Healthcare

CAREFULLY SPEAKING®

A Risk Management Resource for Aging Services | 2022 Issue 2

Resident Documentation: Creating a More Useful Record of Care

The resident care/service record serves a variety of purposes for aging services organizations. It exists primarily to ensure continuity of care. In fact, comprehensive documentation is a prerequisite for the provision of a well-coordinated, responsive array of resident services.

The record also serves as a legal document, satisfying professional and regulatory requirements and becoming the first line of defense against allegations of substandard care. These two functions are intimately linked, as a care/service record that demonstrates a dynamic and all-encompassing concern with continuity of care is significantly easier to defend in court than one that lacks such a focus.

In the event of a claim, the record will prove useful to the extent that it contains accurate and objective resident assessments, pertinent observations by all relevant providers, descriptions of staff interventions focusing on resident needs and deficits, and an overall impression of sustained attention and concerted effort. Specifically, the record should offer proof of the following attributes of quality resident care:

- **Staff compliance with the care/service plan,** including dates and times of services rendered.
- **Continual monitoring of the resident's health status**, including prompt recognition of changes in condition and responses to treatment and care.
- **Close coordination among care team members** from relevant disciplines.
- **Ongoing communication among caregivers** and with residents and families.
- **Evidence-based standards** guiding the delivery of care.

In this issue…

The value of an accurate, comprehensive resident record is universally acknowledged. However, staffing, training and operational problems can adversely affect documentation, potentially increasing liability exposure for both providers and organizations. (See "Some Systemic Causes of Documentation Errors" on page 2.) In fact, according to the CNA Aging Services Claim Report: 11th Edition, inaccurate or incomplete records are a common factor in high severity professional liability claims, such as those involving pressure injuries and resident falls, with an average total incurred indemnity of $252,757 and $226,813, respectively.

This edition of *CareFully Speaking*® focuses on those aspects of resident care/service most vulnerable to documentation deficiencies, ranging from placement determination and risk assessment to medication therapy and changes in condition. For each high-risk area, documentation "must-haves" are noted, including practical strategies to maximize the record's accuracy and clarity, as well as its functional and legal usefulness.

Placement Suitability

Aging services administrators and providers must clearly notify residents and family members of facility capabilities and service limitations, and inform them of conditions that may require transfer to a higher acuity setting.

Must-haves:

Resident placement screening. Accurate screening and assessment of prospective resident needs can help reduce the potential for later placement-related conflicts and litigation. In order to enhance placement decisions, utilize a standard selection screen that captures essential information about the individual's strengths and limitations, focusing on the following areas of concern, among others:

- **Overall health status,** with special attention paid to comorbid conditions.
- **Medication use,** including antipsychotic or anti-anxiety drugs taken for behavioral control.
- **Cognitive patterns,** especially the capacity to make consistent and independent decisions.
- **Sensory patterns** regarding deficits involving sight, hearing or speech.
- **Behavioral patterns,** noting tendencies toward agitation, aggression, wandering and/or exit seeking.
- **Assistive devices needed,** such as daily reliance on canes, walkers and wheelchairs.
- **Functional performance,** especially the ability to eat, groom, bathe, ambulate, use the toilet, dress and transfer by oneself.

LeadingAge™ offers a four-part tool designed to aid in assessing the health and functional status of prospective residents.

Aging services administrators and providers must clearly **notify residents and family members** of facility capabilities and service **limitations**, and inform them of **conditions that may require transfer** to a higher acuity setting.

Disclosure of service limitations. Written disclosure statements for residents and family members should present current capabilities and service offerings in a realistic manner, in order to avoid allegations of misrepresentation. For example, in lieu of promising a "safe environment" or "superior care," note available security features or that licensed staff members are on duty 24 hours a day.

Transfer conditions. Blanket statements implying that a resident may remain indefinitely in the setting invite unrealistic expectations and potential future conflict. Inform residents and family members early in the admissions process that relocation may be necessary as healthcare needs change. Admission contracts should delineate the circumstances – such as the onset of wandering or other unsafe behaviors, or a change in medication therapy mandating closer nursing supervision – that may require transition to another service level. In addition, clearly explain to prospective residents and families that state licensing laws may require transfer if the facility's staffing and resource levels diminish, or resident needs exceed facility capabilities. If such a move becomes necessary, describe the transfer process and related costs.

