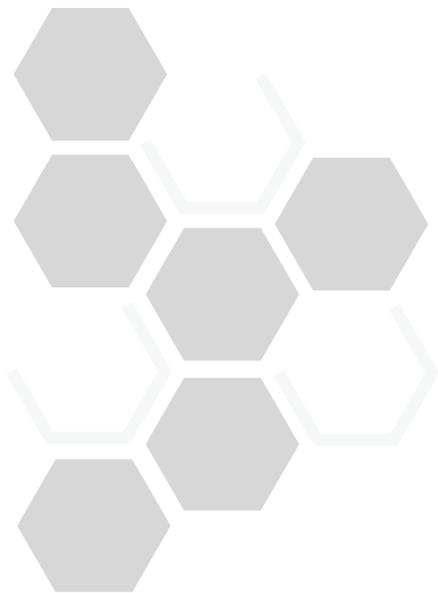


# CLINICAL DOCUMENTATION STRATEGIES FOR HOME HEALTH

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Elizabeth I. Gonzalez, RN, BSN



# **Clinical Documentation Strategies for Home Health**



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# Contents

<b>About the Reviewer</b> .....	vii
<b>Chapter 1: Documentation Intent and Process</b> .....	1
Nurse Case Manager Role .....	4
Clinical Supervisor Role .....	4
Nursing Process as a Guide .....	5
Nursing Diagnosis and Nursing Outcome Classification .....	8
Outcomes Identification .....	10
Planning.....	11
Implementation.....	14
Evaluation .....	14
Organizational Policies, Protocols, and Practices .....	15
Education.....	19
References .....	19
<b>Chapter 2: Defensive Documentation</b> .....	21
OASIS Coding: Always Tell the Truth.....	22
Risk Management Guidelines for Documenting Care.....	23
Legal Risks With IV Therapy .....	24
Legal Risks in Skin Care.....	25
Handling Documentation Errors .....	27
Adverse Events: When Bad Things Happen to Good Nurses .....	28
Risk-Reduction Strategies.....	32
References .....	33

<b>Chapter 3: Contemporary Nursing Practice .....</b>	<b>35</b>
<b>Certification .....</b>	<b>37</b>
<b>Professional Standards .....</b>	<b>40</b>
<b>Code of Ethics .....</b>	<b>42</b>
<b>State Nurse Practice Act .....</b>	<b>43</b>
<b>Threats to Licensure .....</b>	<b>45</b>
<b>Professional Boundaries in Home Health .....</b>	<b>46</b>
<b>Federal and State Regulations .....</b>	<b>47</b>
<b>Organizational Policies and Procedures .....</b>	<b>48</b>
<b>Competency Assessment.....</b>	<b>49</b>
<b>References .....</b>	<b>50</b>
<b>Chapter 4: Clinical Documentation .....</b>	<b>51</b>
<b>Communication Through Documentation.....</b>	<b>52</b>
<b>Compliance Through Documentation.....</b>	<b>53</b>
<b>Peer Review and Managed Care.....</b>	<b>55</b>
<b>The Joint Commission .....</b>	<b>55</b>
<b>Quality and Risk-Management Review .....</b>	<b>57</b>
<b>Clinical Record as a Path to Reimbursement.....</b>	<b>59</b>
<b>Clinical Record and Pay for Performance .....</b>	<b>61</b>
<b>References .....</b>	<b>62</b>
<b>Chapter 5: Nursing Negligence .....</b>	<b>63</b>
<b>Legal Issues for Nurses .....</b>	<b>63</b>
<b>Home Health Litigation .....</b>	<b>66</b>
<b>Data Bank.....</b>	<b>75</b>
<b>References .....</b>	<b>76</b>
<b>Chapter 6: Improving Documentation .....</b>	<b>79</b>
<b>Identify and Correct Mistakes.....</b>	<b>79</b>
<b>Tips to Improve Your Documentation.....</b>	<b>84</b>
<b>References .....</b>	<b>86</b>
<b>Chapter 7: Developing a Foolproof Documentation System.....</b>	<b>87</b>
<b>Evaluating Your Current Documentation System.....</b>	<b>88</b>
<b>Systems of Documentation .....</b>	<b>89</b>
<b>Ten Steps to Ensure a Foolproof Documentation System .....</b>	<b>99</b>
<b>References .....</b>	<b>102</b>
<b>Chapter 8: Auditing Your Documentation System.....</b>	<b>103</b>
<b>Audits Protect You and Your Organization .....</b>	<b>103</b>
<b>Audit Systems and Performance Improvement Goals .....</b>	<b>103</b>
<b>Measuring Compliance and Improvement .....</b>	<b>105</b>
<b>Staff Compliance .....</b>	<b>106</b>
<b>Advantages of Audits for the Clinical Supervisor.....</b>	<b>107</b>
<b>Clinical Supervisor Tips for Auditing .....</b>	<b>108</b>

