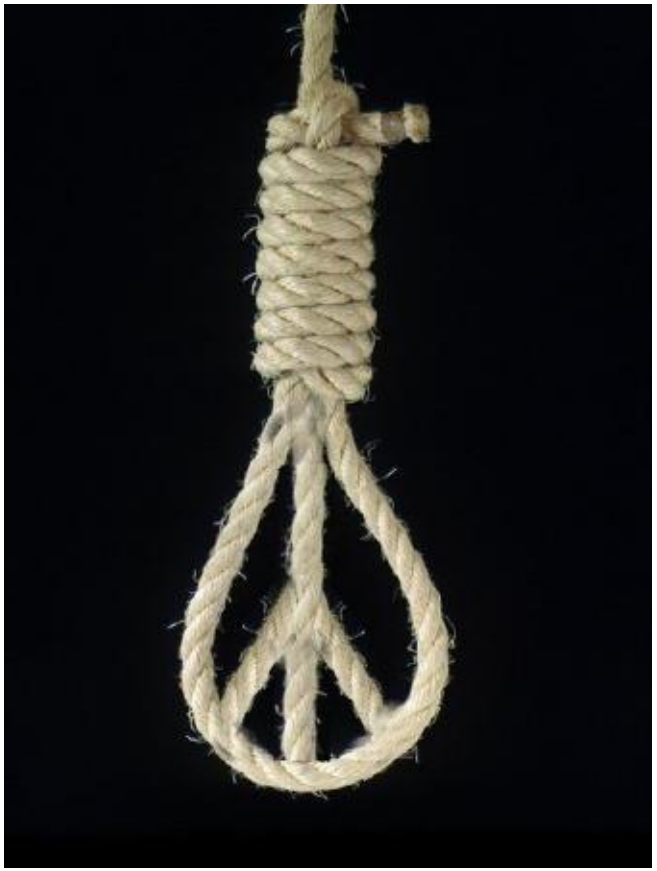
EXAMPLE

- PATIENT TOOK OFF CPAP AND HAD TUBING WRAPPED AROUND HER NECK AND PULLING IT. PLACED O2 BACK ON AT 2L

Example

You were all

Thinking it!



JIMMO VS. SEBELIUS

- Review:

http://www.cms.gov/regulations-and-Guidance/Guidance/Transmittals/Downloads/R17BP.pdf

JIMMO VS. SEBELIUS

SOME BACKGROUND:

- Glenda Jimmo was the lead plaintiff in a Class Action Lawsuit.
- She was denied coverage from Medicare for post acute services (nursing, therapy, etc.) because it was deemed her condition was “unlikely to improve”.
- Several clarifications came out of this lawsuit; however-we will be looking at the documentation piece only.

JIMMO VS. SEBELIUS

Enhanced Guidance on Appropriate Documentation-

- Portions ……now include additional material on the role of appropriate documentation in facilitating accurate coverage determinations for claims involving skilled care. While the presence of appropriate documentation is not, in and of itself, an element of the definition of a “skilled” service, such documentation serves as the *means* by which a provider would be able to establish and a Medicare contractor would be able to confirm that skilled care is, in fact, needed and received in a given case

JIMMO VS. SEBELIUS

- "We note that this material on documentation does not serve to require the presence of any particular phraseology or verbal formulation as a prerequisite for coverage although it does identify certain vague phrases like *"patient tolerated treatment well," "continue with POC,"* and *"patient remains stable"* as being ***insufficiently explanatory*** to establish coverage".

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

“APPETITE FAIR FOR MEAL”

“NO CHANGE IN PATIENT’S CONDITION”

“USUALLY COOPERATIVE WITH CARE”

“PATIENT RESTED WELL”

“WORKS WELL WITH PT/OT”

“BLADDER FUNCTION UNCHANGED”

“PO INTAKE ADEQUATE”

DISCUSSION

- ARE THESE STATEMENTS CONSIDERED ACCEPTABLE OR INSUFFICIENTLY EXPLANATORY? WHY OR WHY NOT
- WHICH STATEMENTS COULD POTENTIALLY BE DAMAGING IN A LAWSUIT?

DOINK DOINK……..

DOCUMENTATION

- WHY IS DOCUMENTION BY NURSES SO IMPORTANT?

