

Long-Term Care
Pocket Guide to

Nursing Documentation



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Section I

The Medical Record

Item I-1: The medical record

The resident's medical record (commonly referred to as the "chart") is used by all members of the healthcare team to communicate the resident's progress and the current treatment. It provides a record of the resident's health status, including observations, measurements, history, and prognosis, and serves as the legal document describing the healthcare services provided to the resident. The chart also is used to determine the appropriateness and quality of care by

- describing the services provided to the resident
- providing evidence that the care was necessary
- documenting the resident's response to the care and changes made to the plan of care
- identifying the standards by which care was delivered

The chart also provides

- supporting documentation for the reimbursement of services provided to the resident
- a source of data for clinical, health services, and outcomes research, as well as public health purposes
- a major resource for healthcare practitioner education, the legal business record for a healthcare organization, and support for business decision-making



Documentation Do's: Who charts in the medical record?

Anyone who documents in the medical record should be credentialed/have the authority and right to document as defined by facility policy.

Item I-2: Resident's name and medical record number

I

Section I: The Medical Record
Item I-2: Resident's name and medical record number

Every page of the medical record or computerized record screen must show the resident's name and medical record number. This includes both sides of the pages, every shingled form, computerized print out, etc.

When double-sided forms are used, the resident's name and medical record number must be on both sides because information is often copied and must be kept with the correct data for that resident.

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Item I-3: Month, day, year, time

I

Section I: The Medical Record
Item I-3: Month, day, year, time

Include the month, day, year, and time of each event or observation with every medical record entry. Include the time in all types of narrative notes even though it may not seem important to the type of entry.

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Documentation don'ts: Time blocks

Do not chart time as a block (e.g., 7–3), especially for narrative notes. Narrative documentation should reflect the actual time the entry was made.

For certain types of flow sheets, such as a treatment record, recording time as a block could be acceptable. For example, a treatment that can be delivered any time during a shift could have a block of time identified on the treatment record with staff signing that they delivered the treatment during that shift.

Indicate the date and time of completion as well as who has completed each section of assessment forms where multiple individuals are completing the form.

Chart entries as soon as possible after an event or observation is made.



Documentation don'ts: Advanced entries and pre- and back-dating

Do not make entries in advance. Pre-dating or back-dating an entry is both unethical and illegal. Entries must be dated with the actual date and time the entry is made.

If it is necessary to summarize events that occurred over a period of time (such as a shift), the notation should indicate the actual time the entry was made with the narrative documentation identifying the time at which the relevant events occurred.

Item I-4: Signatures

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Every entry in the medical record must be signed by the person making the entry. This includes all types of entries, such as narrative/progress notes, assessments, flow sheets, orders, etc., whether in paper or electronic format.

What to include

At minimum, the signature should include the first initial, last name, and title/credential.

If there are two people with the same first initial and last name, both must use their full signatures (and/or middle initial, if applicable).

Countersignatures

Countersignatures should be used as required by state law (e.g., a graduate nurse who is not licensed, a therapy assistant, etc.) The person who is making the countersignature must be qualified to countersign. For example, a licensed nurse who does not have the authority to supervise should not be countersigning an entry for a graduate nurse who is not yet licensed.

Federal regulations for long-term care (LTC) do not require countersignatures for nurse practitioners and physician assistants, but state licensure and professional practice regulations may govern them.

Item I-5: Initials

Any time a facility chooses to use initials in any part of the record for authentication of an entry, there has to be corresponding full identification of the initials on the same form or on a signature legend.

Each person who documents with initials in the medical record must have a corresponding full signature on record.

Three methods that may be used include the following:

- A signature legend can be included on the actual form where the initials are used.
- A separate master signature legend form can be kept with staff initials and signatures for each resident's record.
- The facility may keep one facility master signature legend. A copy of the legend will be made at the time of discharge and placed in the resident record.

When to use initials

Initials can be used to authenticate entries, such as flow sheets, medication records, or treatment records, but should not be used in such entries as narrative notes or assessments.



Documentation don'ts: When not to use initials

Never use initials where a signature is required by law (e.g., on the MDS).

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Section I: The Medical Record
Item I-5: Initials

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Item I-6: Rubber stamp signatures

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If allowed by your state and reimbursement regulations, rubber stamp signatures are acceptable. Federal regulations for nursing facilities allow for the use of rubber stamp signatures by physicians provided that the facility authorizes their use and has a statement on file indicating that the physician is the owner of the stamp and attested that they will be the only one using the signature stamp.

