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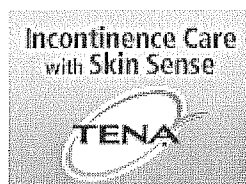
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BY RETA A. UNDERWOOD, ADC

Demystifying documentation

Why does our industry remain so mystified, if not completely psyched out, by documentation? It's amazing to me to see the resources dumped into restudying and forever debating how documentation is compromising direct care when, in fact, it's intended to improve resident outcomes.

Here's a basic analogy: Every automobile has thousands of parts that must fit perfectly into place and be precisely synchronized. Most importantly, the stringent protocols, training, and quality assurance standards in both industries are designed to protect Americans on a daily basis, whether they are 1.5 million nursing facility residents or hundreds of millions of automobile drivers and passengers.

Related to regulatory compliance, though, the analogy weakens, because half of all nursing facilities are deficient in the CFR §483.20 Resident Assessment. According to the DHHS Office of Inspector General's March 2003 report "Nursing Home Deficiency Trends and Survey and Certification Process Consistency," facilities with resident assessment deficiencies *increased* by 11.6% during a recent four-year period. Obviously, consumers and regulators wouldn't tolerate having one of every two vehicles rolling off of the assembly line with any defects whatsoever, with quality trending toward still further decline.

Granted, automobile recalls do occur, but manufacturers don't redesign an entire engine just because one component malfunctions. Yet what I have experienced as a nursing facility consultant is that many well-intended providers are cited for documentation-related deficiencies simply because they are continuously redesigning and overhauling their entire system whenever one part malfunctions. When correcting "immediate jeopardy" situations resulting directly from poor documentation, I quickly traced those citations back to ineffective persons, policies, or practices that were remedial. A management decision to totally disassemble and reassemble a broken documentation system using the same parts (persons, policies, practices) predictably yielded the same noncompliance.

As nursing facility professionals, we can demystify documentation by focusing on and correcting our most glaring miscues, most of which affect patient care, reimbursement, and compliance. For example, although Medicare reimbursement starts with certain required documentation, many physicians and some nurses do not know or follow the required guidelines. Jeffrey Randall, MBA, RHIA, CPHQ, CHC, health information management specialist for Life Care Centers of America, explains that a common problem in documentation is the "lack of physician compliance to



timeliness and signature requirements for Part A Medicare. Correcting this can be as simple as having the hospital include on the transfer form the initial certification language and a place for the physician to sign and date the statement. In addition, 42 CFR §483.40 requires physician compliance with signing and dating all orders, otherwise facilities may experience denials of Medicare claims and in-depth scrutiny of facility billing practices. Conducting medical record audits regularly and prior to submitting claims is imperative.”

Furthermore, the Centers for Medicare & Medicaid Services (CMS) recognize a resident’s current status by the most recent “full” MDS submitted. Quarterly assessments support the fact that a significant change of status hasn’t occurred, which correlates with the course of treatment and corresponding reimbursement. The failure to maintain an accurate MDS and quarterly assessments can typically trigger a series of documentation deficiencies, direct care inconsistencies, and reimbursement complications.

“Many MDS coordinators don’t realize this,” says Amelia Melanson, RN, founder and president of the National Resident Assessment Institute, and author of several books on the subject. “The overall policing must be part of the coordinator’s role.”

Documentation breakdowns for therapy services deserve a category of their own. Therapy minutes may be improperly tracked and recorded, not only inaccurately reflecting the actual services provided, but affecting reimbursement and compliance. Contradictions are often found in physician orders, documented services, and statements of resident status, as presented in the medical record. Because of the prevalence of inaccurate MDS assessment data, CMS initiated the Data Assessment and Verification Project (DAVE) this year. During its relatively short history, DAVE has identified the following inadequacies as commonplace: unjustified carryover of prior assessment data, incorrect observation periods, and lack of resident observation or assessment. (For additional examples, visit www.cms.hhs.gov/providers/psc/DAVE/DiscrepancyReport.asp)

Ensuring that your documentation is complete and timely is more than a one-person job. It starts with establishing clear expectations, regular education, and up-to-date resource tools that are user-friendly and efficient. A few examples:

- Nurses, therapists, and other professionals must be taught more about the interdisciplinary impact of financial or regulatory nuances of the Medicare and Medicaid programs. In line with this, “support of the MDS coordinator is one of the most important roles of management,” says Melanson. “This person is partially responsible for the ‘checkbook,’ survey outcomes and documentation that support the residents’ clinical status.”
- Most disciplines have their own professional standards that are applicable to documentation, and these standards can be written into job descriptions. For example, nursing professionals are expected to document all clinical interventions and services they provide. This documentation must be signed and dated as soon after it is provided as practicable; if this is not completed in timely fashion, entries are clearly labeled “late” in the record; and,
- Documentation tools and forms should be consolidated, where possible, and computer software program(s) should be reviewed to determine how you can better integrate your data and reporting. A classic example of possible consolidation occurs with meals and behaviors. Every facility must document both resident nutritional intake as well as behavior, and many reportable behaviors occur during mealtime. But almost never do you see intake sheets that include a place for behavior to be documented. These behaviors often go unrecorded as a result, and information that could have led to better resident analysis and intervention is lost.

Implementing this simple change in these and other areas—e.g., bath sheets and activity records—would not only result in a more descriptive record, but would save

time for the interdisciplinary care plan team and other staff who spend much of their time trying to “find” documentation for the MDS. According to Melanson, the interdisciplinary completion of the typical resident assessment instrument from start to finish averages about 18 hours, an estimated five hours of which solely involves the MDS coordinator.

Over the course of ten years, I have observed trends in documentation, and I know it’s unrealistic to think that physicians, therapists, and staff have time to pull every resident’s medical record throughout a workday. However, Loretta G. LeBar, Esq., of Stoll, Keenon & Park in Lexington, Kentucky, has her clients around the country prepare “defensive documentation that is timely, accurate, and objective. It doesn’t have to be perfect, but of a reasonable standard. This would be, for example, the explanation of care the resident received that was ordered by the physician and found in the care plan.

LeBar presents some commandments of documentation, which show that reasonable standards are in practice:

- Spell out what you did and didn’t do, using good judgment in your discipline.
- Note all resident noncompliance, using simple sentences.
- Note all family interference.
- Document negative findings. Put enough information in the chart so someone reading it two or ten years from now will know what you were thinking and why you decided to do, or not to do, a particular intervention.
- Use good penmanship.
- Always sign or initial and date your notes.
- Have policies for and judge performance on documentation protocols.
- Have signed and up-to-date physician orders for everything that you do for each resident.
- Always document a complaint and its follow-up, whether it is or isn’t an emergency.

It bears repeating that although your documentation system is comprised of thousands of parts, the process isn’t mystical. Please keep in mind that it’s not necessary to redesign and overhaul your facility’s entire documentation system whenever one part malfunctions; often simple modifications following commonsense rules will suffice. Most importantly, identify and correct the ineffective persons, policies, or practices that drag you into regulatory noncompliance. ■

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