DOCUMENTATION

- **Documentation is important to:**
  - Validate the care rendered to the patient
  - Support reimbursement for the services rendered

- Documentation is the main source of evidence that usually determines the outcome of the inquiry or the lawsuit

"If it wasn't documented, it wasn't done"

DOCUMENTATION

"The **majority** of improper payments for SNF services were due to **insufficient documentation** errors. Providers of SNF services are required to submit documentation to support the medical necessity of SNF services provided. **If supporting documents are missing or incomplete, then documentation is considered insufficient to support the services billed.** *Medicare Fee-for-Service 2012 Improper Payments Report, September 30, 2013*

DOCUMENTATION

- The critical element is that the appropriate and necessary data and information be **documented** in order to provide ***medical necessity*** justification.

- The question of proper documentation can be objective (i.e., is the documentation present?) or subjective (i.e., is the documentation sufficient?)- ***THIS IS WHERE NURSES GET INTO TROUBLE!***

DOCUMENTATION

- DOES THE NOTE SATISFY THE INTENDED PURPOSE?

DOCUMENTING JUST BECAUSE

- *PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

- “SCHEDULED MEDS GIVEN PER ORDER”
- “MEDS GIVEN LATE DUE TO PATIENT LOAD”
- “PATIENT SLEEPING-NO COMPLAINTS”
- “ADEQUATE VISION” (HX STATED PATIENT HAS GLAUCOMA)
- “RESTING, NAD, LINENS AND TRASH TAKEN FROM ROOM”