**Chapter 9: Telehealth and EHRs** ..... 109

**How to Build an Electronic System That Reduces Liability**..... 110

**Legal Issues With EHRs** ..... 111

**Start at the Beginning** ..... 111

**Benefits of Electronic Documentation** ..... 113

**The Clinical Supervisor’s Role** ..... 114

**Challenges Associated With Change**..... 115

**The Dos and Don’ts of Developing an Electronic Documentation System**..... 116

**Strategies for Success** ..... 117

**Certified EHR Technology** ..... 119

**Legal Risks With Telehealth**..... 119

**References** ..... 120

**Chapter 10: Motivation to Document Accurately and Completely** ..... 121

**Why Nurses Document Poorly** ..... 121

**Change: Embrace It or Resist It** ..... 123

**Education and Expectations**..... 124

**The Good, the Bad, and the Ugly Approach** ..... 125

**Monitoring the Work Environment**..... 126

**Staff-Motivation Tips for Clinical Supervisors**..... 128

**References** ..... 129

**Appendix**..... 131





# About the Reviewer

## **Elizabeth I. Gonzalez, RN, BSN**

Elizabeth I. Gonzalez, RN, BSN, is the Director of Patient Care Services and Assistant Administrator at Accent Care Texas Home Health. She has more than 30 years nursing experience, with 20 years in the home healthcare field of nursing. Her previous roles within home health have been as field nurse and clinical manager.

Gonzalez earned her Bachelor of Science Degree in Nursing from the University of Texas at El Paso. She also holds a Certificate of Completion in Business Administration. She is also a member of Sigma Theta Tau International Honor Society for Nursing.

Gonzalez has been dedicated to the profession of nursing since 1983. She is committed to the nursing culture of excellence, the value of pride and professionalism, and quality outcomes and collaborative practice with patient- and family-centered care.





1

# Documentation Intent and Process

Focusing on better rather than more with respect to documentation is a good axiom to remember. The clinical record must be accurate and complete, but does not need to be overwhelming. The information it contains is crucial for a number of people and functions. It is used to communicate patients' progress to other clinical and nonclinical staff. It is also used by the agency's quality and risk management department. Documentation is essential to ensure reimbursement from payer sources and to provide evidence of your patient outcomes along with the quality of care and improvement. If there is a question of the care that was given, it is also used by an auditor to determine substandard professional care, which may also be considered negligent. And if the agency is accredited by CHAP (Community Health Accreditation Program) or The Joint Commission, the clinical record, as well as on-site visits, is used to measure compliance with accreditation standards.

Documenting completely and accurately is considered a professional standard of nursing practice. Documentation demonstrates the quality of care given, establishes reimbursement entitlement, and substantiates the need for services (Mahler, 2001). For every step in the nursing process, the care delivered must be documented. Whether you are a clinical supervisor assisting your staff, a case manager, or an LVN/LPN, it is every nurse's responsibility to fulfill the necessary requirements of good clinical care and documentation. Doing so not only validates the universally recognized professional approach to patient care, it also supplies other care providers with consistent, clear communication and validates critical decision-making that is often necessary for quality patient care.

## Chapter 1

Many research studies have attempted to identify why nurses do not value the importance of their documentation. Although documentation may not be valued by nurses, it is still a requirement. In today's climate of accountability and service expectations, it is more critical now than in past years. We know that documentation has changed over the last few decades in both its appearance and the advent of electronic documentation in an attempt to facilitate data entry and access. What is still missing with these changes is demonstration of patient continuity of care and the evaluation of patient outcomes.

The quality of the care provided to patients can only be measured by the quality of the nursing documentation. The major reasons for documenting nursing care include:

- Creating a record of the patient's ongoing assessment and care
- Creating a working document that is the plan of care
- Coordination of services provided
- Evaluation of the effectiveness of the care provided
- Facilitation of communication with staff, caregivers, or other providers
- Reimbursement for services provided

Remember that the clinical record is:

- The only written source for communication among the home health team members and caregivers
- The written source that supports reimbursement for services provided
- The written evidence of clinical decision-making
- The legal record of client care
- The basis for evaluation of care provided by peers; auditors; licensing, accreditation, and government surveyor review
- The evidence that demonstrates meeting the professional standard of care (Marrelli, 2011)

Failure to document completely can have legal consequences. If documentation is incomplete, contains gaps, or is not consistently completed according to the organization's policies, it can be used to support an allegation that negligent care was provided. Even worse, documentation of care or services provided when in fact they did not occur is open to "failure-of-care" accusation. These failure-of-care cases are initiated by the government when the healthcare provider submits bills for grossly substandard care that are equal to no care at all (Hess, 2005).

Incomplete documentation allows for juries or surveyors to conclude that the nurse did not collect sufficient data and plan appropriate care; implement appropriate interventions according to professional and agency standards; make good clinical decisions; and communicate effectively.

In many ways, if something isn't documented, it didn't happen.

A Medicare survey citation frequently results when documentation does not support that the plan of care was followed, or services delivered were not ordered in the plan of care. According to Marrelli, there are five areas that have increased in importance of clinical documentation (see Figure 1.1).

