

DOCUMENTATION WAKE-UP CALL: HOW TO PREVENT DOCUMENTATION DEFICIENCIES

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I. INTRODUCTION

Concise clinical record documentation is critical to providing long term care residents with quality care as well as receiving accurate and timely reimbursement for furnished services. The clinical record chronologically documents the care of the resident and is required to record and communicate pertinent facts, findings, and observations about the care of the resident. If the clinical record is not appropriately completed or maintained, the regulatory and liability ramifications can be serious.

Under Medicare requirements for long term care facilities, nursing facilities are required to maintain records on each resident in accordance with accepted professional standards and practice (42 CFR §483.75(l) or Tag F-514). In 2008, Tag F-514 was the sixth most cited deficiency by Medicare certification surveyors across the country. Since 2005, Tag F-514 has been in the top ten most cited deficiencies on Medicare certification surveys. This paper provides practical tips on how to enhance nursing facility clinical record documentation to bring it into compliance with Tag F-514 and other related Medicare requirements.

II. MEDICARE REQUIREMENTS FOR CLINICAL RECORD DOCUMENTATION UNDER TAG F-514

The Medicare Program requires nursing facilities to maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

- Complete;

- Accurately documented;
- Easily accessible; and
- Systematically organized.¹

The Centers for Medicare and Medicaid Services (“CMS”) has published Interpretive Guidelines to assist state surveyors during their review of a nursing facility’s clinical record.² Although the CMS Interpretive Guidelines should not be considered legally binding, they provide good compliance benchmarks for the long term care industry. The following discussion summarizes the CMS Interpretive Guidelines and offers practical tips on how to bring a nursing facility’s clinical record into compliance with the CMS guidelines.

A. The clinical record must be “complete.”

According to the CMS Interpretive Guidelines for Tag F-514, “[a] complete clinical record contains an accurate and functional representation of the actual experience of the individual in the facility.” CMS expects the documentation to demonstrate that the nursing facility:

- Knows the status of the resident;
- Has an adequate plan of care for the resident;
- Understands the resident’s progress, response to treatment, or change in condition; and
- Adjusts treatment based on the resident’s status and/or response to treatment.

¹ 42 CFR §483.75(1)(1).

² CMS State Operations Manual (Publication No. 100-07), Appendix PP.

The Medicare regulations provide a list of documents that must be present in a nursing facility resident's clinical record. According to 42 CFR §483.75(1)(5), the nursing facility clinical record must contain:

- Sufficient information to identify the resident;
- A record of the resident's assessments;
- The plan of care and services provided;
- The results of any pre-admission screening conducted by the State; and
- Progress notes.

It is important to note that state licensure rules may have additional content requirements. For example, in addition to the Medicare certification requirements, the licensure rules may require the record to include:

- Designation of attending physician;
- Admitting information, including resident medical history, physical examination and diagnosis;
- Physician orders, including all medications, treatments, diets, restorative and special medical procedures required;
- Nurses notes written in chronological order and signed by the individual making the entry;
- All symptoms and other indications of illness or injury, including date, time, and action taken on each shift;
- Medication and treatment record, including all medications, treatments and special procedures performed;

- Copies of radiology, laboratory and other consultant reports; and
- Discharge summary.

Other Medicare regulations may also have specific requirements relating to the content of the clinical record in certain instances. For example, CMS may have published, in regulations or guidance documents, coverage criteria for a specific service performed in the nursing facility setting, and such coverage criteria may set forth explicit documentation requirements.

There are no explicit rules regarding how frequently a facility must document to maintain a complete record. However, it is clear that it is not enough to just document the resident's annual comprehensive assessment, periodic reassessments due to significant changes and quarterly monitoring assessments. The CMS Interpretive Guidelines for Tag F-514 advise surveyors to “[b]e more concerned with whether the staff has sufficient progress information to work with the resident and less with how often the information is gathered.” CMS explains that for functional and behavioral objectives, the clinical record should document change toward the resident's ability to achieve care plan goals. The Interpretive Guidelines direct state surveyors to ask the following questions during a survey:

- “How is the clinical record used in managing the resident's progress and maintaining or improving functional abilities in mental and psychosocial status?”
- “Is there enough record documentation for staff to conduct care programs and to revise the program, as necessary, to respond to the changing status of the resident as a result of interventions?”

These same questions should be asked by nursing facility staff when determining the type of information to be included in a resident's clinical record. Several best practices that may be

implemented in the nursing facility to ensure that the clinical record is complete include the following:

- Chart as close to the time the interventions occur, and avoid falling into the habit of charting at the end of the nurse's day.
- Reduce redundancy within the clinical record. Redundancy leads to staff omissions and increases the chance of discrepancies in documenting the same information. If charting requires more than one place to record the same information, consider revising nursing facility policies and procedures.
- Take steps to ensure that MAR and TAR documentation is completed prior to the end of each nurse's shift. After a nurse leaves, it is difficult to justify complete recall of medications given.
- Documentation of medication orders should include name, dosage, frequency, route and reason for administration (e.g., diagnosis or signs and symptoms being treated). The nurse's note should discuss the resident assessment or condition that warrants the new medication order, and should document discussions with the physician and/or the resident's responsible party.
- Ensure that all notifications to physicians, responsible parties and other disciplines are documented in the clinical record. Communication books and fax communications must be used with great caution when sending notifications to physicians. The physician is not considered to be notified until the physician receives the fax or reads the communication book. Therefore, merely documenting

that a fax has been sent or a notation has been made in the communications book is not adequate.

