Healthcare

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Documentation Deficiencies: Better Records Mean Stronger Defense

Sound documentation is an essential risk management tool for aging services organizations, enhancing both quality of care and legal defensibility. The healthcare information record serves, first and foremost, as the foundation for communication among providers and caregivers over time. It is also the primary means by which administrators, payors, surveyors, attorneys and others evaluate the level, consistency and effectiveness of resident care. Records that are illegible, inaccurate, lacking in detail or otherwise deficient can potentially place an aging services setting at a serious disadvantage in the event of a claim or regulatory action.

The following illustrative scenario depicts some of the potential consequences of inadequate documentation:

> *A frail male resident suffered from a variety of debilitating ailments, including early-stage dementia, and was essentially bedridden. His care plan mandated that certain steps – such as frequent turning and repositioning – be taken to prevent pressure injuries. Nurse assistants at the facility did, in fact, comply with the care plan's provisions, but they sometimes overlooked routine end-of-shift documentation duties, due to chronic staffing shortages and consequent time pressures. Although administrators were aware of widespread documentation problems, they failed to aggressively address the situation through such means as scheduling adjustments, occasional use of temporary agency staff, in-service programs, training modules and annual performance reviews.*
>
> *Over time, the resident acquired a pressure injury, which was aggravated by underlying comorbidities. Infection developed, which eventually proved fatal. His family subsequently initiated a lawsuit, alleging gross negligence on the part of the facility.*
>
> *During the trial, the plaintiff attorney argued that the care rendered was substandard, given the paucity of documentation in regard to pressure injury prevention and management. Although caregivers testified at length that they carefully followed instructions, their statements were not substantiated by the written record. The lack of accurate and complete documentation resulted in a verdict for the decedent's family and a significant damage award.*

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In today's legal and regulatory climate, all staff members must understand the importance of thorough, clear documentation. This edition of *CareFully Speaking®* presents a series of hypothetical case histories involving common record-keeping lapses, including failure to adequately document the following critical clinical information:

- **Changes in condition,** both physical and mental.
- **Skin assessment findings** and related care.
- **Medication monitoring** and reduction efforts.
- **Fall prevention** and response measures.

In order to be most useful medically and legally, vital resident and treatment data must be presented in a precise, objective and quantitative manner within narrative charting formats.

The five scenarios that follow include a range of recommendations designed to enhance the quality of documentation and minimize risk exposures associated with specific deficiencies. Sidebars discuss two related issues: managing hybrid electronic/paper record systems (page 4) and amending the record of care (page 8).

1. Changes in Condition

Even subtle physical, cognitive and behavioral signs can indicate a potentially serious change in condition or impending crisis. For this reason, detecting, reporting and accurately documenting alterations in resident health status are among a nurse's most important duties, especially regarding fluctuations and disruptions in residents' vital signs, weight, mental status, appetite, urinary and bowel elimination patterns, skin condition and level of pain. Consider the following scenario:

> *After testing positive for a* Clostridium difficile *bowel infection, an 80-year-old male resident was started on an antibiotic. The resident healthcare information record notes that he had frequent runny stools, but does not indicate a compensatory increase in fluid intake. The resident's blood pressure remained stable, but his pulse rate surged from 70 to 100 beats per minute, a change detected only after 24 hours had elapsed. By this point, the resident had developed a high fever, necessitating transfer to an acute care hospital and a lengthy intensive care stay. The resident's family subsequently – and successfully – sued the aging services organization for hospitalization costs incurred, as well as for associated physical suffering and emotional distress.*

Facilities cannot closely monitor every resident on a 24/7 basis, but they can implement certain basic risk control strategies to help staff notice changes more quickly. First, caregivers should be assigned to the same residents, whose baseline status they know. Second, regular care team meetings should be held, enabling staff members to discuss past episodes of illness, as well as to make shift-to-shift comparisons of resident health issues and response to interventions.

The following additional measures can help staff members improve their skills with respect to observing and documenting changes in resident condition:

- **Review existing documentation formats** – both hard copy and electronic – to ensure that they capture the following significant problem signs, among others:

Physical changes:	Behavioral/cognitive changes:
Audible difference in breathing rhythm.	Decreased socializing.
Alterations in body temperature, blood pressure and/or heart rate readings.	Slurred speech or other signs of declining verbal ability.
New onset incontinence, unfamiliar urine smell or changing urinary frequency.	Loss of appetite and reduced interest in meals.
Shift in frequency or composition of bowel movements.	Modified sleep patterns, including dozing off more often during the day and/or interrupted nighttime slumber.
Discolored, swollen or broken skin surfaces.	Increased confusion, agitation and/or disorientation.
Signs of weakness in extremities, including inability to raise arms.	Diminished mobility, including complaints, grimacing, or other signs of pain or discomfort upon transfer.

