When Bad Documentation Happens to Good Long Term Care Facilities

by Lois Yoder, ART, CCS

Good documentation is a must in all settings—but long term care faces some special problems. Improving a long term care documentation program takes education, awareness, vigilance, and attention to detail. Here are some strategies.

It's a fact—when patient loads are high and staff time is limited, documentation responsibilities in a long term care facility are not as high a priority as they should be.

Most long term care or skilled units are still in the implementation phase of Medicare's prospective payment system (PPS), and although documentation is even more important for payment under PPS, direct patient care is the priority over documentation. As a result, many HIM professionals in the long term care setting continually are challenged to improve documentation processes. This article offers some suggestions.

To improve a documentation program in a long term care environment, the first step is educating colleagues. Everyone who works with the medical record needs to understand that it serves as a communication tool among clinical staff, records patient care and related outcomes, outlines the discharge plan, and serves to justify level of care and associated charges. Unless all participants understand the importance of comprehensive documentation, improving documentation will be an uphill battle.

A Good Start

Even though the Joint Commission on Accreditation of Healthcare Organizations' documentation guidelines have become less specific, the goal of quality documentation has not diminished. That's why policies are good places to start during an effort to improve documentation.

Policies and procedures provide a reference for a staff to measure its performance. A documentation policy should state the purpose of documentation, along with some general methodology. Procedures, however, should provide specific instructions as to how chart entries should be completed for everyone who enters information into the record.

It is also useful to incorporate documentation competencies into annual staff performance reviews. Choose several items that can be easily measured and merged into performance evaluations. During chart audits, for example, screen documentation by the clinical staff (e.g., nurses, certified nurse assistants, nutrition counselors, social service staff) for:

- chart entry dates
- entries in correct patient records
- coordination of entry data with MDS data element requirements
- timely entries for each clinical problem

Before a patient is transferred to a unit, intake staff and physicians should initiate the documentation process. Patient evaluations and "reason for transfer" should be appropriately noted on designated forms and signed by either a nurse or physician. Intake or referral forms must state the obvious—diagnoses and plan of care information, which are essential elements for unit staff to move forward with necessary admitting paperwork, including the MDS form.

It is not uncommon for admitting staff to come up short on clinical (admitting) information. If a patient is transferred from an acute care facility, the discharge or transfer summary may not accompany the patient to the unit. One solution for this problem could be for long term care facilities to require that all necessary documentation accompany the patient in order for them to

accept the transfer. If the transferring facility receives several patient complaints about the transfer process, they should get the message.

The Rest of the Story

Situations in which the transferring facility sends incomplete documentation with the patient can be problematic for both staff and patients.

One of the most commonly omitted items in transfer is an accurate or legible diagnosis list. If the diagnosis list is not clear, the long term care unit must then contact the physician for clarification. But more frequently, the staff uses any available information and presses forward with the admitting assessment and MDS form completion.

This is where the risk of reporting incorrect information comes into play. Without the most accurate clinical information, the intake coordinator is likely to establish incorrect severity levels for the patient by simply using deduction or assumption.

Case Study 1

Take a hip fracture case, for example. In this example, a 68-year-old female comes to a long term care facility from the hospital after surgical fixation of a hip fracture. She also has diagnoses of diabetes mellitus, Type II—labile, hypertension, chronic obstructive pulmonary disease (COPD), and rather severe congestive heart failure (CHF).

Unbeknownst to the intake coordinator, the intent of the transfer to long term care is primarily for management of the labile diabetes mellitus, COPD, and CHF. A physical therapy program is also ordered, with the goal of discharging the patient within a month. (The physician felt the patient was too noncompliant with her diabetes regimen and that her frequent lapses into active congestive failure were too risky to send her home with an outpatient physical therapy program.) She needs daily supervision and has no family nearby to assist her.

If the documentation, particularly the hospital discharge plan, is incomplete, the intake coordinator may mistakenly assume that the patient is being transferred to the unit for the hip fracture. While the hip fracture does require physical therapy for several weeks, the patient can bear some weight and is using a walker with assistance.

The transfer order for physical therapy is not complete, requiring the coordinator to place a call to the physician's office for clarification. Obviously, the more therapy the patient requires, the higher her acuity level will be.

Associating acuity level with the plan of care is important. If the patient is non-weight bearing when transferred and requires two to three physical therapy sessions per day, she demonstrates a higher acuity (that is, need for more intensive service). A patient who is transferred as partially weight bearing and requires only one therapy session per day demonstrates a lower acuity level. The physician must be realistic about how much therapy is necessary, particularly when the patient is already up with assistance, and should order the appropriate therapy program.