Figure 1.1

## Expectations of documentation

Factors contributing to importance of documentation	Expectations
Emphasis on value and cost	<ul style="list-style-type: none"> <li>● Third-party payers have increased their scrutiny and control of resources</li> <li>● Documentation must demonstrate skilled care was provided</li> <li>● Pay for performance will be in home healthcare in the future</li> </ul>
Emphasis on quality improvement	<ul style="list-style-type: none"> <li>● Patient outcomes are now indicators of quality care</li> <li>● Documentation must demonstrate care and achievement of stated goals</li> <li>● Documentation needs to demonstrate care coordination and collaboration</li> <li>● Timely returns of the 485 and MD orders within 30 days</li> <li>● Competency assessment of the staff upon hire and annually</li> <li>● OASIS used for demonstrating quality care based on outcomes</li> </ul>
Emphasis on standards of care and processes	<ul style="list-style-type: none"> <li>● Defined levels of care based on evidence-based practices</li> <li>● Use of clinical practice guidelines or clinical pathways</li> <li>● Government has developed clinical practice guidelines to move to a standardization in healthcare (see <a href="http://www.guideline.gov">www.guideline.gov</a>)</li> <li>● Patient/caregiver and payer satisfaction critical to agency's survival</li> <li>● Patient satisfaction surveys by CMS</li> </ul>

Figure 1.1

## Expectations of documentation (cont.)

Factors contributing to importance of documentation	Expectations
Emphasis on capturing fraud and abuse	<ul style="list-style-type: none"> <li>● Clinical documentation must be F-A-C-T (factual, accurate, complete, and timely)</li> </ul>
Emphasis on effectiveness and efficiency	<ul style="list-style-type: none"> <li>● Automation to help prevent duplication of clinical and administrative information</li> <li>● Implementation of the electronic medical record in the homecare agency</li> <li>● Quality versus quantity in documentation</li> <li>● Effective documentation supports appropriate care</li> </ul>

(Marrelli, 2011)

## Nurse Case Manager Role

In home healthcare today, every member of the team is accountable for factual, accurate, complete, and timely documentation. However, the nurse case manager is really the focus of any clinical record review. In today's culture of quality and accountability, the role and scope of responsibilities, as demonstrated by the nurse case manager's documentation, will bring him or her under scrutiny. The documentation reveals commitment to quality patient care. The case manager must recognize the importance of good clinical documentation. It is also vital that he or she assists everyone working on the case to practice defensive documentation and avoid the potential for legal consequences if a case is reviewed for alleged malpractice, substandard care, or fraudulent practices. The key is to be organized and complete the visit documentation as soon as the visit is completed.

## Clinical Supervisor Role

As a member of the management team, it is your responsibility to assist your staff in adhering to both clinical and documentation standards. It is also your responsibility to provide continuing education, professional feedback, and input into policy and documentation-system changes whenever possible. It is to your advantage to fulfill these responsibilities because if your staff is involved in a government audit or survey, your ability to manage and meet quality and risk-management standards will be called into question.

In home healthcare the clinical supervisor must not only demonstrate a commitment to providing safe and efficient patient care, but also ensure that every clinical record reflects that commitment. That is, although you must ensure that nursing staff comply with up-to-date standards, it is equally important to ensure that they document that compliance accurately and completely.

Your role is to support an efficient and effective documentation system and to create an expectation that the system be followed. It is also your responsibility to ensure competent and contemporary care is being given to the clients. The nurse case managers must have excellent assessment and documentation skills. The assessment skills are needed for reimbursement, and the documentation of that comprehensive assessment within the defined time frames determines the reimbursement (Marrelli, 2011).

Nursing management can demonstrate support for such an environment by:

- Developing an efficient system that meets the requirements of regulatory standards.
- Involving the end users in the development of the system.
- Emphasizing the importance of documentation through routine audits, written guidelines, policies, job descriptions, and performance appraisals. The language should include stipulations for daily supervisory oversight, audits of the system, and feedback to the staff.

## Nursing Process as a Guide

The nursing process, as outlined by the American Nurses Association's (ANA's) Nursing Scope and Standards of Practice, provides us with an established, scientific approach to providing nursing care. Not only does each step guide us in our approach, it also tells us how to validate what we saw, heard, felt, smelled, said, and did while providing that care. The process accounts for all significant data and actions taken by a registered nurse, the documentation of which is used for critical decision-making. Therefore, your documentation of patient care should follow the framework of the nursing process.

### Assessment

The first step of the nursing process is assessment. In this step, the nurse collects information about the patient's condition, which could include the patient's history, the physical exam, laboratory data, and so on. So as not to become overwhelmed, the nurse must decide which information is most useful to the care of the patient. For example, a nurse could limit the assessment data to the admission signs and symptoms, the chief complaint, or medical diagnosis.

This first step should always be evident in the medical record as it provides a complete clinical picture of the patient. In home healthcare, the Outcome and Assessment Information Set (OASIS) is an integral piece of an agency's clinical documentation system. The OASIS "represents core items of a comprehensive assessment for an adult home care patient and forms the basis for measuring patient outcomes for purposes of outcome-based quality improvement. The OASIS is a key component of Medicare's partner-

ship with the home care industry to foster and monitor improved home healthcare outcomes” according to the Centers for Medicare & Medicaid Systems, which requires home health agencies to use OASIS in order to be Medicare-certified.