- **Adopt a standard early warning tool** to facilitate staff observation and notation of changes in resident condition.
- **Consistently utilize an abbreviated documentation format,** such as SBAR (i.e., **S**ituation, **B**ackground, **A**ppearance, **R**eview or Recommendation), which is designed to help staff describe and convey observed changes more clearly and concisely.
- **Train staff in the TeamSTEPPS "I PASS the BATON" strategy** for safer resident transfers. (See Activity #2 within the linked site.)
- **Implement a "Situational Monitoring" program** to enhance responsiveness, teamwork and communication among staff.
- **Encourage receptionists, therapists, social workers, housekeeping staff, volunteers, visitors and others to serve as "ancillary observers,"** reporting real or suspected changes in residents to members of the clinical team.

2. Skin Assessment and Care

The accuracy and completeness of skin care-related documentation is often the determining factor in lawsuits involving pressure injuries. Consider the following scenario:

A 72-year-old female resident with several comorbidities – including obesity, diabetes, hypertension, kidney disease, chronic anemia and venous disease – grew increasingly confused and bedridden following admission. Her initial skin assessment revealed no bruising or wounds. However, by week eight, two pressure injuries in the sacral region had been documented and staged at I and II. Notwithstanding an organizational emphasis on documenting pressure injuries, the healthcare information record was lacking in several areas, including the following:

- ***No severity ranking of risk factors for pressure injury development could be found,*** *although written policy directed staff to compile such a list upon admission.*
- ***The timeline of care was unclear,*** *making it impossible to determine exactly when the resident had been turned, cleansed and repositioned.*
- ***Notes were handwritten and difficult to read,*** *with many sections of the nursing commentary and flow sheets left incomplete.*
- ***Some orders appear to have been overlooked,*** *including one for a pressure redistribution mattress.*
- ***Wound photographs were mislabeled*** *and out of sequence.*
- ***There was no indication that the resident's family had been informed of the situation*** *and educated about pressure injury prevention and treatment.*

The resident ultimately required surgical debridement of worsening injuries, followed by a six-month skilled rehabilitation stay. A lawsuit was filed, alleging that nurses failed to properly assess and monitor wounds, communicate significant findings to supervisors and document treatment in accordance with the facility's pressure injury protocol. Lacking written supportive evidence of therapeutic measures taken, the defendant organization decided to settle the claim for a significant sum.

Prompt, thorough and clearly documented skin assessments are critical to legal defensibility in the event of a pressure injury-related lawsuit. The following measures, among others, can help improve resident outcomes while minimizing risk:

- **In written policy, specify the party responsible for performing the first skin assessment** and initiating the skin care-planning process.
- **Draft a protocol indicating when a wound care specialist must be consulted** for further skin-related evaluation and treatment purposes (e.g., for injuries classified as Stage III and above).
- **Perform an initial head-to-toe skin assessment upon resident admission,** documenting skin color, temperature, sensation, moisture, integrity and turgor, as well as the presence of pressure injury risk factors, such as reduced mobility, diabetes, hypertension and peripheral vascular disease.
- **Utilize the Braden Scale or Norton Plus Pressure Ulcer Scale** to gauge the risk of pressure injuries.
- **Answer all prompts on standard skin assessment and wound care checklists or flow sheets,** responding "not applicable" or "not assessed" when necessary, rather than leaving any areas blank.
- **Write legibly in hard-copy records,** using approved medical terminology and abbreviations.
- **If a wound is detected, identify its probable cause,** or note in the record that it is of unknown origin. For guidance on determining and documenting root causes, see the Root Cause Analysis Toolkit, which is available for purchase from the National Pressure Injury Advisory Panel. (See also this related instructional video on conducting a root cause analysis of a pressure injury.)
- **Compile a detailed record of wound assessments,** including such characteristics as location, dimensions, and presence of drainage or odor, as well as response to treatment interventions. For example: "*Left posterior calf wound measures 1.7 cm x 2.3 cm. Wound bed is beefy red in appearance with serosanguineous drainage, no foul odor. Condition improving, resident ambulates from room to recreational area twice daily with assistance of a walker.*"
- **Ensure that authorized photographers and nursing staff are conversant with written policy on wound photography and documentation requirements,** including such critical issues as patient identification, body positioning, image-capture technique and photo dating. (See CNA *AlertBulletin*®, "Photographic Wound Documentation: Digital Imaging Guidelines Help Minimize Exposure," republished 2017.)

