# NEWS & VIEWS

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Med-Net Concepts, LLC

## Medical Records Documentation: If It's Missing, It Did Not Happen

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When it comes to medical records documentation (who, what, when, where and how), getting cited by a state surveyor or receiving notice of a lawsuit is not the ideal time for a long-term and post-acute care (LTPAC) facility to start evaluating its medical records' policies and procedures, training and auditing processes. That is like "closing the gate after the cows have wandered off" as the old saying goes. The optimal approach is one of continuous, constant review and evaluation.

When it comes to medical records documentation, whether a facility uses an electronic medical records system or maintains handwritten files in folders, **Title 42 of the Code of Federal Regulations, Section §483.70 Administration F-842 Medical Records** requires that the medical records of each resident in a LTPAC facility be accurate, accessible and systematically organized. They must also be kept confidential, protected against loss, destruction or unauthorized use regardless of the method used to store them. Medical records must be kept for specified periods of time dependent upon State law and other factors. The contents of the medical record must provide information to allow the resident to be identified and be informative about the resident's assessments, comprehensive plan of care and services provided. They must include the progress notes of physicians, nurses and other licensed healthcare professionals and include State conducted preadmission screenings and evaluations. Also, they should include any laboratory, radiology and other diagnostic reports.

Medical records form the hub from which communication flows between healthcare providers, e.g., doctors, nurses, skilled nursing facilities and hospitals, and extends into virtually every aspect of a resident's care. Physicians rely on the medical records to determine what medications to prescribe or avoid and the effect (positive or negative) those medications and treatments may have on a resident. Facility administrators, state surveyors, insurance companies, and federal and state insurers (Medicare and Medicaid) rely on medical records to evaluate the level and quality of care being provided.

A resident's medical record provides an historic account of the resident-provider interaction, and it is used as a legal document in legal actions. In fact, a medical record may be the only evidence that is presented in a

lawsuit because it provides the basis used by attorneys, legal experts, and expert witnesses for the type of care a resident received from the healthcare provider during the period in question. All documentation regarding care and services provided to each resident becomes part of that resident's legal medical record, and it is not possible to prove care was delivered without complete documentation.

Medical record documentation and nurses are inextricably linked due to the important role that nurses play in the documentation process. Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) are required by Nurse Practice Acts to document all treatments and medications that have been given to a resident.

Certified Nursing Assistants (CNAs) do not write directly into a medical record, but they do complete forms with information regarding the care they provide to residents, and this information is transcribed by nurses into the medical record. In many facilities, CNAs now use an electronic program to record the care they provide.

Notes should not be copied over and over using the same repetitive words and may lead to error entries because of failure to meet chronological entry requirements.

**Some Do's and Don'ts Regarding Nurses and Documentation**

Documentation may seem burdensome and considered by some as not important compared to the care a nurse provides. Many nurses fail to take the time to complete required documentation, but the reality is that accurate documentation can be very helpful to nurses-helping them avoid medication errors and legal allegations regarding the quality of care they provide. Documentation allows a nurse to demonstrate that the care provided to a resident meets or exceeds the standards of care required by federal or state law.

Providing care but failing to document in a timely manner is considered by law to be irresponsible nursing care. Documentation requirements are applicable even when caring for seriously ill residents in an understaffed setting. Failing to document the care provided can put a resident at risk for receiving a double dose of their medications, unnecessary treatments or cause discontinuity in medical care.

Attorneys focus in and look for red flags in a resident's medical record documentation in both written and electronic medical records. The following are some common documentation "red flags":

- Illegible writing - messy writing may be interpreted as disorganized practice.
- Using uncommon abbreviations - avoid non-medical abbreviations or texting language.
- Including subjective information - refrain from entering non-objective comments about a resident like, "She's angry and rude," or "He is demanding and unappreciative."
- Leaving large time sections blank - if it isn't documented, it wasn't done!
- Adding late entries - don't try adding an entry late to make it look like it was documented in a timely manner.
- Failing to document a change - any change in a resident's or family's status that happens on a nurse's shift should be documented.
- Documenting an adverse event.
- Erasing or using different colored ink - this often occurs in handwritten documentation.
- Including meaningless jargon - stick to the basics and make concise entries.

When focusing in on documentation, it is a good habit to keep these positive documentation elements in mind and to remember that charting is to be objective not subjective (stay away from words like "appears to be," "seems to be" or "resting comfortably"):

- Use objective data - if a resident refuses his medication, document exactly what happened in the medical record.
- Include date, time, your title, and your full name and signature in every entry.
- Document how state and facility standards of care were provided.
- Include nursing interventions and the resident's response to treatment.
- Include any resident refusals - document the incident and include verbal and non-verbal responses using objective detail.
- Include follow-up care provided - if the resident's status changed and the physician was notified, document that change, the notification to the physician, any changes the physician made, and the response of the resident to those changes.
- Make documentation a continuous, ongoing process - do not leave large spaces of time blank.
- Document education of the resident about his/her discharge plan and how their understanding was demonstrated.
- Document care delegated to another staff member and when that care was provided.
- Document according to your senses (sight, smell, touch, hearing).
- Document any objections you have regarding treatment plans or interventions and how the situation was handled.

Before determining changes in a resident's condition, it is a good practice for nurses to read the nurses' notes at the beginning of a shift before assessing a resident or making entries into a medical record.

To correct an error in a medical record, draw a single line through the error and place the correct entry above or next to the error, and then date, initial or sign the corrections. A nurse should never alter a record at someone else's request.

Along with the importance of documenting the level of care provided to residents, details make the difference and play a significant role in accurate coding, timely billing and ensuring that optimal reimbursement is received from insurers. Ultimately, the only accurate record of an event that may be questioned in the future is created by thorough documentation today.

## ADMINISTRATORS TAKE NOTE

Two Series of Fraud Modules with NAB/NCERS CEs Are Now Available

A new set of NAB/NCERS approved fraud modules 9 -16 offering 3.75 CEs is now available on our website. These new modules, as well as modules 1-8 which offer 3 NAB/NCERS CEs, provide education on fraud, waste, and abuse prevention, and offer a combined total of 6.75 CEs for successful completion. All courses were developed by Betty Frandsen, our Director of Healthcare Education Development, and her staff.

Visit the Med-Net Compliance, LLC website at:
**https://www.mednetcompliance.com/med-net-academy/nab-accredited-courses/**

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