- Never leave “loose ends” in the chart. If a nurse’s note must be continued onto the next page of the chart, the nurse should sign the bottom of the page and write “continued.” On the next page, the nurse should write “continued” from the date and time of the previous note, and sign at the completion of the note.
- For incidents that occur in the nursing facility, the medical record of the resident involved should contain contemporaneous notations regarding: (1) pertinent facts of what happened; (2) pertinent medical status of resident; (3) medical care rendered in response; and (4) who was notified and time of notification.³

B. The clinical record must be “accurately documented.”

When performing a self audit, long term care facilities may gauge whether their documentation is accurate by asking themselves the following questions:

- Is there internal consistency across all record entries?
- Are there any transcription errors?
- Is the medical record legible?
- Are entries timely?
- Are entries chronological?
- Is the record unaltered and truthful?
- Are acceptable abbreviations and techniques used?

³ Please see Attachment A for a Case Study, which may be used for nursing facility staff training sessions examining documentation best practices for resident changes of conditions and incidents. The Case Study also includes an audit tool.

- Is proper spelling/grammar used?
- Are the entries consistent in how time is documented (e.g., military time)?
- Are entries appropriately signed and/or initialed?

To enhance the accuracy of the long term care clinical record, certain best practices may be implemented. For example, each page (both sides) of the clinical record should be clearly labeled with the resident's name and medical record number and/or room number. Long term care facilities should only use approved abbreviations and chart the date and time of each entry. Every entry in the medical record must be authenticated by the author. At a minimum, the author's signature should include the author's first initial, full last name and title. While facility policy may allow initials on some forms (e.g., MAR, TAR, Flow Sheets, etc.), the clinical record should always include a mechanism to identify the initials with the author's full signature. Also, it is important to note that there are some documents, on which it is inappropriate to use initials (e.g., the MDS).

1. *Verbal Orders*

Every long term care facility should have a policy on how to document verbal orders in the clinical record. The policy should set forth the specific process and timeframe for documenting verbal orders. The policy should also address which individuals in the facility are authorized to accept verbal orders, and how quickly such verbal orders must be countersigned. Oftentimes, state licensure requirements for long term care facilities will set forth specific requirements for documentation of verbal orders in the clinical record.

2. *Rubber Stamp Signatures*

While the Medicare certification requirements for nursing facilities (Tag F-386) allow physicians to use rubber stamp signatures in certain situations, the Medicare reimbursement rules bar the use of rubber stamp signatures. In March of 2008, CMS published Transmittal 248, which banned the use of physician signature stamps on medical records. This Transmittal was further clarified by a CMS MLN Matters Article (SE0829), which stated that physicians and other providers who bill Medicare Contractors may not use stamp signatures.

3. *Correcting Errors in the Clinical Record*

No matter how careful nursing facility staff may be, documentation mistakes are inevitable. To correct a documentation mistake, a single line should be drawn through the erroneous documentation, and the correction should be noted. The correction should be made only by the person who made the original entry. Finally, the correction should be initialed and dated. Never use “white out” or destroy the erroneous documentation.

When using a late entry, document the entry as soon as possible. Although there are no regulatory time limitations to writing the late entry, the entry becomes less reliable as more time passes. Always document the date and time that the entry is made and record the date and time, to which the note refers. Addendums may also be made to the clinical record to provide additional information in conjunction with the previous entry. The addendum should always include the date and time that the addendum was made, and the reason for the addendum.

C. The clinical record must be “readily accessible.”

To comply with this requirement, facilities must appropriately store and maintain the clinical records to ensure that the clinical record is accessible to providers, residents’ authorized

representatives and surveyors. If the facility has transitioned from a paper-based to an Electronic Medical Record (“EMR”) system, the facility must provide surveyors access to the EMR system and any printouts of records that are requested.⁴

D. The clinical record must be “systematically organized.”

The clinical record must be completed using forms, methods, and systems that are consistent both state and federal requirements and facility policies. Nursing facilities should review licensure requirements, which typically require facilities to have written policies and procedures in place that specify what goes into the clinical record and how it is completed.

Not only must the clinical record be organized, the provider should have policies and procedures relating to clinical record retention. Medicare requires a nursing facility’s clinical record to be retained for (i) the period of time required by State law; or (ii) five years from the date of discharge when there is no requirement in State law; or (iii) for a minor, three years after a resident reaches legal age under State law.⁵

Some states may have legal requirements that permanent information be kept indefinitely for all residents. For example, Virginia licensure requirements for nursing facilities require that the following information be kept for each resident:

- Name;
- Social security number;
- Date of birth;
- Date of admission;

⁴ S&C Letter 09-53 (August 14, 2009). See also Attachment B, which includes practical tips for transitioning from a paper-based to an EMR system.

⁵ 42 CFR §483.75(1)(2).

- Date of discharge; and
- Name/address of guardian, if applicable.⁶

III. CONCLUSION

Never before has it been more important to improve documentation practices. While Medicare launches its Recovery Auditor Contractor (“RAC”) program, many state Medicaid programs have already sent Medicaid Integrity Program auditors into nursing facilities. These government contractors examine nursing facility clinical record documentation in an effort to uncover deficient documentation and overpayments made to the facilities.

Over the past few years, there has also been a rise in medical malpractice litigation involving nursing facilities. The cost to maintain liability insurance coverage has also skyrocketed for nursing facilities. Quality care and a well-documented clinical record are a nursing facility’s best defense against a medical malpractice claim.

Indeed, the long term care clinical record is a legal document. The quality of the clinical record impacts the facility’s performance during a licensure and/or certification survey, exposure to medical malpractice liability and financial performance. It is critical that documentation best practices become the topic of frequent nursing facility staff training programs. Attachment C includes a 1-page flyer that outlines “Principles of Documentation” that may be posted in facilities as a reminder to staff of both proper and improper documentation techniques.

⁶ 12 VAC 5-371-360.