Some Systemic Causes of Documentation Errors

A pattern of substandard documentation may reflect underlying organizational problems, as noted below:

- **Shortage of qualified nursing care staff,** which may result in incomplete or missing documentation, improper addition of late entries and information entered into the wrong resident chart.
- **Inadequate training in the documentation process,** which may result in inclusion of subjective observations, use of confusing abbreviations, and failure to sign and date non-digital entries.
- **Lack of critical thinking in the nursing care process,** which may result in failure to question confusing or problematic physician orders and to document clinical reasoning when altering a routine.
- **Technological obsolescence,** which may result in miscommunication due to illegible handwriting or use of unapproved and misleading abbreviations in hard copy documentation formats.
- **Poorly designed environment of care,** which may result in frequent distractions and consequent gaps in documentation.

Resident Safety

Protecting residents from injuries requires thorough assessment of functional and cognitive levels, documentation of proclivity for high-risk activities and inclusion of targeted interventions within the care plan.

Must-haves:

Baseline assessment of functional and cognitive levels. Falls and wandering are among the leading causes of resident injury and associated liability. In order to provide residents with the clinical and environmental safeguards they need, staff must first complete a thorough, documented analysis of the resident's physical and cognitive status, which includes the following information:

- **Evidence of dementia, incontinence or other conditions** that may predispose a resident to engage in hazardous activities, such as wandering, exit seeking or ambulating without needed assistance.
- **Onset, frequency and duration of risky behavior,** as noted by family members and caregivers, or through review of past medical records.
- **Precipitating factors for high risk behavior,** such as certain events or times of day.
- **Symptoms of underlying depression,** agitation, anxiety or other emotional disorder.

Also note personal insights about the nature and possible motivations for potentially harmful behavior, such as whether the repeated activity appears random or goal-oriented.

Customized interventions. Resident care plans should be tailored to known deficits and incorporate the least intrusive safeguards that are compatible with the resident's well-being. The following planning tips can help balance resident safety and autonomy, while also enhancing legal defensibility in the event that a claim arises:

- **Avoid computer-generated plans** that are overly generic and focus solely on core problems.
- **Identify the subjective feelings or sensations** – e.g., hunger, thirst, incontinence, confusion, anxiety, restlessness, or isolation and boredom – that appear to motivate the resident's non-compliant behavior, and implement and document focused interventions.
- **Offer alternative care possibilities or therapies when available,** such as flexible instead of standard meal times, and honor the resident's right to refuse certain interventions.
- **Include family members in the care/service planning process** and document their approval of the plan.
- **Review the plan's effectiveness on a quarterly basis** (or more frequently, if required by state regulations or changes in the resident's condition), noting in the care/service record whether offered services have helped the resident maintain a desired level of physical, mental and psychological well-being.

Safety checks. Conduct routine, documented safety checks of the resident care environment, in order to ensure that …

- **Residential areas are clean,** clutter-free and sanitized on a routine basis.
- **Hallways are clear and well-lighted,** as are stairways, foyers and other trafficked areas.
- **Bathrooms have dry floors** and sturdy grab bars.
- **Resident alarms and tracking devices are operational,** as are door and window locks and boundary lasers.

Skin Integrity

The resident record should include findings from skin assessments performed upon admission and regularly thereafter, as well as documentation of pressure injury evaluation and treatment, including notations by wound care specialists and/or contracted skin care providers.

Must-haves:

Prompt initial skin evaluation. Complete a skin assessment upon admission, utilizing a well-established risk assessment tool, such as the Braden Scale for Predicting Pressure Sore Risk or Norton Plus Pressure Ulcer Scale. The following additional strategies can help strengthen wound documentation:

- **Do not delay the initial evaluation.** The more time that elapses between admission and assessment, the less credible are defense claims that the wound was already present or unavoidable. The assessment should accurately describe all pre-existing wounds and their probable cause(s), such as comorbid conditions, poor nutritional status or end-of-life complications.
- **Complete an independent skin assessment.** Do not blindly accept the findings of the referring physician or home care provider. Conduct a comprehensive evaluation, including the resident's head, feet and other potentially overlooked areas.
- **Accurately stage wounds.** Strictly adhere to standard staging criteria, such as those promulgated by the National Pressure Injury Advisory Panel. If possible, use high-frequency/high-resolution ultrasound to reveal skin changes under the epidermis that may not be visible to the naked eye.