From a reimbursement perspective, some fiscal intermediaries (FI) have local policies prohibiting the use of rubber stamp signatures in the medical record even though federal regulation allows for their use.

Facility policies should indicate whether rubber stamp signatures are acceptable and define the circumstances for their use after review of state regulations and payer policies.

Item I-7: Fax signatures

I

Section I: The Medical Record
Item I-7: Fax signatures

Rules about fax signatures depend on state, federal, and reimbursement regulations. Federal regulations for nursing facilities do not prohibit the use of fax signatures. Unless specifically prohibited by state regulations or facility policy, fax signatures are acceptable.

The original signature should be retrievable when fax document/signatures are included in the medical record.

Item I-8: Faxed records

I

If fax records are maintained in the medical record, the facility must be sure that the record will maintain its integrity over time.

For example, if a thermal paper fax paper is used, a copy of it must be made for filing in the medical record since the print on thermal paper fades over time.

The medical record should contain original documents whenever possible. There are times when it is acceptable to have copies of records and signatures, particularly when records are sent from another healthcare facility or provider.

If there is a question about the permanency of the paper (e.g., NCR, or carbon paper) when the carbon paper is the permanent entry, it needs to be photocopied.

At times carbon copies of documents (e.g., telephone orders) may be used on a temporary basis and the original will replace the carbon when it is received.

Item I-9: Legible, ink entries

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Section I: The Medical Record
Item I-9: Legible, ink entries

All entries in the medical record, regardless of form or format, must be in ink so that changes are noticeable and the record is permanent.

Black or dark blue ink reproduces especially well on microfilm.



Documentation don'ts: Colored ink and pencil

No other colored ink should be used in the event that any part of the record needs to be copied. The ink should be permanent (no erasable or water-soluble ink should be used). Never use a pencil to document in the medical record.

Legibility

All entries in the medical record must be legible. Illegible documentation can put the resident at risk. Readable documentation assists other caregivers and helps to ensure continuation of the resident's plan of care.

If an entry cannot be read, the author should rewrite the entry on the next available line, define what the entry is for, referring back to the original documentation, and legibly rewrite the entry. For example, start with "Clarified entry of (date)", then rewrite entry, date, and sign. The rewritten entry must be the same as the original.

Item I-10: Do not skip lines

I

Section I: The Medical Record
Item I-10: Do not skip lines

Document entries on the next available space—do not skip lines or leave blanks. There must be a continuous flow of information without gaps or extra space between documentation.

A new form should not be started until all previous lines are filled. If a new sheet was started, the lines available on the previous page must be crossed off.



Documentation do's: Out-of-order entries

If an entry is made out of chronological order it should be documented as a late entry.

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Section I: The Medical Record
Item I-10: Do not skip lines

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Item I-1 1: All fields/blocks are to be filled

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Section I: The Medical Record
Item I-1 1: All fields/blocks are to be filled

On assessments, flow sheets, and on checklist documents, some of the questions or fields may not be applicable to the resident. All fields or blocks should have some entry made whether or not it applies to the resident.

If a field is not applicable, an entry like "N/A" should be made to show that the question was reviewed and answered.

Fields or blocks left blank may be suspect to tampering or back-dating after the document has been completed and signed. If the documentation will be reported by exception (e.g., documenting only on shifts where a behavior occurs), there should be a statement on the form indicating how charting will be completed.

Item I-12: Language of the medical record

When making entries in the medical record, use language that is specific rather than vague or generalized.

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Section I: The Medical Record
Item I-12: Language of the medical record



Documentation don'ts: Speculation and personal opinions

Do not speculate when documenting – the record should only reflect factual information (what is known, not what is thought or presumed) and be written using factual statements. Personal opinions should not be used when charting.

Document what can be seen, heard, touched, and smelled. Describe signs and symptoms, use quotation marks to quote the resident, and document the resident's response to care.

Document all facts and pertinent information related to an event, course of treatment, resident condition, response to care, and deviation from standard treatment (including the reason for it). Make sure the entry is complete and contains all significant information. If the original entry is incomplete, follow guidelines for making a late entry, addendum, or clarification.

Item I-13: Acceptable abbreviations

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Section I: The Medical Record
Item I-13: Acceptable abbreviations

Every facility should set a standard for acceptable abbreviations to be used in the medical record. Only those abbreviations approved by the facility should be used in the medical record. When there is more than one meaning for an approved abbreviation, one meaning should be chosen or the context should be identified in which the abbreviation is to be used.