- **Record all support services provided for wound care,** such as use of special mattresses or hydrotherapy sessions, and document when such resident care initiatives are begun, modified and terminated.
- **Perform multidisciplinary assessments on challenging wound care cases,** soliciting feedback from physicians, nurses and nursing assistants, as well as nutritional and rehabilitation personnel.
- **If wound healing is impaired, note the reason(s), such as diabetes or other underlying medical condition,** nutritional deficits, non-adherence to the treatment plan and/or hospice care status.

Perform **multidisciplinary assessments** on **challenging wound care cases**, soliciting feedback from **physicians, nurses** and **nursing assistants**, as well as **nutritional** and **rehabilitation personnel**.

Managing Hybrid-type Resident Care Records

Many aging services organizations utilize "hybrid" – i.e., part paper, part digital – resident care records while they adapt to an electronic healthcare record (EHR) system. During this phase, staff members' basic computing skills should be evaluated, as well as their readiness to navigate between paper and electronic formats. Lack of transitional planning and training can lead to confusion and errors, potentially hobbling EHR initiatives even before they are fully implemented.

The following risk management strategies can help safeguard against loss or compromise of important information when moving toward electronic records:

- **Determine the components of the healthcare record that will remain in paper form during the transition to EHR** and devise policies to protect, preserve and eventually digitize written notes and data.
- **Create written parameters for use of paper notes in the hybrid record,** and require all staff to use the paper format for these designated types of information, in order to reduce the risk of duplication, inconsistency or omission across paper and electronic systems of documentation.
- **Train staff to record resident information in a clear, accurate and timely manner** – especially in key areas such as medication administration, allergy notation, care planning, skin condition and care, and follow-up on lab and diagnostic reports – whether using a digital or paper-based system.
- **Ensure that staff members possess necessary computer-related competencies before proceeding with EHR implementation.** If necessary, assign IT staff to unit settings to assist during the transitional period, or contract with outside training consultants.
- **Acknowledge the increased workload and professional development implications of a newly implemented EHR system,** and provide useful support in the form of a call center, continuing hands-on training sessions and/or reduced work loads for caregivers during the transition period.

For more information about the practical and legal considerations involved in evolving toward an electronic record system, see "EHRs as the Business and Legal Records of Healthcare Organizations, Appendix A: Issues in Electronic Health Record Management," from the American Health Information Management Association.

3. Medication Monitoring and Reduction

Aging services organizations have a duty to protect residents from unnecessary and potentially dangerous drugs, especially psychotropic medications used to treat dementia and other mental health conditions. In the event of a medication error and subsequent lawsuit, the resident healthcare information record is scrupulously examined by plaintiff attorneys to determine whether providers evaluated the possible side effects and adverse interactions of prescribed drugs, and discontinued them when clinical risks became apparent. Consider the following scenario:

> *A 68-year-old male resident suffering from depression, anxiety and schizophrenia became increasingly combative. After an extended episode of unmanageable aggression, he was given numerous oral doses of an antipsychotic medication, central nervous system depressant and sedative over the course of a few days. This drug cocktail induced temporary paralysis, requiring an extended hospital stay. The resident subsequently filed a lawsuit against the aging services organization for damages related to overdose.*
>
> *During the discovery process, the resident healthcare information record was found to be missing a signed informed consent form for administration of the psychotropic medications, as well as the following key components of an effective medication regimen review:*
>
> - ***The clinical rationale for drug dosing in excess of manufacturer's recommendations,*** *and also for the concurrent use of two or more medications in the same pharmacological class.*
> - ***Duration orders*** *for PRN (i.e., taken as needed) medications.*
> - ***Resident response*** *to initial dosing.*
> - ***Orders to monitor the resident*** *for potential side effects, interactions or other complications while the psychoactive medications were being administered.*
>
> *Due in part to the fact that the written record of care provided only meager support for the legal defense team, the organization settled the claim for a mid-six-figure amount.*

To minimize the likelihood of allegations such as missed drug intoxication and failure to monitor, caregivers should assess residents' usage of prescription pharmaceuticals, over-the-counter products and dietary supplements during the intake process, regularly thereafter and upon readmission from inpatient stays.