Nurses must understand the importance of data collection and its long-term impact on home care. Your critical thinking skills are self-evident when you are able to combine all assessment data and OASIS items, which then provide a complete picture of the patient and his or her care needs. An assessment should include both subjective and objective data. When documenting this data, beware of inappropriate documentation practices and focus on quality and risk-management strategies.

### **Subjective data**

In this context, subjective data are data that can be observed, but not measured. Statements made by the patient or family/significant other are examples of subjective data. Although every conversation may not be relevant to the interaction, there will be times when a patient’s words need to be recorded to establish a clear picture of how the patient perceives his or her status. For instance, if the patient says something that can be used to demonstrate mental, behavioral, or cognitive status at the time of the assessment, documentation of the conversation can be used to measure progress or decline over the course of treatment. If patients are unable to speak or are cognitively impaired, nonverbal cues are essential in determining whether there has been any change in status. These conversations with the patient/family will need to be captured in the clinical record in order to provide other clinicians with an accurate depiction of the patient’s current status.

### **Objective data**

Nurses establish patients’ clinical status based on objective data, which are observable and measurable. Physical exams of patients, which include key assessment techniques such as inspection, palpation, percussion, and auscultation, provide objective data about patients’ health status. In simpler terms, nurses’ objective assessments are based on what is seen, heard, palpated, smelled, or any other observation by the senses. Healthcare providers find this much easier to validate and include in their documentation than subjective data. Objective data also includes the results of diagnostic tests.

When recording this data, however, there are risks your staff should consider. If the objective data is not reviewed in a timely manner, a reviewer of the clinical record may point out that you failed to interpret the data and address significant changes of condition. There also may be situations in which critical objective data were present but there was no subsequent documentation of an appropriate intervention. In addition, if the absence of critical objective data resulted in a gap in the clinical picture of the patient, it may contribute to a lack of appropriate intervention identification. All of these situations can lead to quality and risk-management issues.

Good nursing documentation should tell a story about the client and their problems. Just like when reading a book, the reader can understand the story. There is a beginning, middle, and end. The nurse must document every visit in a way that supports moving the client to the stated goals and outcomes on the

485. Documentation also includes the client's homebound, admission, or general assessment status as well as the skill provided at that visit. "Focus is on the patient's problems in the documentation and why home care is involved; and, from any payer's perspective is what they must see to authorize payment" (Marrelli, 2001).

Your documentation must show that you are aware of the physician orders, are following the physician orders, and that you are updating the physician, the patient, and the family on all changes related to the patient that are not on the physician orders.

OASIS data elements are the basis for appropriate reimbursement and demonstrate client outcomes by:

- Representing core items, to be integrated into a comprehensive assessment for an adult home care patient
- Forming the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI)
- Providing quality data for consumer's use on Home Health Compare, the website that publicly compares healthcare quality by agency
- Providing information on the patient's conditions and needs to formulate the proper reimbursement (*CMS.gov*)

Gaps in documentation on any clinical assessment tool leave the nurse and the agency open to allegations that they failed to document assessments or failed to address significant changes of condition. For example, in the case of an incomplete assessment of intake and output (I&O), it could be alleged that the lack of analysis, intervention, and accurate documentation was the cause of circulatory collapse, dehydration, renal failure, infections, skin breakdown, or even death.

For the nurse to arrive at a nursing diagnosis and the development of a nursing plan of care, the assessment findings are crucial. Be sure you are completing all assessment tools thoroughly.

The following are some risk-management tips for documenting assessment findings:

- Describe everything exactly as found by inspection, palpation, percussion, or auscultation
- Do not allow the use of general terms such as "normal," "abnormal," "good," or "poor"
- Be specific, and include both negative and positive aspects
- Adhere to your policies' time frames on completion of assessments
- Document your assessment as soon as possible after completing it

## Nursing Diagnosis and Nursing Outcome Classification

If nurses accurately perform the assessment process, they will be able to appropriately establish nursing diagnoses. This phase of the nursing process demonstrates that the nurse reviewed the appropriate data available at the time and made a professional determination of the clinical problem(s) at that time. Once the nurse makes a clinical nursing diagnosis based on a thorough assessment, the rest of the process falls into place.

The nursing diagnosis expresses the nurse's professional judgment of the patient's clinical status, the anticipated response to treatment, and the potential nursing-care needs. It guides the nurse and subsequent providers in their understanding of the patient's problem(s) and the plan of care developed specifically for that problem(s).

### Nursing Terminology

If your agency chooses to include the nursing diagnosis in its documentation system, you should promote consistency and use of correct terminology by adopting the North American Nursing Diagnosis Association International (NANDA International) terminology. The NANDA International diagnostic headings, coupled with the patient's clinical etiology, provide a clear picture of the patient's needs.

A research team at the University of Iowa has given nursing a standardized terminology for nursing-specific and nursing-sensitive outcomes. This comprehensive classification of nursing outcomes is called the Nursing Outcomes Classification (NOC).

Since the outcomes describe patient/client status, other disciplines may find them useful for the evaluation of their interventions.