The transfer information says little about the patient's noncompliance with her diabetes regimen, nor does it include much information about her CHF. The intake coordinator identifies the condition of COPD through the medication orders, but misses the diagnosis of hypertension because it is not well documented in the chart copies from the hospital.

Since the information accompanying the patient is incomplete, establishing a correct care plan for this patient could be difficult. The care plan team must evaluate the case closely and become acquainted with the patient's risk factors. The intake coordinator and the dietician both note the patient is overweight (which is not noted in the transfer papers). She likes to hoard food in her bedside drawer and does not like to follow a diabetic diet. Her mobility threshold is not extremely limited, and her COPD and CHF seem to be compensated at the time of admission. The patient demonstrates some stamina and determination, primarily because she wants to go home.

About six hours into the long-term stay, the nurse notices that the patient is having difficulty breathing. The nurse reevaluates the patient, who appears to be less stable than when she was admitted earlier in the day. She admits to eating a candy bar she had hidden, and she has neglected to use her airway inhaler as prescribed. Both violations caused her to rather quickly decompensate, requiring the staff to try to stabilize the situation.

In this case, the coordinator and all persons participating in the patient's care plan development need to know about this occurrence. Nursing staff will need to monitor the patient closely, watching for signs of any exacerbation of her conditions, and the dietary staff now has a challenge to maintain her nutritional intake. Nursing may need to consider options for monitoring the patient's respiratory status—more frequent assessments, pulse oximetry checks, etc.

If the patient had not decompensated so soon after admission to the skilled unit, the staff might not have had a true appreciation for her clinical status. Her condition was certainly not evident in the transfer papers, and the unit staff was just getting acquainted with her.

Case Study 2

In another case, a 96-year-old patient is admitted with a hip fracture, but (unlike the previously discussed case) this patient does not show signs of a good recovery. She is bedridden, nonambulatory, and exhibits a "failure-to-thrive" status, showing little interest in her recovery plan. Documentation in the transfer papers does not indicate an order for physical therapy, and the dietary order is for a general diet. No other coexisting or comorbid conditions are listed.

During the clinical assessment, the nurse realizes that other conditions must be significant to the patient's plan of care development. She realizes that the patient is not a candidate for aggressive physical therapy and is concerned about her nutritional status. At first, the nurse assumes that the patient was transferred because of the hip fracture and is inclined to document the primary diagnosis as "left hip fracture." But after completing the assessment, she questions the true primary diagnosis.

In this case, the nurse must clarify why the patient was transferred—her failure to thrive or the hip fracture. After she discusses the case with the patient's physician, it becomes evident that the patient will only have passive physical therapy, at least until her nutritional and cognitive status can be improved.

If the diagnosis of left hip fracture is maintained as the primary diagnosis, with no initial order for a physical therapy program that includes more than passive exercise for the left extremity, the acuity level of the patient would be lower (for the hip fracture diagnosis) because the level of therapy is less intense than that of the partial-weight patient who has a therapy order for two to three sessions per day.

In both examples, the lack of good transfer information causes the long term care staff to struggle to outline all pertinent clinical problems and develop a subsequent care plan that meets the skill level of the patient.

More Quality Issues

After a care plan has been established, it becomes the multidisciplinary team's responsibility to deliver appropriate care. But because many units carry very close staff-patient ratios, managing patient care and paperwork time is a difficult task. Usually, patient care and associated tasks win out over paperwork.

However, failure to document appropriately in the medical record can now lead to potential quality of care issues, not only from a patient standpoint but from a data management perspective. For instance, during an audit, when an auditor reviews a case for acuity or skill level, he or she is looking for documentation that describes the amount of time and resources needed to rehabilitate the patient on a daily basis.

A patient's skill level is described by abilities that clinical staff or therapists observe (e.g., a patient's ability to ambulate with or without assistance). If a patient requires a great deal of assistance, the skill level should be documented as low and the acuity level high. If chart entries do not support the acuity or skill level denoted on the MDS form, the facility or unit is at risk for financial take-backs due to poor documentation. Similarly, if a patient demonstrates a higher skill level (e.g., can walk with a cane) but the documentation implies a lower level of ability, the facility is again at risk for not documenting the case appropriately.

As technology becomes more powerful, the potential for pitfalls multiplies. In the information age, payers, clinical auditors, and others can actually monitor provider performance—comparing charges against a diagnosis list or remotely comparing supply usage against documentation. If nontraditional patterns emerge, they may choose to audit on site, using the actual medical record.