The following additional strategies can help providers and caregivers enhance prescribing and monitoring practices and reduce the incidence of harmful polypharmacy and consequent allegations of medication mismanagement:

- **Establish a policy for assessing residents' response to medications,** such as every shift for up to 72 hours subsequent to the initial dose. Documentation should focus on the following questions, among others:
  - *Why was the medication prescribed,* and has it been effective in meeting therapeutic objectives?
  - *Are there any indications of distress* and, if so, what are the precise symptoms and when did they begin?
  - *What are the resident's vital signs,* and are they stable?
  - *Has the medication produced or contributed to any adverse physical or psychological effects,* such as unexplained bleeding or bruising, functional decline, falls, headaches or dizziness, increased agitation or other mood alterations, or abrupt weight gain or loss?
  - *Have standard follow-up lab tests been performed* – e.g., INR testing related to warfarin administration – and the results reviewed by providers?
- **Review medication regimes monthly and document the status of all prescriptions,** especially potentially hazardous types of drugs, such as opioids, psychotropics, anticoagulants, diuretics, insulin and antibiotics.
- **Clearly note accepted clinical indications for use of each drug,** as well as the specific signs, symptoms or conditions that require initiation or continuation of medication therapy.
- **If medication frequency or dosage is altered, note the reason,** e.g., illness, change in condition, drug reaction, resident refusal or transfer to inpatient setting.
- **Adhere to a system of gradual dose reduction for psychotropic medications,** unless clinically contraindicated, and document non-pharmacological approaches attempted in lieu of drug-based therapy. (See Matthew, R. et al. "An Electronic Template to Improve Psychotropic Medication Review and Gradual Dose-reduction Documentation." *Federal Practitioner*, October 2016.)
- **Require attending physicians or other prescribers to periodically evaluate residents and determine whether PRN medication orders remain clinically necessary,** as well as to document related signs of improvement in residents and the rationale for continued use of these drugs.

4. Fall Prevention and Mitigation

Aging services organizations are required to assess falling risk, develop preventive plans for residents who are prone to falls, implement precautionary measures and train staff to respond properly when falls do occur. A healthcare information record lacking evidence of sound care planning can seriously hamper legal defense efforts. Consider the following scenario:

A 78-year-old female resident with advanced dementia, who relied on a walker to ambulate and had a long history of incontinence, slipped on a wet spot next to her bed and fell, fracturing her hip. She required surgical hip replacement, followed by an extended rehabilitation stay. The resident's family filed a lawsuit asserting that the aging services organization had failed to provide adequate supervision, adjust her bed to a safe height and install basic safety equipment, such as anti-wander alarms, bed brakes and proper bed rails. In addition, the resident's healthcare information record revealed that her fall prevention plan had not been updated for two years despite previous falls, including one that resulted in a fractured elbow. Nursing notes omit any reference to hourly resident safety checks, while detailing periods of short staffing and overcrowding. After mounting an unsuccessful defense, the organization ultimately paid both actual and punitive damages to the plaintiff in an atmosphere of negative media attention.

The following actions can help enhance documentation of fall-related safety measures and strengthen the organization's legal defense posture if a claim is filed:

- **During the admission process, evaluate all residents for fall risk and degree of mobility,** utilizing such tools as the Johns Hopkins Fall Risk Assessment Tool, Morse Fall Scale or Timed Up & Go (TUG) Test.
- **Draft individualized care plan interventions** – including staged and progressive activity plans, ambulation programs and rehabilitation referrals, when needed – for residents with impaired judgment, mental illness and/or a history of bone weakness and fractures, and document the effectiveness of these measures.
- **Describe hourly safety rounds** in the resident healthcare information record, using a checklist or other user-friendly format to capture the "five P's":
  - *Pain level* and associated medication requirements.
  - *Personal needs,* including hydration/nutrition and toileting.
  - *Position of body* and turning schedule for immobile residents.
  - *Placement of personal items* within easy reach of the bed.
  - *Prevention of falls* through use of basic safety equipment, including call lights, urinals and walkers.
- **Adopt a standard shift report format** that draws attention to fall risk factors and resident safety needs.
- **Avoid referring to staffing problems** or including potentially incriminating statements in nursing notes, e.g., *"We were down two nurses on my shift"* or *"I was on break when the fall happened."*
- **Conduct retrospective reviews of injury-causing falls,** utilizing a post-fall huddle investigation worksheet. (Note that this and other quality improvement worksheets are not intended to become part of the healthcare information record.)