The 490 outcomes in *Nursing Outcomes Classification (NOC) (5th ed.)* are listed in alphabetical order. Each outcome has a definition, a list of indicators that can be used to evaluate patient status in relation to the outcome, a target outcome rating, scale(s) to measure patient status, and a short list of references used in the development and refinement of the outcome. A five-point Likert scale is used with all outcomes and indicators.

The NOC outcomes are grouped in a coded taxonomy that organizes the outcomes within a conceptual framework to facilitate identifying an outcome. NOC is different from a nursing diagnosis, which describes a patient's problem, either actual or potential. However, NOC can help the nursing diagnosis to be made. (See an NOC example in Figure 1.2).

Figure 1.2

## NOC example

<b>Domain—Health Knowledge and Behavior</b>						
<b>Class—Health Knowledge</b>						
<b>Scale(s)—None to Extensive (i)</b>						
<b>Indicators</b>		<b>None 1</b>	<b>Limited 2</b>	<b>Moderate 3</b>	<b>Substantial 4</b>	<b>Extensive 5</b>
180302	Description of specific disease process	1	2	3	4	5
180303	Description of cause or contributing factors	1	2	3	4	5
180304	Description of risk factors	1	2	3	4	5
180305	Description of effects of disease	1	2	3	4	5
180306	Description of signs and symptoms	1	2	3	4	5
180307	Description of usual disease course	1	2	3	4	5
180308	Description of measures to minimize disease progression	1	2	3	4	5
180309	Description of complications	1	2	3	4	5
180310	Description of signs and symptoms of complications	1	2	3	4	5
180311	Description of precautions to prevent complications	1	2	3	4	5
Specify disease:						

*1st edition 1997; Revised 3rd edition*

*Reprinted from Iowa Outcomes Project Nursing Outcomes Classification (NOC), 3rd edition, page 352. Copyright 2004 with permission from Elsevier.*

Or you could simply state your outcomes as:

- The patient will explain the disease state, recognize the need for medications, and understand treatments [insert end date of the 60-day plan]
- The patient will demonstrate how to perform health-related procedures satisfactorily by [insert time frame] (Ladwig, 2006)

*Nursing Outcomes Classification*, 3rd edition, matched those nursing diagnoses to NOC outcomes home-care nurses selected.

Figure 1.3

## NOC and NANDA diagnosis example

NOC outcomes selected for NANDA diagnoses for home care patients	
NANDA diagnoses	Possible NOC outcomes to use
Knowledge deficit	<ul style="list-style-type: none"> <li>● Knowledge: Diet</li> <li>● Knowledge: Disease process</li> <li>● Knowledge: Energy conservation</li> <li>● Knowledge: Health resources</li> <li>● Knowledge: Infection control</li> <li>● Knowledge: Medication</li> <li>● Knowledge: Prescribed activity</li> <li>● Knowledge: Treatment procedures</li> <li>● Knowledge: Treatment regimen</li> <li>● Self-Care: Nonparenteral medication</li> <li>● Self-Care: Parenteral medication</li> </ul>

In using the NOC outcomes, you are demonstrating evidence-based nursing practice with quantitative data to support the effects of your nursing actions and progress in the plan of care.

## OASIS

A good example of the integration and use of outcomes identification can be found in home healthcare. The Centers for Medicare & Medicaid Services (CMS) requires all Medicare-certified home health organizations to use the OASIS data set, which contains core measures that have been identified as applicable to all client groups. It also contains measures specific to client groups with a particular diagnosis or problem, the outcomes of which are measured on scales specific to them. Using the OASIS outcome system, nurses assess whether home health clients have improved, stabilized, or deteriorated (Sparks and Taylor, 2001).

## Outcomes Identification

If you do not elect to use the NOC outcomes, then the next step in the nursing process is to determine an expected outcome, or goal, for the patient. The outcome must be derived from the nursing diagnosis and documented as a measurable, realistic, and patient-focused goal. It must include a target time or date as well as an objective measurable action that the patient is expected to achieve.

Whenever possible, include the patient/family's perspective on the goal of treatment and the time frame. The expected outcomes also should reflect the continuum of care, from admission, addressing immediate and intermediate outcomes, for planning for discharge and follow-up care.

**Tips for documenting expected outcomes**

- Be specific
- Be realistic
- It must be measurable
- Define the time frame for achieving the outcome
- Include the patient/family's desires and resources (Doenges, 2006)

Goal setting is stated in the locator 22 on the CMS 485. Usually the goals are stated in generic terms. The best way to write goals is to think about your expectations about the outcomes and write them according to the tips above.

**EXAMPLE of GENERIC:**

"All body systems will return to WNL."

"Client will not have any urinary incontinence."

**OUTCOME-BASED:**

"Client will regain independence in dressing upper body."

"Client will be able to control urinary incontinence through timed voiding."

## Planning

The next step in the nursing process is to develop a plan of care for the patient based on the nurse's assessment/diagnosis. Documentation of this phase demonstrates that the clinical status of the patient was recognized and that the nurse then developed an appropriate plan of care. It shows that the nursing process was in place and thereby decreases the risk of incomplete or incorrect care. Having a written road map helps everyone involved provide safe and quality care.