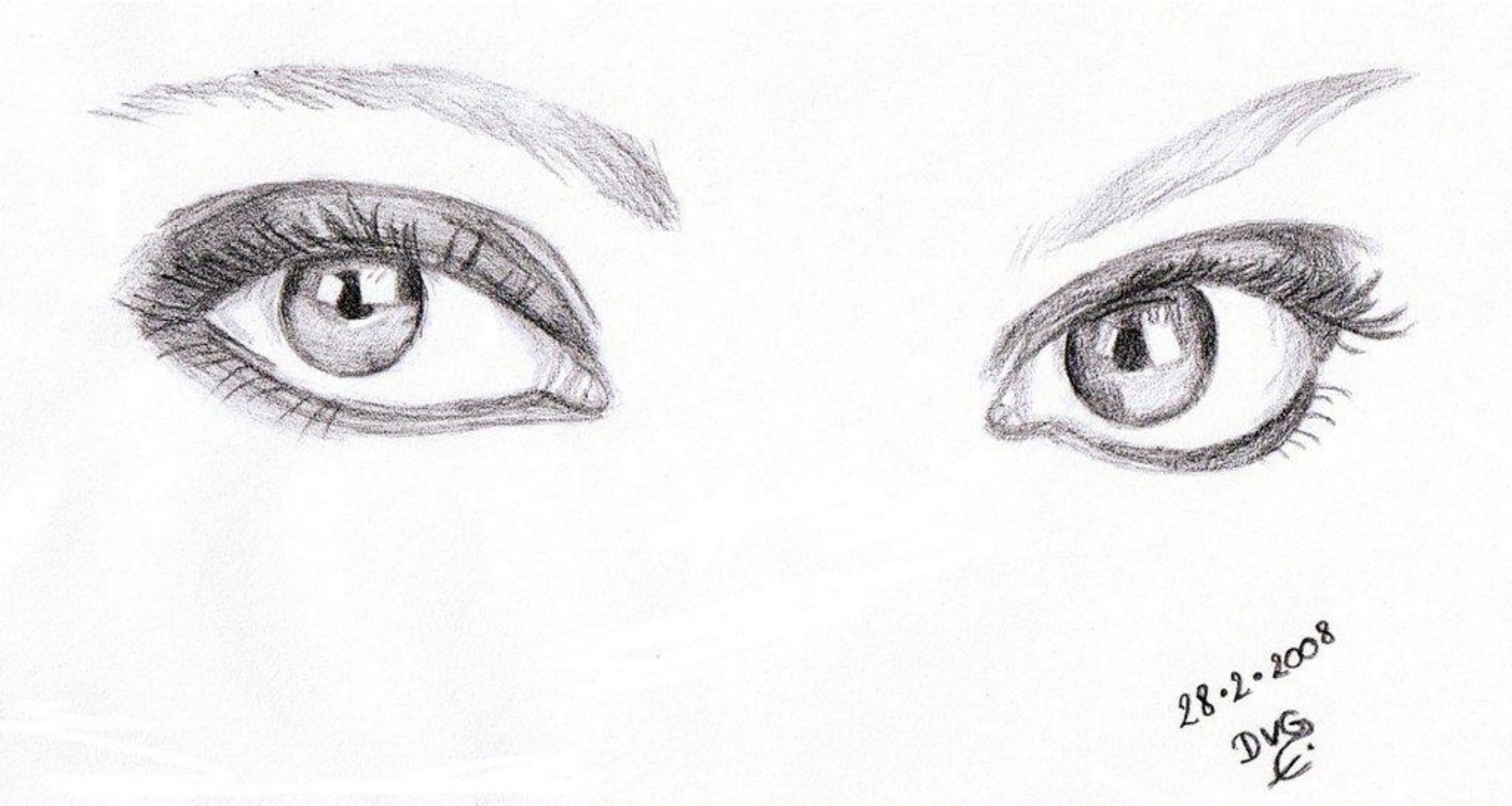
DOCUMENTATION

- RULES FOR GOOD CHARTING:
  - BE FACTUAL
  - DON'T JUMP TO CONCLUSIONS
  - AVOID MAKING GENERALIZATIONS
  - CHART WHAT YOU ACTUALLY OBSERVE
  - ALWAYS NOTE THE ACTUAL TIME FOR ANY SITUATION OUT OF THE ORDINARY
  - USE PROPER ABBREVIATIONS

DOCUMENTATION

- FOR EXCEPTIONAL DOCUMENTATION REMEMBER TO INCLUDE:
- **Who**-performing, supervising and referring practitioners
- **What** (and how many)-services and quantities of services performed
- **Where**-place of service
- **When**-Date of service
- **Why**-Medical Necessity and diagnosis

Lets look at some examples



EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

“PATIENT STATES -CAN’T YOU SEE I’VE GIVEN UP- PRAYING AND WAITING FOR GOD”

DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

“OUTBURSTS OF ANXIETY AND AGITATION-PATIENT STATES HAS PTSD”

DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

“ONLY COMPLAINS OF URINATING TOO MUCH”

DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

"RSD WAS FOUND SITTING IN FLOOR WITH W/C BEHIND HER BY NSG STAFF. TAB ALARM SOUNDING NO INJURY NOTED. RSD DENIED PAIN. RSD SELF RELEASE BELT HAD BEEN SENT TO LAUNDRY AND WAS NOT IN PLACE".

DISCUSSION PLEASE……..

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

"RESIDENT LEANS FORWARD IN W/C ALL THE TIME TO PUSH SOMEONE ELSES CHAIR. WE TELL HER NOT TO BUT SHE IS VERY DETERMINED."

DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

“PATIENT TURNED OFF BED ALARM-OOB BY SELF”

DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

“COMPLAINS OF SOB-SATS 81%, WILL MONITOR”

DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

“PO INTAKE WITHIN NORMAL LIMITS”

DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

- RES UP IN GERI RECLINER WITH TABLE TOP ATTACHED. NO S/S OF DISTRESS. VSS SKIN WARM AND DRY. LSCTA. BOWEL SOUNDS PAL. WALKED A SHORT WITH RESTORATIVE. DID NOT TOLERATE WELL."

- DISCUSSION PLEASE…….

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

- RES AGITATED THIS EVENING. SHE CONSTANTLY REMOVES TAB ALARM, TRIES TO TEAR IT UP. OFTEN THROWS IT IN THE TRASH CAN. SHE WAS IN GERI CHAIR AT NURSES STATION. AFTER MANY ATTEMPTS AT THIS SHE FINALLY BECAME SLEEPY."

DISCUSSION PLEASE…….


Did I do that?

EXAMPLES

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

- “WARM CLOTH APPLIED TO THE REDDENNED L HAND FOR COMFORT, BUT PT INDICATED AN ICE PACK GAVE MORE RELIEF, AND SO AN ICE PACK WAS PROVIDED FOR THE AREA”

- DISCUSSION PLEASE…….

But Wait …..There's more

*PLEASE KEEP IN MIND THESE EXCERPTS ARE ACTUAL DOCUMENTATION FROM MEDICAL RECORDS

- CONTINENT WITH OCCASIONAL ACCIDENTS
- IV HW TO L W INTACT, SITE CL
- TOLERATES SCHEDULED MEDS WITHOUT DIFFICULTY

And more

- RES UP IN GC W/TT ATTACHED. NO S/S DISTRESS. NO C/O PAIN. VSS STABLE. SKIN W/D. LSCTA. BS PAL IN ALL 4 QUADS. BILATERAL PPP.