Item I-14: Entries consistent with the rest of the medical record

All entries should be consistent with

- concurrent entries
- other parts of the medical record—the assessments, care plan, physician's orders, medication and treatment records, etc.
- other facility documents—incident reports, 24-hour reports, nursing service shift reports, etc.

Ongoing treatments and conditions (feeding tube, vent, trach, catheter, etc.) should be noted as continuing. Avoid repetitive (copycat or parrot) charting. The current entry should document current observations, outcomes/progress.



Documentation do's: Handling contradictory entries

If an entry is made that contradicts previous documentation, the new entry should elaborate or explain why there is a contraindication or why there has been a change.

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Section I: The Medical Record
Item I-14: Entries consistent with the rest of the medical record

27

Item I-15: Change in the resident's condition

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Section I: The Medical Record
Item I-15: Change in the resident's condition

Every change in a resident's condition or significant resident care issue must be noted and charted until the resident's condition is stabilized or the situation is otherwise resolved. Documentation that provides evidence of follow-through is critical.

Item I-16: Informed consent

I

Section I: The Medical Record
Item I-16: Informed consent

Informed consent should be carefully documented whenever applicable. An informed consent entry should include an explanation of the risks and benefits of a treatment/procedure, alternatives to the treatment/procedure, and evidence that the resident or appropriate legal surrogate understands and consents to the resident undergoing the treatment/procedure.

Item I-17: Note/discharge summary

I

Section I: The Medical Record
Item I-17: Note/discharge summary

The resident's initial admission note and discharge summary should fully and accurately describe the resident's condition at the times of admission and discharge, respectively.

Documentation should include the following:

- The method/mode of arrival/discharge
- Resident's response to admission/discharge
- Physical assessment



Documentation do's: Discharging a resident

When discharging a resident, take special care in documenting resident education when applicable, including instructions for self-care, and that the resident/responsible party demonstrated an understanding of the self-care program.

I

Section I: The Medical Record
Item I-17: Note/discharge summary

Item I-18: Notification

I

Section I: The Medical Record
Item I-18: Notification

All communication (including attempts at notification) should be charted if notification to the resident's physician or family is required, or a discussion with the resident's family occurs regarding the care of the resident.

Include the time and method of all communications or attempts. The entry should include any orders received or responses, the implementation of such orders, if any, and the resident's response.

Messages left on answering machines should be limited to a request to return the call. These messages do not meet the definition of notification.

Item I-19: Charge nurse responsibilities

I

Section I: The Medical Record
Item I-19: Charge nurse responsibilities

All entries made by nursing assistants are to be reviewed by the charge nurse for completeness and to make sure they are consistent with the remainder of the record. All entries by nursing assistants should be reviewed by the charge nurse at the end of each shift.

The charge nurse is responsible for all delegated nursing acts, as allowed by state/federal requirements, including charting of such care in the resident's medical record on forms such as flow sheets.

Item I-20: Incident reporting

I

Section I: The Medical Record
Item I-20: Incident reporting

When an incident occurs, the facts surrounding the event should be documented in the progress notes.



Documentation don'ts: Incident reporting

Do not chart that an incident report has been completed or refer to the report in charting.

Item I-21: Factual and objective information

I

Section I: The Medical Record
Item I-21: Factual and objective information

Do not let emotions show up in charting. The medical record should only contain documentation that pertains to the direct care of the resident.

Charting should be free of statements that blame, accuse, or compromise other caregivers, the resident, or his/her family.

The medical record should be a compilation of factual and objective information about the resident. The record should not be used to voice complaints about other caregivers, departments, physicians, or the facility, family fights, fights between disciplines, gripes, staffing issues, vendor issues, etc.

Item I-22: Narrative charting and summaries

I

Section I: The Medical Record
Item I-22: Narrative charting and summaries

Narrative notes are a narration, or telling, of information. Most narrative charting is done in chronological order. You begin your statement with the data that were observed or that occurred first and move forward in time.

Item I-23: Admission/readmission narrative note

It is a standard of practice to write a narrative note at the time of admission that documents

- the date and time of admission/readmission
- how resident was transported
- the reason of admission
- the resident's condition

State regulations may have specific requirements for admission documentation and the time frame for completion.

Item I-24: Content of narrative charting

I

Section I: The Medical Record
Item I-24: Content of narrative charting

A complete record contains an accurate and functional representation of the actual experience of the individual in the facility.