5. Objective, Comprehensive Charting

In the event of a claim, effective legal defense depends upon factual, objective documentation. Plaintiff attorneys will seize upon any ambiguity or other deficiencies in the written record to raise questions about the quality of resident care. Consider the following scenario:

An 88-year-old female resident with a history of chronic obstructive pulmonary disease developed an upper respiratory cough and complained of shortness of breath (SOB). She was given nebulizer treatments over the course of 12 hours, but her SOB worsened. As her condition continued to decline, she developed a high fever, and was promptly transferred to an acute care setting. A chest X-ray revealed bilateral pneumonia, necessitating admittance to the intensive care unit, where she was intubated. Notwithstanding the best efforts of medical personnel, she eventually succumbed to the underlying infection.

Family members brought a lawsuit against the aging services organization and various caregivers, alleging negligent care. During discovery, the resident's healthcare information record was examined and found to be riddled with vague and unprofessional statements, as demonstrated by these back-to-back narrative charting entries:

- *20:45 – Resident received nebulizer treatment for complaints of SOB. Tolerated treatment well. RR [respiratory rate] appears stable. Resident grew agitated and slapped me. Told her not to be nasty and calm down. PRN Xanax given.*
- *21:45 – Condition OK. Will continue with POC [plan of care]. Resident expected to improve by morning.*

As a result of inadequate documentation, the organization could not establish a strong legal defense and agreed to a substantial settlement.

Narrative charting is one of the most familiar methods of documentation, enabling staff to document resident care in a cohesive, chronological and readable manner. However, the format's effectiveness can be compromised by a lack of concrete detail and inclusion of personal opinions, emotions, interpretations and judgments. This common problem can be seen in the scenario above, which contains the following documentation lapses, among others:

- **The phrases "tolerated treatment well" and "appears stable" should be supported by solid clinical data,** e.g., the number of respirations per minute and color of the resident's skin, as well as a note on whether breathing is labored and airways are patent.
- **The description of the resident as "nasty" is emotionally charged** and inappropriate for the healthcare information record.
- **The notation about the medication administered on a PRN basis is incomplete,** as it lacks any description of the drug's effectiveness and the resident's response.
- **The phrase "Condition OK" lacks substance and specificity,** as does the nurse's comment that the resident is expected to improve.

For documentation to be most useful, assessments must contain objective information – i.e., a succinct account of what caregivers see, hear, feel and smell – along with corresponding clinical data. Established methods of narrative charting – such as SOAP (i.e., **S**ubjective, **O**bjective, **A**ssessment, **P**lan) and F-DAR (i.e., **F**ocus, **D**ata, **A**ction, **R**esponse) – are designed to enhance documentation proficiency by lending a clear, uniform structure to factual observations, conclusions and plans of care. The following additional measures can further aid caregivers in drafting more consistent, detailed and cogent chart entries:

- **Document positive assessment findings, as well as significant negative ones,** e.g., *"BP is low – 92/60. Resident has no complaints of dizziness upon standing up and is steady when ambulating."*
- **Describe signs and symptoms using objective measurements,** e.g., *"Weight 179 pounds, increase of 2 pounds from 5 days ago. 1+ pitting edema in left lower extremity. Right lower extremity, no edema. Slight wheeze heard in left lower lobe. Resident states, 'I'm tired.'"*
- **Include actions taken and/or changes made to the resident care plan,** e.g., *"Will assess lung sounds once per shift and weigh resident daily. Lasix 40 mg increased to twice a day."*
- **Support observations and conclusions with clinical findings,** e.g., rather than simply noting *"condition improving,"* explain that *"condition improving as indicated by …."*
- **Refrain from using vague or overly broad terms and phrases,** e.g., *"normal," "resident had a good night/day," "appears to be healing," "generalized weakness"* and *"voiced no complaints,"* among others.
- **When describing resident behavior and interactions with staff, be specific and avoid expressing personal feelings and judgments,** e.g., instead of noting that *"resident is out of control and acting out,"* state that *"resident is slapping caregivers and yelling 'leave me alone.'"*
- **Avoid making entries that contradict prior therapeutic documentation,** e.g., a therapist notes, *"Resident ambulated 25 feet to shower with 1 assistant and independently washed upper body,"* while a nurse observes about the same resident, *"Continues non-weight-bearing status. AM care provided in full by nurse's aide."* (If earlier entries seem inaccurate, bring the discrepancy to the attention of a supervisor.)
- **Do not argue with or criticize other providers on record, or include negative statements about the facility,** e.g., *"Dr. Jones ordered a different drug today, although it has not helped in the past"* or *"The shift is short two CNAs for the third straight day."*
- **Describe all efforts to educate residents and family members about self-care requirements,** including their response to training and instances of noncompliance, e.g., *"Provided resident with pamphlet on diabetic foot care. Emphasized importance of daily inspection of soles of feet using a hand mirror. Informed resident and wife to report to staff or doctor any breaks in the skin of the feet. Resident returned demonstration and indicated he understood what changes or problems to report. However, resident refuses to apply skin lotion to lower extremities on daily basis as prescribed, stating 'it smells bad.' Reiterated the importance of keeping skin clean, dry and lubricated."*

