Defensive Documentation for Long-Term Care

Strategies for creating a more lawsuit-proof resident record
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Since the introduction of the Medicare prospective payment system and its diagnosis-related groups, documentation in the medical record has assumed a new importance in the long-term care (LTC) profession. Documentation is important not only to validate the care rendered to the resident but also to support reimbursement for the services performed.

In today’s litigious culture, this documentation has become legally complex. All entries in the medical record must now be made with a potential lawsuit in mind. If questions arise regarding care or services or if a lawsuit is filed, the medical record will be used to verify the nature of the care provided or to reconstruct events surrounding the incident that has given rise to the questions or the lawsuit. It will become the main source of evidence that usually determines the outcome of the inquiry or the lawsuit. This book was written to assist those involved in medical record keeping to meet the challenges of documenting defensively.

If it wasn’t documented . . .

Most caregivers are very familiar with the old saying, “If it wasn’t documented, it wasn’t done.” However, those who work in LTC know there are many interactions between caregivers and residents that are not captured in the medical record. The goal is to select interactions that support the well-being of the resident and to record information about those interactions, along with observation and assessment findings, all the while avoiding pitfalls that can lead to adverse outcomes in the courtroom.
Chapter 1

**The purpose of documentation**

Ask various caregivers about the purpose of documentation and you will get a variety of answers. The paraprofessional may say documentation is a requirement of the facility. The pharmacist may say it is a regulatory requirement. The therapist may feel it is done to support the cost of services. The physician often looks at it from the ethical and legal standpoints. When the question is asked of nurses, the most frequent response is, “It’s for the resident.” Nurses, who have been looked upon as resident advocates for years, have difficulty seeing documentation for other purposes. Satisfying legal necessities or supporting fiscal viability has not been the focal point of the nurse who initiates a medical record note for the resident.

Documentation has been, for the most part, a matter of maintenance of the continuity of care through communication from caregiver to caregiver. Now the medical record is used for many purposes and by many people who focus on a specific area or a particular word to determine cause and effect. The nurse who writes the majority of entries in the record must decide what words and phrases would not only meet the needs of communication, but also assist outside medical record auditors in their need for information.

The nurse should ask himself or herself the following questions:

- What is the purpose of this entry?
- Have I communicated clearly to other team members?
- Does this note satisfy its intended purpose?

If documentation is intended to provide a complete picture of the care and the services provided to the resident, the nurse’s note can no longer be the only source of information for completing a picture of the resident’s clinical condition. A defensible record takes the collaboration of all those involved in the resident’s care.
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