When developing a plan of care, use the following guidelines:

- Review identified nursing diagnoses and rank them in order of priority/exacerbation
- Use evidence-based nursing interventions or clinical guidelines/pathways
- Include nursing diagnosis, expected outcomes, nursing interventions, and evaluation of care
- The plan of care should be used as a communication tool between all home care team members, caregivers, and the client

This step of the nursing process can be documented in a variety of ways. You can use a specially designed form, flow sheet, 485, daily visit notes, nursing progress notes, clinical pathway, or specific software module. But whatever format is used, remember that the patient plan of care is a permanent part of the clinical record and is used to evaluate the care that was provided. Adjustments to the plan of care should reflect a progression of care based on the client's needs. Key components of documentation for each qualifying service can be seen in Figure 1.4.

Figure 1.4

## Care planning by service

Medicare care planning	
Qualifying service	<ul style="list-style-type: none"> <li>● Key components of documentation</li> </ul>
Skilled observation and assessment	<ul style="list-style-type: none"> <li>● Findings and judgments</li> <li>● Contacts with physician when indicated</li> <li>● In-depth assessment of issues or body systems relevant to patient's medical instability</li> </ul>
Client education	<ul style="list-style-type: none"> <li>● Comprehension level</li> <li>● Subject matter taught</li> <li>● Response to the teaching</li> <li>● Knowledge and skills acquired</li> </ul>
Therapy services	<ul style="list-style-type: none"> <li>● Performance of treatments based on MD orders</li> <li>● Response to treatment</li> <li>● Any efforts to locate caregivers who can learn to safely and appropriately perform treatments</li> <li>● Communication with MD of any evidence of ineffective treatment</li> </ul>
Management and evaluation of a complex plan of care	<ul style="list-style-type: none"> <li>● Interventions and evaluations showing management of the plan</li> <li>● Successes and failures</li> <li>● Modifications made</li> <li>● Patient/caregiver satisfaction and condition</li> <li>● Capability and endurance of the caregivers</li> <li>● Contribution of other professionals</li> </ul>

What to write in a home healthcare patient's plan of care can be a difficult task for the case manager. We are bound by the Medicare Conditions of Participation (CoPs) and must follow their directives. According to the Medicare CoPs, "the Plan of Care (POC) must contain all pertinent diagnoses, including:

- The patient's mental status
- The types of services, supplies, and equipment required
- The frequency of the visits to be made
- Prognosis
- Rehabilitation potential

- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments
- Safety measures to protect against injury
- Instructions for timely discharge or referral
- Homebound status
- Any additional items the home health agency (HHA) or physician chooses to include.” (CMS Manual, Chapter 6, Section 3.1)

CMS also states the following regarding the 485 Form:

*Standardized data collection facilitates accurate coverage decisions, helps to ensure correct payment for covered services, and promotes compliance with federal laws and regulations. The CMS-485—the Home Health Certification and Plan of Care—meet regulatory and national survey requirements for the physician’s plan of care, certification, and re-certification. Form CMS-485 provides a convenient way to submit a signed and dated POC. However, HHAs may submit any document that is signed and dated by the physician that contains all of the required data elements in a readily identifiable location within the medical record and in accordance with the current rules governing the home health POC. The signed POC is maintained in the beneficiary’s medical record at the HHA with a copy of the signed POC available upon request when needed for medical review (MR). (www.CMS.gov)*

## Plan of care pitfalls

Unfortunately, one of the most commonly cited deficiencies in home healthcare is the failure to follow the plan of care. Be sure that you have a thorough assessment to begin the process. Then decide the critical nursing interventions and measurable outcomes. Some agencies have software to help case managers. The OASIS data is integrated into the plan of care (485). However, it still requires the case manager to analyze the assessment data and determine the pertinent diagnoses and the development of a realistic plan of care.

### Top Deficiencies Cited by CMS Surveyors:

- Incomplete documentation of care and services
- Incomplete or missing physician orders for all services, medications, and treatments
- Inconsistent documentation—information varies on the OASIS, 485, clinical notes, progress summaries, and between disciplines
- Vague and/or unrealistic goals for all disciplines
- Visits for all disciplines not made at the frequency ordered on the plan of care
- No explanation for missed visits
- No documentation that the physician was notified of missed visits and reasons

- Lack of compliance with physician orders for assessment and teaching related to the specific disease process assessment and management; pain assessment and management, wound assessment and care.
- Lack of orders for changes in medications and treatments
- Lack of complete resumption of care orders post-hospitalization
- The home health aide supervisory visits were not conducted as needed
- There was no evidence of coordination of services
- The clinical record did not identify coordination of services
- The case manager (RN) did not routinely reevaluate the patient care needs (*www.CMS.gov*)

## Implementation

Based on the nursing plan of care and contemporary standards of nursing care, the nurse then documents the care provided for the patient. This phase of the nursing process includes working collaboratively with other members of the healthcare team, the patient, and the patient's family. Implementation may include some of the following interventions:

- Assessing and monitoring
- Therapeutic interventions
- Comfort measures
- Assistance with activities of daily living
- Supporting respiratory functions
- Supporting elimination functions
- Providing skin care
- Managing the environment to promote a therapeutic condition
- Providing food and fluids
- Giving emotional support
- Teaching and/or counseling
- Referral to other agencies or services

Documentation will need to include the specific nurse's intervention and the patient's response to the intervention. It should reflect the coordination of care, health teaching and promotion, and any consultation that was done on behalf of the patient. Like the documentation of planning, the documentation of care provided can be assigned to a specific form or location in the clinical record.

