RECORD KEEPING AND DOCUMENTATION: HOW TO PROTECT YOURSELF AND YOUR RESIDENTS

Introduction

WHY DOCUMENTATION IS SO IMPORTANT

- Regulatory requirement
- Track and prove the care provided
- Coordinate care between providers/staff
- Financial records/support
- Risk management
WHY DOCUMENTATION IS SO IMPORTANT

If it wasn’t documented, it wasn’t done!

DOCUMENTATION BASICS
1. Be accurate and objective
2. Always record date and time
3. Do not assign blame
4. Only use standard and setting-approved abbreviations
5. Do not leave blank spaces

DOCUMENTATION BASICS
6. Write legibly
7. Write in ink
8. Do not document for someone else
9. Correct errors
10. Sign all documentation
1. BE ACCURATE AND OBJECTIVE

- Document only the things you see, hear, or touch.
- Never document something was done if you didn’t in fact do it yourself or witness first hand.
- If documenting something done by someone else, make that clear.

2. DATE AND TIME

- Every record, form, narrative entry, and piece of documentation should be dated
- The time should also be recorded with narrative entries
- Be clear when documenting times
- In some care settings “military time” may be used for better clarity, e.g., 1300 instead of 1:00 pm
- Clarify the policy in your Community

3. DO NOT ASSIGN BLAME

- Avoid assigning blame or calling attention to errors
- Staff disputes regarding resident care may occur and may be valid, but they do not belong in the resident’s record
- Concerns should be addressed directly with a supervisor
4. ABBREVIATIONS

• It is best to avoid abbreviations
• If you allow them in your Community only use standard and setting-approved abbreviations
• Have a list of approved abbreviations

5. NO BLANK SPACES

• Do not leave any blank spaced on a form or in a record
• Blank spaces could be filled out by someone else at a later time, allowing your entry to be modified
• Always line out blank spaces or list “n/a” as appropriate

6. WRITE LEGIBLY

• Your documentation doesn’t help anyone if you are the only person who can read it
• Although we sometimes find ourselves in a hurry at work, take time to write neatly and clearly
• Use electronic records when possible
Ensure seamless information exchanges between providers through the use of electronic health records (EHRs).

**PERCENTAGE OF COMMUNITIES USING EHR**

- Source: National Survey of Residential Care Facilities

**COMMUNICATING WITH OTHER PROVIDERS**

- Source: National Survey of Residential Care Facilities
7. INK

- Always write in blue or black ink
- Prevents the possibility of a record being modified at a later date
- If it is ever necessary to photocopy or fax a document blue or black ink will reproduce clearly

8. DO NOT DOCUMENT CARE BY SOMEONE ELSE

- Unless stated otherwise, anyone reading your documentation assumes that you performed the care being described
- If, for example, another caregiver assisted a resident with their morning shower, that caregiver should be the one to note it in the record

9. CORRECT ERRORS

- It's ok if you make a mistake in a record, it's not ok to use the wrong technique when correcting it
- Line it out with a single straight line, write the word “error” and initial the entry
- Go to the next blank line and start a new entry
- NEVER: Use white out, completely obscure an error with a pen or marker, destroy a document and attempt to recreate it, or erase an entry
10. SIGN

- Last, but certainly not least, always sign your entries, forms, and documents
- Be sure to include your credentials, if applicable, such as “RN”

Resident Records

- Admission agreements
- Identification and emergency information
- Physician’s report with TB results
- Telecommunications device notification form
- Medical consent
- Pre-admission appraisal
- Resident cash resources
- Resident property record
- Personal rights
- Medication records
- Advance health care directive information
### TWO RECORDS?

- Care record and business record
- Limits access to financial information
- The financial record (sometimes called a business file) can be stored in an area accessible only to those that are involved in billing and payments (such as the administrator’s office)
- Prevents caregivers and outside professionals from viewing potentially sensitive financial data

### THE “RESIDENT CARE” RECORD

- Admission and ongoing assessments
- Service/care plans
- Medication records
- Physician orders
- Narrative charting entries
- Vital signs records
- Miscellaneous other resident care information

### THE “BUSINESS FILE”

- The signed copy of the residency/admission agreement
- Financial records, such as invoices, payment receipts, etc
HOW LONG TO RETAIN RESIDENT RECORDS?

- CCL: "Original records or photographic reproductions shall be retained for a minimum of three (3) years following termination of service to the resident"
- Often recommended to keep records for at least 7 years for tax, legal, and other purposes
- Some providers will choose to keep records archived indefinitely

Employee Records

EMPLOYEE RECORDS

- Personnel record
- Health screening/TB test
- Criminal record statement
- Criminal clearance
- Administrator certificate, if applicable
- First aid card, if applicable
- Verification of education/experience
- Copy of driver’s license
- Training documentation
- SOC 341A
State and Federal laws require that employers conspicuously post a number of posters where they can be read by employees.

Some posters need to be displayed where they can be read by job applicants as well.