- **Complete assessment forms in their totality.** Empty spaces can give the impression that an assessment is incomplete. All inapplicable fields should be indicated as such.

Ongoing wound evaluation. The use of vague, non-descriptive terms when describing a wound potentially weakens both coordination of care and defensibility, as do gaps in care-tracking flowsheets and missing assessment dates or wound measurements. Entries that fail to mention ongoing support services provided for wound care, such as specialty mattresses and hydrotherapy, or that do not describe the effectiveness of implemented measures, are similarly problematic from both a resident care and legal perspective.

Specialist referrals for non-healing wounds. Absence of documented consultations with a certified wound care expert can impede treatment and compromise legal defense in the event of a claim. Request referrals whenever wounds are slow to respond to therapy, and especially for injuries classified as Stage 3 and above.

Contracted care documentation. Multidisciplinary feedback on challenging wounds is essential to effective treatment and legal defensibility. Document the credentials, experience, education and training of all independent skin care contractors who work for the organization, and require them to note the care they provide in the resident record.

Falls Prevention

Detailed fall risk assessment and history, initial screening for risk factors and a customized care plan can help protect residents and reduce exposure to lawsuits. In the event of a fall, scrupulously document post-fall care provisions, as well as measures taken to mitigate injuries and prevent recurrence.

Must-haves:

Fall evaluations. In malpractice trials, jurors are often instructed to view fall assessment and prevention as a continuous process, as opposed to a one-time screening upon admission. Therefore, residents must be examined upon admission and readmission, as well as following a fall or any change in condition. In addition, assessment findings must be included in resident care/service records.

Historical falls and compliance expectations. Resident admission records should note the number of falls sustained in the 12 months prior to admission, as well as dates, details, assistive devices used at the time of the fall and any post-fall treatment. If a resident fails to comply with safety expectations, schedule a documented family meeting to inform family members of the need to adhere to rules and expectations, as well as the risks of continued noncompliance.

Resident self-safety awareness. In addition to documenting communication with family members, note in the record the resident's own degree of safety awareness, including the need for consistently using a walker, cane or other ambulatory/transfer aid.

Documenting Resident Falls

The following tips are aimed at helping staff document falls in a more comprehensive and useful manner:

1. **Notify the primary care physician,** charge nurse and family representative, and document these communications.
2. **Provide a detailed account of the incident,** describing *where* the resident fell, *how* the fall occurred, *who* witnessed the fall and *what* injuries were sustained. If no witness saw the fall, note "resident found on floor."
3. **Include assessment findings,** such as vital signs, observations of functional and neurological status, and potential injuries, e.g., fractures and skin tears.
4. **Note physician orders,** including diagnostic imaging and any emergent interventions.
5. **Perform a post-fall assessment,** noting functional and neurological changes, as well as the resident's response to physician-ordered interventions.

Also, enter the incident into the facility's risk management system or complete a hard copy form, following written protocol. (Note: The completion of an incident report should not be referred to in the resident care/service record.)

Medication Therapy

A pattern of prescribing more drugs than are clinically justified invites patient harm and unnecessary liability exposure. Resident care/service records should include a monthly review of prescription activity, initial responses to drug doses and related care plan measures, such as prescription support consultation and drug administration safeguards.

Must-haves:

Polypharmacy screening. A documented screening of residents who receive multiple medications can reduce costly adverse drug reactions that emanate from improper indications, inappropriate dosages, adverse interactions and other clinical toxicities. Standard screening aids – such as the Assess, Review, Minimize, Optimize and Reassess (ARMOR) tool – provide a structured approach to reducing risk in residents who receive more than nine medications, or who have a history of falls and/or other adverse behaviors related to medication therapy.

Monthly medication reconciliation. Residents who screen positive for actual or potential polypharmacy require careful monitoring to eliminate unnecessary and duplicate drugs, as well as to detect any deterioration due to excessive or interacting medications. Perform a documented monthly review that encompasses prescription and over-the-counter drugs, as well as all supplements and herbal preparations. To minimize risk, clearly note in the resident record higher risk medication use; possible drug-drug, drug-disease or drug-diet interactions; and measures taken to increase medication safety, including consultation with physicians and/or pharmacists for prescription support.