## Evaluation

In this step of the nursing process, the nurse reviews the progress made in achieving established outcomes. The documentation needed to validate this step includes the nurse's comments on whether his

or her assessment, diagnosis, achievement of outcomes, plan of care, and nursing interventions were successful. In addition, when developing a documentation system or a continuing education program for nurses, ensure that each nurse assesses the effectiveness of the nursing process.

In determining whether the patient received high-quality care, the nurse must document the patient's response to care, the patient's compliance with prescribed medications and therapies, the progress being made toward the stated goal, and the caregiver's ability to learn and resume all or part of the treatment plan).

If the nurse uses the evaluation phase properly, the documentation will reflect high-quality nursing care.

Figure 1.5 shows the flow of the process and identifies the tools associated with each phase.

## Organizational Policies, Protocols, and Practices

When nurse experts are asked to review a medical record in preparation for a legal case, they rely heavily on the clinical record to determine the following:

- Did the healthcare provider meet the policies and protocols of the organization at the time of the care?
- More importantly, did the healthcare provider meet the standards of nursing practice at the time of the care?

It is therefore the responsibility of the nursing management team and the nursing staff to follow the established policies of the organization, and to ensure that this compliance is demonstrated in the documentation system for that organization.

Organizational policies, protocols, and practices will always be called into review when there is an allegation of substandard patient care. Nursing practice will be held to national and local professional nursing standards, which are available through the ANA and through specialty nursing associations. If you derive your policies and procedures from these, your organization will be better able to justify that the care that was delivered met established professional standards. See Figure 1.6 as a documentation case study.