One Last Item

- Spoke with dtr as res is hoh and unable to recall why in hosp. She did state her name and dtr's name. DTR signed consents and gave most info. Dtr said she was promised a sitter when she leaves @2030 by the doctor. I informed her that the doctor can not make such a promise as hospital can only supply sitter if there is an order and if a sitter is available. I told her we are a nursing home and if her mother was in_____ nursing home they would not provide a sitter.

WHAT CAN YOU DO?

- Avoid “Dangerous Documentation”
  - –TEMPLATES
  - –DOCUMENTATION BY EXCEPTION
  - –CLONED NOTES

RULES FOR GOOD CHARTING

- **BE FACTUAL**
  - Use you sense of sight, hearing and smell when you record your observations
  - Do not offer your opinion
  - Avoid making generalizations
  - Avoid using “seems”, “appears”

RULES FOR GOOD CHARTING

- **WATCH THE TIME**
  - ALWAYS MAKE NOTE OF THE TIME FOR ANY SITUATION THAT IS OUT OF THE ORDINARY
  - THE TIME THAT YOU GAVE A MEDICATION, PERFORMED A PROCEDURE OR CALLED THE MD COULD PROVE A KEY FACTOR IN A MEDICAL MALPRACTICE LAWSUIT

RULES FOR GOOD CHARTING

- **GUARD YOUR NAME**
  - MAKE SURE NOTES ARE LEGIBLE
  - SIGN YOUR NAME LEGIBLY (FIRST INITIAL, LAST NAME AND TITLE AFTER EACH ENTRY)
  - DO NOT LEAVE BLANKS SO ANOTHER NURSE CAN DOCUMENT
  - USE PROPER ABBREVIATIONS

RULES FOR GOOD CHARTING

- MAINTAIN NURSING CARE PLANS
- USE FLOW SHEETS AND CHECKLISTS
- DOCUMENT VARIANCES
- PROTECT YOURSELF

RULES FOR GOOD CHARTING

- **USE PROMPTS**
  - USING PROMPTS HELPS NURSES UNDERSTAND WHAT SHOULD BE WRITTEN, AT A MINIMUM, TO SUPPORT MEDICAL NECESSITY OF THE PATIENT STAY.

USE OF PROMPTS

- **Pain Control**
- Type of Pain: Sharp, Pounding or pressing Location, Intensity Number according to pain scale
- Presence of Pain: What time of day, during what type of
- activity
- Medication: How (P.O., I.M., I.V.) Scheduled or PRN. Is medication effective? How long does it take to relieve the pain? How long does the relief last? How often is pain medication given and/or requested in a shift?
- Other Comfort Measures provided: Position Change, Massage, Emotional Support, Diversion, Decreased Stimuli
- Observation for respiratory depression, Cognitive Changes,
- Balance and Motor Function Deterioration, Side Effects

USE OF PROMPTS

- **Orthopedic Surgery / Fracture**
- Activities of Daily Living: DESCRIBE WHAT THEY CANNOT DO
- ASSISTANCE NEEDED WITH WHAT? Bathing, Dressing, Shaving, Oral Hygiene, Bed Mobility, Toileting(Continent, Incontinent, Foley Catheter, Bladder Retraining, Constipation, Transfer(Lift, 1 -2 person) Ambulation(With or without devices walker, cane, w/c, Distance in ft.)
- Attending PT and/or OT, Frequency and time, check therapy progress notes and compare to progress on the unit
- TOLERANCE.
- Incision : Intact, Well approximated, signs of infection, Treatment
- Cast, Splint Care: Neuro / Vascular Checks
- Abductor Pillow, Hip Precautions, CPM, Polar Ice, TED Hose, PAS Stockings
- Goals set by resident and staff
- Teaching Performed to resident and/or family, Ability to Learn

Follow up!

- **READ** your Nurses documentation.
- Bring ambiguous notes to the attention of the writer.
- Point out discrepancies
- Address ***Insufficiently Explanatory*** statements
- Discuss with staff how documentation affects reimbursement
- Educate, Educate, Educate!

QUESTIONS?

LISA PANDO

GPS HEALTHCARE CONSULTANTS

LISA.PANDO@GPSHEALTHCON.COM

321-544-8819