A **documented screening of residents** who receive **multiple medications** can **reduce costly adverse drug reactions** that emanate from **improper indications, inappropriate dosages, adverse interactions** and other clinical toxicities.

Responses to initial drug doses and reactions. Resident records should convey vigilance in regard to drug-related risks, noting, for example, that initial doses reflect individual factors, such as age, weight, renal function and general health status. In addition, reactions to new medications – especially those in potentially hazardous categories, such as antibiotics, antidepressants, benzodiazepines, antipsychotics, vasodilators and cardiac drugs – should be promptly reported to the resident's physician and noted in the resident record.

Administration safeguards. Medication administration records should demonstrate strict compliance with prescription orders, including the "eight rights" of medication administration, i.e., the right person, drug, dose, route, time, documentation, reason and response. In the case of self-administered medications, care/service plans should indicate that residents have been properly instructed in the process. Both residents and family members should be educated about prescription drug use, dosage, potential side effects and warning signs, and this communication should be documented in the resident record.

Documenting Medication Errors

The following strategies can help ensure that documentation of medication-related errors in the resident healthcare information record is factually accurate without ascribing or implying blame:

1. **Acknowledge that an unexpected event occurred,** without prematurely asserting the cause of the error (e.g., *"resident experienced a reaction after taking the medication"*).
2. **Describe the nature of the error,** referring solely to established facts and indicating what is not yet known (e.g., *"a dose of 20 mgs was given instead of the prescribed 10 mgs; staff compliance with medication dispensing protocols will be reviewed over the next few days"*).
3. **Note the clinical effects of the error,** including changes in resident assessment findings (e.g., *"resident's BP decreased to 102/62"*).
4. **State the actions that have been and will be taken** to ameliorate the medical consequences of the error, focusing on the resident's immediate care needs and condition.
5. **Notify the attending physician or medical provider regarding the error,** and document the actions taken in response to physician orders.
6. **Document notification of the family,** including a description of the event and the resident's condition, as well as progress made in investigating the cause of the error and associated time frames.

Physician Assessments

Quality care involves timely notification of attending physicians and/or medical providers of a new onset or worsening resident condition. Documentation should include details of communication with physicians, consequent orders written and the resident's overall response.

Must-haves:

Physical and non-physical changes. Unless the resident care/service record clearly indicates that a nurse informed the medical provider of a significant change in the resident's condition, jury members may infer that no such notification occurred. The following events require timely medical attention and corresponding notation in the record:

- Abnormal lab results.
- Falls or other accidents.
- Changes in mental status.
- The appearance or worsening of a pressure injury.
- Signs of infection.
- Complaints of new or intensified pain.
- Any other problem or complication that cannot be resolved without the assistance of a physician.

Response times. To achieve optimal treatment outcomes, physicians must be promptly informed that a resident's condition has deteriorated or new symptoms have developed. In the event of a claim, gaps in the response timeline can prove detrimental to the defense. Thus, the record must note when physicians are called, how quickly they respond, when treatment orders and requests for additional monitoring are carried out, and how soon the resident is next assessed.

Changes in Resident Condition

Allegations of delayed intervention are most effectively refuted by timely and concise documentation regarding changes in a resident's physical, medical and mental conditions, including remedial actions taken by staff.

Must-haves:

Shift-to-shift comparisons. In cases involving an allegation of delayed response, plaintiff attorneys will often scrutinize records to see if the resident's decline was sudden in nature or occurred over a period of time. By comparing shift-to-shift assessment notes, and documenting this comparison in the record, nurses can demonstrate their awareness of an unfolding situation. And by utilizing a standard documentation format, such as SBAR (**S**ituation, **B**ackground, **A**ppearance, **R**eview and notify), they can easily identify significant changes and highlight them in the resident care/service record.

Timely reporting. The INTERACT Stop and Watch Early Warning Tool streamlines the process of documenting and reporting changes in resident condition by having staff note *what* change occurred, *when* they reported it and *to whom* they reported it. Residents themselves play a vital role in alerting staff to perceived changes in their health status, and the care/service record should include efforts by staff to educate residents about symptoms to report.