Update Annually

For more information:
www.dol.gov/elaws/posters.htm

- Industrial Welfare Commission (IWC) Orders
- Pay Day Notice
- Harassment or Discrimination in Employment is Prohibited by Law
- Equal Employment Opportunity is the Law (includes ADA poster)
- Safety and Health Protection on the Job (CAL-OSHA)
- Notice of Workers’ Compensation Carrier
- Notice to Employees: Unemployment Insurance & Disability Insurance
- Emergency Phone Numbers
- Notice: Employee Polygraph Protection Act
- Notice to Employees: Time Off to Vote
- Minimum Wage (State)
- Minimum Wage (Federal)
- Family and Medical Leave Act of 1993 (Federal) (50 or more employees)
- Family Care/Medical Leave/Pregnancy Disability (State) (50 or more employees)
- Pregnancy Disability Leave (five or more employees)
- No Smoking/Smoking Prohibited Except in Designated Areas
- Your Rights Under USERRA (Only certain size employers: Contact Labor Board)
- Military Duty
- National Labor Relations Act Notice
- Your Right to Know - Injuries Caused by Work
DOL eLAW TOOL

VOLUNTEER RECORDS

- Health statement
- Criminal clearance

Staff Training Records
CAREGIVER ORIENTATION TRAINING
- 40 hours total orientation
- 20 hours before working independently
  - 6 hours dementia
  - 4 hours postural supports, hospice
- 20 hours within first 4 weeks of employment
  - 6 hours dementia

CAREGIVER ONGOING TRAINING
- 20 hours annually
- 8 hours dementia
- 4 hours postural supports, hospice

MEDICATION TRAINING
- 16 or more residents
  - 24 hours training
  - 16 hours hands-on shadowing
  - 8 hours of other training
- 1-15 residents
  - 10 hours training
  - 6 hours hands-on shadowing
  - 4 hours of other training
RCFE ADMINISTRATOR CERTIFICATION

- 80 hour initial certification course
  - 60 hours must be in person
  - 20 hours online
- 100 question exam
- Updated by DSS annually

CCG CAN HELP

Section 87406(a) of title 22 regulations requires all individuals to be certified prior to being employed as an administrator.

To become certified a person must:
1. Complete the initial certification course
2. Pass the state exam
3. Apply for certification

DOCUMENTING STAFF TRAINING

- Trainer’s full name
- Subject(s) covered in the training
- Date(s) of attendance
- Number of training hours per subject
- Certificates of completion
- Specialized forms
CCG CAN HELP

All your records in one place!
✓ Manage one or multiple locations
✓ Automatic reporting features
✓ Automatic email reminders for staff
✓ Easy to Use

Assessments, Appraisals, and Service Plans

APPRAISALS AND ASSESSMENTS

• Is this resident appropriate for my community?
• Is my community appropriate for this resident?
Assessments
Performed by licensed medical professionals (RN, MD, etc.)
Physician report, etc.

Appraisals
Can be performed by appropriately trained staff
Pre-admission appraisal, etc.

ASSESSMENT/APPRaisal BASICS
- Ask open-ended questions
- Avoid “yes” or “no questions”
- Be mindful of non-verbal communication (wincing, confusion, intimidation, etc.)
- Family/responsible party – get them involved, but don’t let them take over
- Where to conduct the interview? In their home? At the community?
- Self-reporting vs. direct observation

IS THIS PERSON APPROPRIATE?
- Conduct an interview with the applicant and his responsible person
- Perform a pre-admission appraisal
- Obtain and evaluate a recent medical assessment
- Execute the admissions agreement
PRE-ADMISSION APPRAISAL

- Functional capabilities
- Mental condition
- Social factors

FUNCTIONAL CAPABILITY ASSESSMENT

- LIC9172
**MEDICAL ASSESSMENT**
- Physician report
- Prior to acceptance!
- Made within the last year
- Recent is preferable

**MEDICAL ASSESSMENT**
- LIC602A

**SERVICE PLANS**
- Resident participation in decision-making
- Prior to, or within two weeks of admission
- Meet with resident and key stakeholders
- Develop written plan of care
- Update upon change in condition, or at least once every 12 months
SERVICE PLANS

- LIC625

REAPPRAISALS

Shall be updated upon significant changes:
- Physical trauma such as a heart attack or stroke
- Mental/social trauma such as the loss of a loved one
- Any illness, injury, trauma, or change in the health care needs of the resident that results in a prohibited health condition

CHANGES IN CONDITION

- Educate staff to watch for, and report changes
- Caregivers often identify changes before anyone else
- Report changes to the right people: 911 (when applicable), physician, family/responsible party, CCL (when applicable), etc…
CHANGES IN CONDITION

- INTERACT
- Reduce unnecessary hospitalizations and readmissions
- “Stop and Watch”
- SBAR (Situation, Background, Appraisal, Request)
- www.interact2.net