**Figure 1.5** Nursing process flow chart

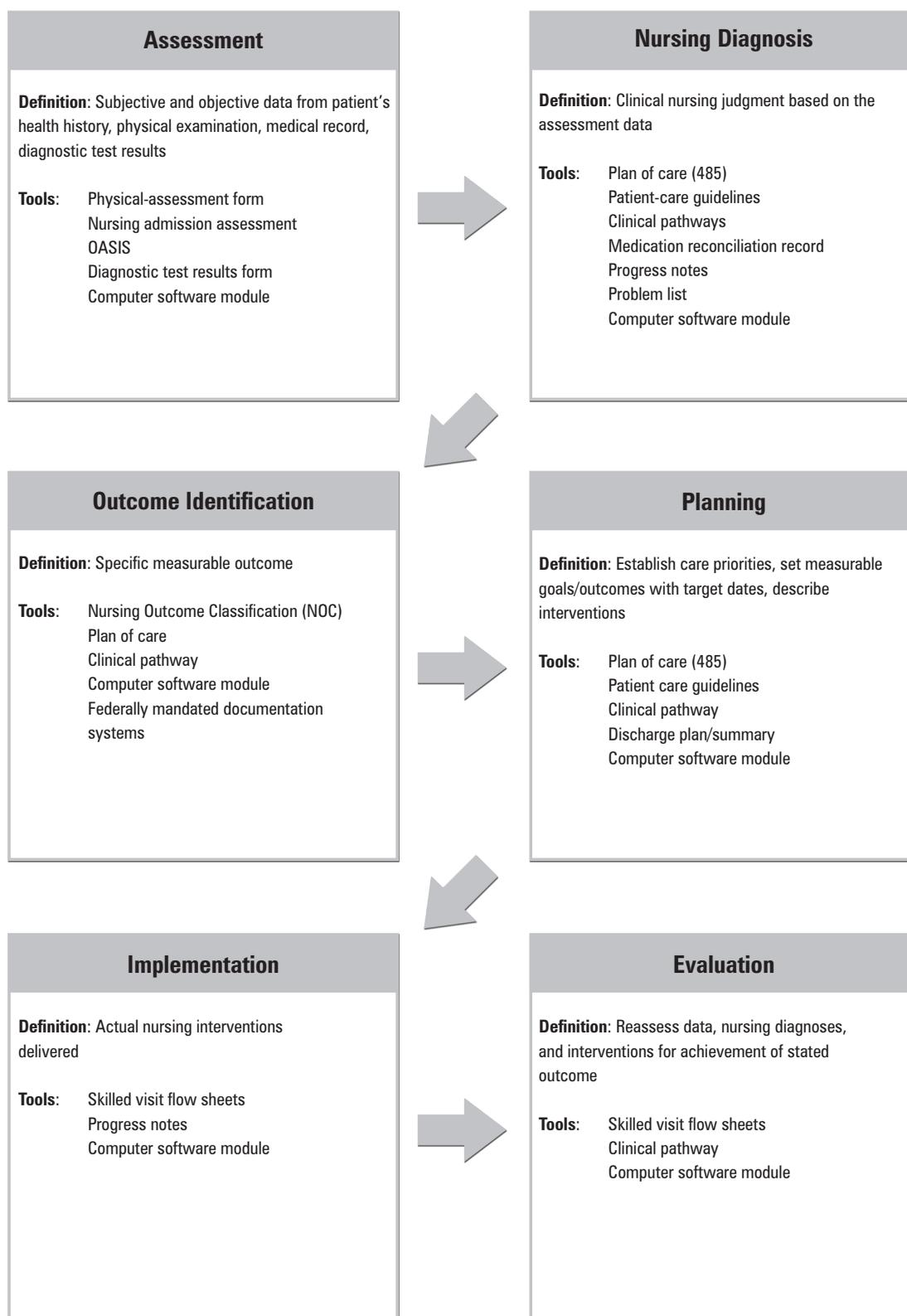


Figure 1.6

## Documentation case study

**Case study****Good documentation reflects the nursing process**

Scenario: A patient complains of chest pain. The nurse takes the patient seriously, as the subjective complaint may indicate a myocardial infarction. He or she acts quickly, performing a focused assessment and documenting the essential information. Here are the critical elements of good documentation of a patient with chest pain.

**Documentation of what the patient said: Subjective data**

7/15/14 1600

Patient stated, "Nurse, I am having chest pain." See pain flow sheet for description, location, intensity noted. Patient in chair, increasingly anxious. Used calm, reassuring behavior with patient. Redirected her to focus on remaining calm for interventions to work. Patient responded, and pulse and respirations decreased. See VS section of flow sheet.

The patient's exact description of the symptom was noted, and the nurse used quotations around the patient's words, rather than recording his or her interpretation of them.

On the pain flow sheet, the nurse indicates pain was located in the substernal region, radiating to the left shoulder. Pain level 10 out of 10. The nurse appropriately uses the pain scale to measure the level of intensity.

The nurse also notes on the pain flow sheet: No preceding activity or past history of this type of pain. Steady pain: 2–3 minutes. Not short of breath (SOB).

Patient care flow sheet indicated that the initial pulse and respirations at the time of the nurse's initial assessment of pain were:

7/15/14 1600      P: 120   R: 40   BP: 146/90

7/15/14 1604      P: 96    R: 28   BP: 124/85

**Documentation of what was assessed: Objective data**

In the cardiopulmonary section of the patient care flow sheet, the nurse writes

AR. Irregular regular rhythm. No JVD. O<sub>2</sub> sats on RA: 92%.

Color ashen, skin cool and clammy.

Figure 1.6

## Documentation case study (cont.)

The nurse documents the vital signs, noting tachycardia, an increased respiratory rate, and above-baseline blood pressure for this patient. In addition, the nurse records auscultation of heart sounds (e.g., regular/irregular heart rate, murmur, gallops, rubs).

The nurse assesses lung sounds and the respiratory rate and pattern, and measures abnormal O<sub>2</sub> saturation via pulse oximetry. The patient's actions are already noted as increasingly anxious. There is no clutching of the chest by the patient. Skin assessment also is conducted and documented.

In the cognitive section of the patient care flow sheet, the notations indicated:

*No changes in mental status; no decreased level of consciousness, disorientation, or confusion.*

*In the narrative notes, the nurse notes: Skin cool, clammy, no peripheral edema, ashen in color. No cyanosis noted.*

*Documentation of what was done: Intervention*

The nurse continues to document his or her interventions and the patient's responses.

**Frequent monitoring:** The VSs were noted every few minutes until the chest pain subsided. 911 was called. All treatment activities are documented, including medications administered, such as aspirin and/or nitroglycerin.

**Oxygen therapy:** The nurse documents the patient's initial pulse-oximetry reading, respiratory-assessment findings.

The pulse-oximetry assessments are documented until within normal range or transferred to emergency personnel.

**Cardiac monitoring:** 7/15/14 1615

Patient placed on cardiac monitor by EMS. Patient informed as to the reason for continuous monitoring.

The nurse does document notification of the physician of the patient's change of condition and transfer to the hospital. He or she records the physician's response and his or her actions.

**Communication:** The nurse is good at documenting his or her communication with other healthcare team members.

It is found in his or her narrative notes, names, time of notification, etc.

Figure 1.6

## Documentation case study (cont.)

**Emotional support:** 7/15/14 16200 patient increasing in anxiety; reassurance given and questions answered.

**Transfer to hospital:** This patient needed to be transferred, and the nurse documented the aspects of the patient's condition that warranted the transfer. The report to the physician was documented. The nurse also would have recorded the name of the person who accompanied the patient and which monitoring devices were in place during the transport.

## Education

The teaching plan needs to be individualized to the patient's condition and treatment. Documentation of patient/family teaching needs to include what was taught, the method of teaching, the materials used for teaching, how well the patient/family understood the teaching, etc.

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# CLINICAL DOCUMENTATION STRATEGIES FOR HOME HEALTH

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Are you looking for training assistance to help your homecare staff enhance their patient assessment documentation skills? Look no further than ***Clinical Documentation Strategies for Home Health***.

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