Unless the resident care/service **record clearly indicates** that a **nurse informed the medical provider of a significant change** in the resident's condition, **jury members may infer that no such notification occurred**.

Communication with Family

Open, ongoing and documented communication with residents and family members regarding facility capabilities, changes in therapeutic orders, adverse events and resident noncompliance is the best means of avoiding potential misunderstanding and defending against allegations of delayed intervention.

Must-haves:

Care expectations. Residents and family members should be apprised of the scope, limitations, frequency and duration of available services, the extent of physician involvement and any modifications made to resident care/service plans, including the need for transfer due to rising medical acuity. By doing so, and by documenting these communications in the resident care/service record, facilities can better withstand allegations that family members were not informed about or objected to the services provided. When permitted by the resident, include family or other responsible parties in the planning process and document their approval of the care/service plan, as well as their participation in regular family council meetings.

Critical notifications. The care/service record should convey ongoing communication with family members or designated representatives regarding the following high priority events, among others:

- **Changes in therapy** or the required level of care.
- **New physician orders** for services and therapeutics.
- **Accidents,** falls and injuries.
- **Risky, noncompliant or disruptive behavior** and potential consequences.

In addition to describing the nature and outcome of these events, note whether they raise concerns about the facility's continuing ability to safely accommodate the resident.

Sound documentation is fundamental to both continuity of care and risk management, and the two purposes reinforce each other. To maximize defensibility in the event of a claim, the record should capture all relevant points of care and convey a unified, personalized range of services and interventions, as well as a commitment to treating the resident in a compassionate and dignified manner.

Ten Keys to Effective Documentation

The following 10 strategies, if followed consistently, can help ensure that resident care/service records function as a comprehensive and reliable narrative of resident health status, deficits, assessments and interventions:

1. **Perform baseline assessments.** Document the presence of all high risk conditions, including polypharmacy, skin disturbances, falls risk and history, and cognitive decline.
2. **Follow applicable standards of care.** When creating a care/service plan, adhere to state and facility standards of care, and note awareness of and compliance with these standards.
3. **Record nursing interventions.** Document in detail all measures taken, including the resident's response to treatment.
4. **Note any change in resident condition.** Record when the physician was notified, what new orders were given and how the resident responded to changes in care. In addition, document any discussion with the family regarding the change in condition.
5. **Document all incidents of resident noncompliance.** Note refusals of care and uncooperative behavior in detail, as well as efforts made by staff to explain the risks of noncompliance.
6. **Track delegation of care.** Whenever care duties are shifted from a licensed provider to a less trained staff member, note the reason for the delegation in staffing-related records and assign a supervisor to monitor the delegated activity.
7. **Make documentation a continuous process.** Avoid large, empty blocs of time in the resident's record.
8. **Avoid subjective comments.** Instead, limit notations to objective sensory observations, i.e., what can be seen, heard, smelled and touched.
9. **Authenticate every entry.** In addition to using a full-name signature, include date, time and provider title.
10. **Periodically reassess residents.** Follow evidence-based guidelines when determining assessment intervals and update care plans when conditions change.

Quick Links

- CNA *AlertBulletin*® 2021-4, "EHR System Outages: Minimizing the Impact of Downtime."
- CNA *AlertBulletin*® 2020-4, "Independent Living: Major Risk Factors, Effective Intervention."
- CNA *AlertBulletin*® Republished 2017, "Photographic Wound Documentation: Digital Imaging Guidelines Help Minimize Exposure."
- CNA *AlertBulletin*® 2021-2, "Pre-admission Screening: Key to Reducing Unsafe Retention Risks."
- CNA *CareFully Speaking*® 2020-2, "Documentation Deficiencies: Better Records Mean Stronger Defense."
- CNA *CareFully Speaking*® 2022-1, "Pressure Injuries: Sound Documentation is Key to Defensibility."
- CNA *CareFully Speaking*® 2018-1, "Resident Care Planning: Avoid These Seven Common Deficiencies."
- CNA *CareFully Speaking*® 2021-1, "Resident Falls: A Collaborative Strategy for Risk Mitigation."
- CNA *CareFully Speaking*® 2018-2, "Strengthening Facility-Family Relationships: Transparency Is Key."

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