Sound documentation is a key sign of a well-managed aging services facility, one that focuses on delivering quality care and employs a competent, conscientious and well-trained workforce. By ensuring that staff members maintain an accurate, comprehensive, timely and professional record of the changing condition of residents and the care they have received, leaders help reduce the possibility of miscommunication and consequent error, while significantly bolstering the organization's defense posture in the event of later legal action.

Amending the Record of Care

In the event of litigation, haphazard amendment of resident healthcare information records – even if well-intended – may appear as a form of evidence tampering, potentially compromising an aging services organization's legal position. Caregivers should be taught appropriate amendment procedures, in order to ensure that *corrections* (which remedy errors), *late entries* (which add relevant information unintentionally omitted from the original notation) and *addenda* (which provide information not known at the time of the original entry) clarify residents' health status and precisely describe the care and therapy they have received, without weakening defensibility.

Written policy should include these essential guidelines for amending hard-copy records:

- **Insert late entries and addenda into the current day's record,** rather than writing them in the margin of the original entry.
- **Sign late entries,** noting date and time, and indicate that they correspond to an earlier record using the following verbiage: *"Late entry to the original notation from [date]."*
- **Label addenda clearly** and indicate that they contain additional information, e.g., *"Addendum: the following information was not included in the original documentation on [date] because of [reason for the delay]."* Sign addenda and include date and time.
- **Correct entries by drawing a single line through the original erroneous content** and writing the modified entry into the current day's record. Sign revisions, indicating date and time.
- **Never cover over original content when making a correction,** or attempt to mask any part of the initial entry with correction fluid.

Electronic healthcare records (EHRs) help simplify the amendment process by automatically identifying entries by author, date and time. However, EHR products differ, and administrators should ensure that the system they are using incorporates the following risk control features:

- **Original content cannot be deleted** or overwritten by amendments.
- **Records are automatically flagged when revisions are made,** and amendments are linked electronically to the original entry for easy reference.
- **Amendments are clearly labeled** as corrections, late entries or addenda.
- **Users are prompted to include the rationale for any modification of the record** or addition of new information.
- **Revisions made to original entries are tracked** to facilitate record audits.

The following strategies can help reinforce staff consistency when modifying hard-copy or digital records:

- **Strictly prohibit falsification of resident healthcare information records,** such as changing dates, deleting information or failing to properly indicate emendations.
- **Do not permit changes to records requested by a government agency** or involved in any ongoing or potential litigation.
- **Always notify the original author when amending another caregiver's documentation,** and obtain his/her signature, indicating approval of the revision.
- **Specify in written policy the acceptable circumstances and appropriate time frame for amending records.** The sooner an entry is revised, the more likely it is to be perceived as trustworthy. Changes made more than 30 days after the event are generally considered questionable as evidence.
- **Ensure that amendment-related protocols and procedures comply with relevant federal laws and regulations,** including the HIPAA Privacy Rule and Centers for Medicare & Medicaid Services requirements, as well as state laws regarding licensure of healthcare facilities and nurse practice acts.

Quick Links

- *AHIMA's Long-term Care Health Information Practice & Documentation Guidelines.* American Health Information Management Association, 2011.
- Bjarnadottir, R. et al. "Implementation of Electronic Health Records in U.S. Nursing Homes." *CIN (Computers, Informatics, Nursing)*, August 2017, volume 35:8, pages 417-424.
- "Falls Investigation Guide Toolkit: How-To Guide." Nursing Home Expert Panel, Oregon Patient Safety Commision, 2017.
- Krasner, D. "Wound Documentation Dos & Don'ts: 10 Tips for Success." *Wound Source*, posted January 25, 2018.

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