RESIDENT RECORD DOCUMENTATION DO'S AND DON'TS

The resident record should tell a story. When charting, assume someone unaffiliated with the organization/resident were looking at the record. Would he/she be able to understand the resident's condition and clearly follow from shift to shift and day to day?

- Audit documentation on a regular basis to look for any gaps in the charting.

- Document in the right patient's chart
  - Triple check prior to documenting you are charting in the correct resident's record. Paper records should have the resident's name on every page.
  - If possible, the electronic health record should include the patient's photograph. This significantly lowers the rate of documenting in the wrong chart.
  - Other strategies may include entering the medical record number before locking any entry.

- Be objective.
  - Rather than stating, "resident was fatigued," state objective observations: "resident was short of breath while ambulating and requested to sit down after walking 20 steps down the hallway."
  - Rather than stating, "resident was confused," state objective observations: "resident was unable to recall the day of the week and didn't recognize his wife when she visited."
  - Include objective assessment information when applicable such as vital signs, oxygen saturation, blood sugars, etc.

- Terms to avoid:
  - "normal"
  - "good"
  - "Resident had a good night/day"
  - "appears"
  - "seems"
  - "generalized weakness"
  - "voiced no complaints"

- Use uniform abbreviations consistent with your facility's approved abbreviations. For example, OOB may mean "out of bed" to you, but not to anyone else.

- Date, time (use military or designate AM/PM) and sign each entry with your first name/initial, last name, and any designation – typed or automatically stamped if on EMR, legibly printed if on paper chart.
- Never chart or sign-off on cares/treatments or medications ahead of the time they were given.
- Adequately chart refusal of care (treatment, medication, appointment, skin check, bath, etc.). Include whether education was provided to resident on the benefits and potential negative outcomes by refusing.
- Do not chart "excuses" or "blame" other colleagues, "work" or the resident for treatments, appointments or medications not being completed.
- If caregivers use check sheets to make notations throughout their shift and then transfer information onto the resident record, ensure that your facility is consistent as to what happens to the original check sheet – either discarded or kept with the resident record.
- Chart for yourself. Only document on a chart what you did, what you observed, and the outcomes you witnessed. Don't chart resident information that was witnessed/performed by a co-worker. For example, are nurses documenting weekly skin checks performed by unlicensed staff on "bath days" without completing their own assessment?
- Document only what you're qualified to do. IDT staff should only chart information pertinent to their role. For example, activity staff should not be charting about a resident's condition – "Resident had a fall so did not attend activities today".

TEXTING RESIDENT PHI

Do you have a policy?

- Solutions
  - Use a secure platform
  - Confirm that texts are encrypted both in transit and at rest
  - Ensure mobile devices are password protected with multi-factor authentication
  - Limit identifying information to what is relevant
  - Confirm delivery and receipt of message
  - If used for clinical decision making, communication must be documented in clinical record
- Management
  - Stipulate that device must be able to be swiped
  - Maintain a retention policy for texts

- Limit narrative charting and utilize "button words" as much as possible in the electronic health record.
- Be descriptive rather than "diagnosing." For example, don't say "wound looked infected." Rather, "edges of wound are red with thick yellow drainage in the center."
- If documented any improvement or worsening in condition, be sure to state facts supporting your note (i.e. exact measurements, "as evidenced by").
- Don't use language that suggests a negative attitude toward the resident, family, or another health care worker.

- Note the exact time of any resident changes, significant events, and nursing actions. Document pertinent information/significant changes as soon as possible after the event. If you can't document in the resident's chart at once, note the time when you charted, as well as the time that the event occurred.

- Charting by exception – yes or no? Advantages: minimizes lengthy or repetitive charting; makes use of flow sheets. Disadvantages: assumes caregiver is able to accurately assess a change in resident status; could lead to a blank record if caregiver believes there are no "exceptions" to resident's usual status.

- Identify late entries as such. It is better to have a late entry than no documentation at all.

- Don't make assumptions or jump to conclusions. If a resident is found on the floor: Did the resident fall out of bed? Did the resident fall while trying to ambulate when they knew they shouldn't have? Chart objectively: "resident found lying on floor next to bed."

- Don't alter or destroy documentation. When a Request for Records is received, sequester the record to prevent it from being altered.

- Do not include incident reports, investigations, or grievances as part of the resident record.

- Do not refer to incident reports, investigations, and grievance forms in the record. For example, do not document, “see incident report” or “see investigation”.

META DATA OF THE RESIDENT RECORD

Meta data identifies the individual who access a patient’s medical chart and tracks the dates and times of actions performed.

During litigation, the attorney and the resident are entitled to this information and are tailoring requests to include the sequestering of this data.

- Do create a policy or procedure on the retrieval of metadata. The policy should address employees’ and others’ access to the record when litigation is pending.

- Do not delete entries or modify entries. Rather, create a late entry addendum if needed.

- Don’t write personal comments about a resident, e.g., “Mr. Jones was in a bad mood as usual.”

- Never criticize or blame other medical professionals/personnel in your documentation.

- Document all calls to physician and resident representative at change of condition. Note any repeated attempts to contact the physician and resident representative. Don't simply chart "message left for physician." If it is charted that the task of notifying the resident representative was passed on to the next shift, there needs to be documentation from the next shift that the notification actually occurred.

- Don’t chart words associated with errors, like “accidentally,” “unintentionally,” “miscalculated,” or “by mistake.”

- Paper Charting
  - Write in ink and write legibly.
  - Don't leave any blank lines.
  - Never use white-out or totally obliterate an entry. Strike through with one line and initial "documentation error."
  - Use the correct form or flow sheet. Make sure you're charting on the correct resident's chart. The resident's name should be on every page.
  - Identify when a note is a late entry. Don't squeeze it in on previous lines or write in the margin.