Other guidelines should be considered as well. Data collection practices now used by the Health Care Financing Administration (HCFA) for Medicare patients under skilled nursing facility (SNF) prospective payment require providers to submit the MDS form within five days of admission to establish the payment level for each patient. Because payment levels are established using this data, it is critical that the person completing the form have good transfer information and chart entries for a comprehensive and accurate MDS report.

It may be prudent for HIM personnel to assist in collecting and coding clinical data for patients as soon as they are admitted. One facility uses HIM staff to assist in the initial data collection process, in tandem with an intake nurse, to review transfer information and sequence and code all diagnoses pertinent to the case. If questions arise, the HIM staff can help phrase queries to clinicians to get the best information in response. The HIM staff continues its review function throughout the patient's stay, checking for changes in condition for coding purposes or helping with documentation audits to assure that the medical record contains timely and accurate information.

After the care plan has been established and the MDS form is submitted to HCFA, information should be charted daily about the patient's condition, daily care, response to treatment, and progress toward discharge.

The Big Picture

While it is easy to check off boxes on flow sheets, enter vital signs, and check off medicine dosages, this information does not come together without summaries by clinical staff.

When patients develop infections or other conditions while they are in the unit, clear descriptive information must document:

- calls to the physician
- referral orders for ancillary testing
- changes in the care plan
- calls to family members
- communication between staff members on various shifts

For example, if a patient develops an upper respiratory infection, a clinical assessment must be clearly documented and used as the resource when calling the physician for an order for antibiotic therapy or decongestive medications. The physician may ask about other medications the patient is taking to consider effects of drug combinations, allergies, or history of intolerance to certain drugs.

In this example, a patient's medical record indicates the patient had an upper respiratory infection four months ago and was treated with penicillin and cough suppressant. The patient developed an intolerance to cough medicine and suffered gastrointestinal symptoms. If this scenario is not well documented in the medical record, the physician receiving the request for new orders for this episode of care may not know what happened four months ago and may give the same order for cough suppressant.

This example may sound elementary, but from a documentation standpoint it is not. All too frequently, clinical staff members fail to document specific information about patient intolerances or response to certain treatments; as a result, they are subsequently repeated.

Another point of difficulty in the long term care medical record is often nutritional information. It is easy to find a prescribed diet in the record; however, it is not necessarily easy to learn how well the patient is tolerating the diet or how much food is eaten. Between-meal snacks are even more difficult to track. An appropriate snack may be served to the patient, but if the patient is not monitored to see if the snack was actually consumed, credit for the nutritional supplement cannot be recorded.

Monthly weight charts may tell the story if information is properly recorded and dated. But if monthly statistics like body weight are not readily available, a condition like failure to thrive may not be easily identified until a patient exhibits extreme symptoms.

Nutritional assessments, progress notes, and dietary changes are very important chart entries. They support the patient's recovery from surgical status situations and therapy programs and provide comparative data for cognition assessments and

general physical status reports. If the patient is not receiving adequate nutritional intake, the skill level may go up depending on what appears in the chart, along with physician assessments.

Along with nutritional documentation, social service entries related to patient progress in the discharge plan, cognitive skill level changes, and social activities are just as important. If the social service staff makes new physical or mental observations, these should be reported to the clinical staff immediately and documented in the appropriate section of the record. If a facility has specific documentation guidelines for these situations, they should be followed. If not, guidelines should be developed.

A physician or other clinical personnel may be able to piece together the nutritional and social information to create a new clinical or mental status which may need to be reported for a change in the care plan, or the skill level (of care).

In addition, physical, speech, or occupational therapies must constantly document the patient's progress or response to therapy modalities and plans. If a patient fails to respond to treatment, the treatment plan must be changed or discontinued. Follow guidelines for documentation for both assessments and daily visits.

It is not acceptable, for example, for therapists to document all visits for the month once per month (say, because they don't have time to do it when they see the patient). This approach fails to communicate any improvements observed to the clinical staff.

Justification of service is becoming as important in the long term care environment as in acute care. Facilities need to give some thought to how they will handle cases where patients fail to meet the discharge plan outline, do not respond to treatment, or even fail to meet payer-specific criteria for an extended stay. If the patient remains in a long term care facility for family or physician convenience, then the risk of inaccurate patient care profiling may occur on the side of the payer, or payment may eventually be denied due to lack of documented evidence of the need for skilled care.

A Shared Responsibility

Documentation by long term care staff participating in the care plan of each patient must be timely, accurate, and consistent. Medical record information must support the cost of patient care, charges, acuity or skill level, and clinical decision making. HIM professionals understand these needs. But in the long term care environment, all disciplines must embrace their share of responsibility to document information about the patient and must be able to defend their documentation practices.

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