It must contain enough information to show that the facility knows the status of the individual, has adequate plans of care, and provides sufficient documentation of the effects of the care provided.

Documentation should provide a picture of the resident, including response to treatment, change in condition, and changes in treatment.

Good practice indicates that for functional and behavioral objectives, the clinical record should document change toward achieving care plan goals.

Item I-25: Monthly summary charting

I

Section I: The Medical Record
Item I-25: Monthly summary charting

Federal regulations do not require the completion of summary notes; however, some states may require a summary per licensure or reimbursement regulations. Typically summary documentation is used as a mechanism to provide an update of the resident's status.

The summary note should be based on the care plan. If there are changes in the resident's status from the previous summary or that are not reflected in the care plan, the summary should describe the following:

- The resident's status
- The reason for the change
- Updates made to the care plan



Documentation do's: Flow sheets and checklists

If flow sheets or checklists are used, they should contain an area for narrative documentation to supplement the check boxes. All fields should be completed. If a section does not apply, the writer should indicate that it is not applicable.

When using a flow sheet or checklist, the care plan should still be the basis for the documentation. If there is a change from the previous summary or a change not reflected in the care plan, include a note explaining the reason for the change and the updates made to the care plan.

The use of monthly summary notes or flow sheets should not preclude the staff from maintaining documentation throughout the month that reflect any changes in the resident's condition or status.

Item I-26: Medicare documentation

I

Section I: The Medical Record
Item I-26: Medicare documentation

Medicare documentation must provide an accurate, timely, and complete picture of the skilled nursing or therapy needs of the resident. Documentation must justify the

- clinical reasons and medical necessity for Medicare Part A coverage
- skilled services being delivered
- ongoing need for coverage

Documentation along with data gathered from observation and interviews should support the MDS used to determine the Resource Utilization Group (RUG) payment level for the Medicare recipient.

The medical record must also support the ancillary services provided to the resident that are billed to Medicare by documenting that the services were both delivered and medically necessary.

41

Item I-27: Skilled nursing/therapy charting

The medical record must prove that the resident needed and received skilled services on a daily basis—either nursing or therapy. Medicare charting may be more frequent if necessitated by the resident's condition.

The content of the documentation should be specific to the clinical reasons for coverage and services delivered and must be objective and measurable.

When therapy services are justifying Medicare coverage, nursing documentation should be consistent with therapy documentation addressing how skills learned in therapy are applied on the nursing unit.

The methods of charting can vary based on the reason for Medicare coverage and the services delivered. Documentation can be

- written narratively
- captured on flow records or graphics
- done by exception
- structured notes, like "SOAP" (Subjective data, Objective data, Assessment/analysis, Plan)

Item I-28: Therapy treatment time

I

The individual and group therapy treatment minutes for each resident must be documented in the medical record for all dates in which services were delivered.

The treatment minute documentation is then used to complete and support the MDS and RUG level.

The physician order for therapy must include the following:

- Treatment time
- Treatment frequency
- Treatment duration
- Scope of treatment

Item I-29: Omissions in documentation

I

Section I: The Medical Record
Item I-29: Omissions in documentation

There will be times when it will be necessary to make an entry that is late (out of sequence) or provide additional documentation to supplement entries previously written.

Making a late entry

A late entry should be used to record information in the medical record when a pertinent entry was missed or not written in a timely manner. When this occurs, follow these steps:

- Identify the new entry as a “late entry”
- Enter the current date and time—do not try to give the appearance that the entry was made on a previous date or at an earlier time
- Identify or refer to the date and incident for which the late entry is written

If the late entry is used to document an omission, validate the source of additional information as much as possible, that is, where did you get the information to write the late entry? For example, use of supporting documentation on other facility worksheets or forms.



Documentation do's: Late entries

When using a late entry, document it as soon as possible. There is not a time limit to writing a late entry; however, the more time that passes, the less reliable the entry becomes.

Addenda

An addendum is another type of late entry that is used to provide additional information in conjunction with a previous entry.

With this type of correction, a previous note has been made and the addendum provides additional information to address a specific situation or incident.

With an addendum, additional information is provided, but would not be used to document information that was forgotten or written in error.

When making an addendum, follow these guidelines:

- Document the current date and time
- Write “addendum” and state the reason for the addendum referring back to the original entry
- Identify any sources of information used to support the addendum

When writing an addendum, complete it as soon after the original note as possible.