SBAR

IMPACT ON YOUR BOTTOM LINE

- Levels of care, a la carte, or fee for service payment models
- Outdated or inaccurate assessments can hurt your bottom line
- Are you providing care/services that you aren’t being paid for?
Incident Reporting

REPORTING REQUIREMENTS

- Calling 911
- Incident reports
- Abuse reporting
- Notifying family/responsible party

CALLING 911

- When in doubt, call 911
- Follow 911 operator’s instructions
- Be aware of Advanced directives and DNR status (addressed in detail on day 5)
- Document!
Applicable Regulations

- 87211

INCIDENT REPORTING

- A written report shall be submitted to the licensing agency and to the person responsible for the resident **within seven days** of the occurrence

INCIDENT REPORTING

- Death of any resident from any cause
- Any serious injury
- The use of an Automated External Defibrillator
- Any incident which threatens the welfare, safety or health of any resident

SHOULD YOU REPORT EVERY FALL?

- Yes or no? ______________________________
- If yes, why? ______________________________
- If no, why? ______________________________
Mary Smith is an 84 year old female resident living in your RCFE. Mary’s daughter brought her to your Community when her cognitive functioning became more impaired after her third stroke a year ago.

Mary fell while walking to the dining room one morning and hit her head on the tile floor. She had a small cut on her temple, but otherwise reported that she felt fine. Mary asked a caregiver to simply place a bandage on the cut and let her go to bed.

How should you handle this? Should you call 911?
ABUSE REPORTING

- Mandated reporters
- Failure to report is a misdemeanor

STAFF TRAINING

- “Your Legal Duty” (on YouTube)
- Use of the SOC 341
- Mandated reporter status
- Responsibilities in reporting abuse
- Initially upon hire and annually
- Sign SOC341A

CCG CAN HELP

Abuse Reporting Training Kit
Failure to report physical or financial abuse of an elder or dependent adult is a misdemeanor. As a mandated reporter, the licensee, administrator, and staff in a residential care facility must understand when and how to report suspected or alleged incidences of abuse.
YOUR LEGAL DUTY

REPORTING ELDER AND DEPENDENT ADULT ABUSE

Your Legal Duty: Reporting Elder and Dependent Adult Abuse

Any suspected or witnessed abuse, including violation of resident rights, is to be reported. Use the SOC341 and report to the Long Term Care Ombudsman in the community's county.
ABUSE REPORTING

• Ombudsman cannot report suspected abuse cases to law enforcement without the consent of the resident involved.
• Mandated reporters must also report directly to law enforcement in cases of physical abuse.

If suspected or alleged physical abuse results in serious bodily injury:
1. Call local law enforcement immediately, and no later than within 2 hours AND
2. Send a written report to law enforcement, local ombudsman, and CCL within 2 hours

If suspected or alleged physical abuse does NOT result in serious bodily injury:
1. Call local law enforcement within 24 hours AND
2. Send a written report to law enforcement, local ombudsman, and CCL within 24 hours
If suspected or alleged physical abuse is caused by a resident with dementia, and does NOT result in serious bodily injury:

1. Call the local ombudsman OR law enforcement agency immediately or as soon as possible AND
2. Make a written report within 24 hours

If suspected or alleged abuse is not physical abuse (abandonment, abduction, isolation, financial, neglect):

1. Call the local ombudsman OR law enforcement agency immediately or as soon as possible AND
2. Make a written report within two working days

Serious bodily injury means:
- An injury involving extreme physical pain, substantial risk of death, or protracted loss of impairment of function of a bodily member, organ or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation.
HOW OFTEN TO NARRATIVE CHART?

- Daily?
- Weekly?
- Every shift?
- Charting to the exception?

WHO?

- Administrator
- Department heads
- Nurses
- Medication Aides
- Caregivers?
- Others?

DAR CHARTING

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DATA

- 8/11/08 7:45 am
  Entered Jane’s room and found her on the floor next to her bed. Jane stated “I don’t remember what happened, but I think I feel down, please help me up.” Resident reported significant pain on the right side of her chest when attempting to move. Small amount of blood identified on right side of head just above her right ear.

ACTION

- Instructed resident to remain on the floor and radioed for assistance from another caregiver. Caregiver John Doe entered the room and I asked him to call 9-1-1. I remained with resident, told her the paramedics would arrive soon.

RESPONSE

- 8/11/08 8:15 am
  Paramedics arrived and transported resident to St. Mary’s Hospital.
- 8/11/08 1:30 pm
  Spoke to doctor James Doe from St. Mary’s Hospital. She informed me that Jane has two broken ribs and will be staying in the hospital overnight.
Case Studies

CASE STUDIES

MEDICATION RECORDS
- Outdated records
- Outdated assessments
- Final notes
- Narrative charting

CASE STUDIES

GROUP PROJECT

- Break into small groups
- Each group will be provided a sample record/document to review
- Identify at least three areas of concern and how you would correct each of them
- Be prepared to share with the group