Writing a clarification

A clarification note is another type of late entry. It is written to avoid incorrect interpretation of information that has been previously documented. For example, after reading an entry there is a concern that the entry could be misinterpreted.

Include this information when making a clarification note:

- Document the current date and time.
- Write “clarification,” state the reason and refer back to the entry being clarified.
- Identify any sources of information used to support the clarification.
- When writing a clarification note, complete it as soon after the original entry as possible.

Item I-30: Omissions on medication/treatment records, graphic, and other flow sheets

Going back and completing/filling in signature “holes” on medication and treatment records or other graphic/flow records in the medical record is considered willful falsification and is illegal.

Facility protocol should establish procedures for documenting a late entry when there is total recall and other supporting information to prove that a medication or treatment was administered.

Some states have established time frames in which the omissions can be completed if the nurse recalls administering the medication or treatment, such as no more than 24 hours should go by in which a nurse is allowed to complete a medication, treatment, graphic or flow record and only when there is a clear recollection of administering the medication or treatment or other information pertinent to a flow/graphic record.

If an omission is older than 24 hours, the staff member does not have a clear recollection, or there is no supporting documentation (e.g., worksheets, narcotic

I**Section I: The Medical Record****Item I-30: Omissions on medication/treatment records, graphic, and other flow sheets**

records, drug delivery records, initialed punch cards, etc.), the record should be left blank.

At no time should the records be audited after a period of time (e.g., at the end of the month, with the intent of identifying omissions and filling in "holes").

Item I-31: Documenting care provided by another nurse

Every nurse should document his/her own observations, data, etc., in the medical record. Documentation must reflect who performed the action.

If it is absolutely necessary to document care given by another person, document factual information. For example, if a call is received from a nurse from the previous shift, who indicates that s/he forgot to chart something in the resident's medical record, you may enter the date and time of the telephone call and note:

"At 4 PM Linda Smith, RN, called to report that at 11 AM this morning, Mr. James indicated that he had leg pain and requested Tylenol. Tylenol 650 mg was given p.o. by Mrs. Smith at 11:10 AM. Mrs. Smith stated that Mr. James verbalized he was free from pain at 12:30 PM. (Signed by Jenny Grover, RN)."

Also place initials on the medication record as follows: "JG for LS."

When Linda Smith returns to work, she should review your note for accuracy and countersign it. She should also place her initials by your entry on the medication record. If there is not adequate room on the medication record for your entry, enter your initials on the medication record and circle the entry. On the back of the medication record, document your entry in the style of this example.

Item I-32: Resident amendments to the medical record

Under HIPAA, the resident has the right to request an amendment as long as their medical record is maintained by the facility. The facility may require a resident to make the request for an amendment in writing and provide a reason.

The facility must act on the individual's request for an amendment no later than 60 days after receipt (a 30-day extension may be granted if the resident is notified). Once the amendment request has been reviewed, the facility must inform the resident whether the amendment was granted in whole or in part.

If all or a portion of the amendment request was denied, the facility must provide the resident with a written reason for the denial. The resident has the right to make a written statement of disagreement with the denial that will become part of the medical record. The facility can also document a rebuttal statement. When disclosing information pertaining to the disagreement, the written statement by the resident and the rebuttal by the facility must be included.

A separate entry (progress note, form, typed letter, etc.) can be used for resident amendment documentation. The amendment should refer back to the information in question, date, and time.

The amendment should document the information believed to be inaccurate and the information the resident/responsible party believes to be correct.



Documentation don'ts: Resident amendments

At no time should the documentation in question be removed from the chart or obliterated in any way. The resident cannot require that the records be removed or deleted.

I

Section I: The Medical Record
Item I-32: Resident amendments to the medical record

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Item I-33: Proper error correction procedure

Handling corrections, errors, and omissions are all major legal concerns in documentation. There will be times when documentation problems or mistakes occur and changes or clarifications will be necessary. You must follow the proper procedure when these situations arise.

If you make an error in a medical record entry

- draw a line through the entry using a thin pen line. Make sure that the inaccurate information is still legible.
- initial and date the entry.
- state the reason for the error in the margin or above the note if there is room.
- record the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space, documenting the current date and time, and referring back to the incorrect entry.
- do not obliterate or otherwise alter the original entry by blacking it out with a marker, using white out, or writing over the entry.



Documentation do's: Correcting errors in electronic medical records

Correcting an error in an electronic/computerized medical record system should follow the same basic principles. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated. When correcting or making a change to an entry in a computerized medical record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.

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