DEFENSIVE DOCUMENTATION

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OBJECTIVES

Review the role of the medical record in litigation.

Describe key requirements of a defensible medical record.

Identify the focus of the plaintiff attorney.

Understand how the medical record is used to prove/disprove allegations

Medical Record Purpose

Responsibility, accountability and communication are primary purposes for maintaining the medical Record

The facility must maintain a clinical record for every resident receiving care and services in the facility

The medical record is the Key Witness

Nursing Home Litigation

Fastest Growing Area of Health Care Litigation

Characteristics of Residents and Plaintiffs

- Primary Initiators
- Chronic long-stay nursing home residents
- Medicaid Beneficiaries
- Residents with Dementia or Alzheimer's Disease

Top Five By Alleged Injury

Wrongful Death

Pressure Ulcers/Bedsores

Dehydration/Weight Loss

Emotional Distress

Falls

The estimated calculation of each case varies

Several Determining Factors

- Severity of injuries
- Age of the victim
- Need for future medical expenses and rehabilitation care
- Level of pain and suffering
- Level of emotional distress

Reasons for Lawsuits

Basic Needs Neglect — This occurs when the nursing home neglects to provide food, water, or a safe and clean environment for their residents.

Emotional Neglect — When the elder resident is ignored, isolated, or accidentally snapped at by a nursing home staff, it can have severe consequences on the elderly person's emotional psychology.

Personal Hygiene Neglect — Residents will require assistance for most, if not all, activity. This can include such things as laundry, cleaning, bathing, oral hygiene, and other forms of hygienic practice.

Medical Neglect — Nursing homes need to provide reasonable medical treatment. This can be in the form of attention, prevention, and medication for infection, bedsores, cuts, diabetes, arthritis, cognitive disease, and mobility concerns.

Her family maintained that fall was caused by negligence and that her cardiac condition was the real cause of her death (and she only suffered for six days from the fall). They also denied responsibility, which is not difficult in most of these fall cases with a substantial factual predicate.

March, 2014, Maryland $1,000,000 Verdict.

An 86-year-old nursing home resident was sick with fever, was vomiting, and developed severe diarrhea that continued unabated

A certified aide was told to evaluate the woman. “But she never got around to it.” Her condition worsens and begins to have rectal bleeding. The facility placed the resident in her recliner

Her son comes to see her in the morning and realizes the severity of her condition,but it is too late.

Jury awards the woman's family $1 million for her wrongful death and survival action claims.

The award is reduced to $710,000 after the application of the Maryland cap on noneconomic damages that applies in nursing home cases.

January 2014, Alabama: $400,000 Arbitration Verdict:

A 101-year-old man with a feeding tube placed in his abdomen with orders to keep his head elevated at all times. A daytime sitter was hired by the family to assist in his care. The sitter arrived one afternoon to find the man gasping for air and feeding formula coming out of his mouth. He was rushed to a local hospital where he was found to have choked on the feeding formula in his lung. He died five days later.

The man's daughters sued the nursing facility for negligence and wrongful death. They claimed the nursing staff failed to keep the head of the bed elevated and failed to monitor the decedent. Defendant denied all allegations and argued that the fault was that of the sitter.

This case went to arbitration and the arbitrator awarded $400,000.

September 2013, Mississippi: $1,000,000 Verdict:

A 78-year-old, widowed housewife and mother of nine admitted in frail condition with Alzheimer's and dementia. Two weeks into her stay, she was pushing a food tray down the hall and sustained a fall. One week later the resident attempted to get out of her wheelchair and fell again sustaining a fractured hip. Emergency surgery was conducted.

Resident died six days later from a pulmonary embolus that the physicians had unanimously linked to the hip fracture.

The facility was sued for neglect, alleging the facility did not monitor the decedent adequately. Plaintiff claimed that although the nursing home used a body alarm, it was not effective because the decedent could still wander away from her wheelchair after it was applied and should have been temporarily restrained to the wheelchair when not being monitored by the nursing staff. Plaintiff also alleged that the nursing home was not adequately staffed at the time of the occurrence. Defendants denied liability claiming that the decedent was properly monitored and that the staffing levels met all necessary standards of care. Defendants also argued that using restraints on the decedent's chair would not have been appropriate for her conditions. The jury found on behalf of the decedent and awarded the Plaintiff $1,000,000.

June 2013, New Jersey: $1,100,000 Verdict

- 57 year old resident with diagnosis of Alzheimer's and uncontrolled diabetes.
- Two weeks after her arrival she went into hypoglycemic shock, was rushed to a hospital, and passed away shortly after that.
- Her daughter sued on her behalf alleging failure to adequately monitor her mother's diet as they coincided with her medication.
- Plaintiff also alleged the nursing facility was understaffed at the time of the occurrence
- . Defendants denied liability contending that a proper meal monitoring plan was in place (although at the time of trial, they were unable to produce any forms evidencing such claims).
- Defendant also stated that they followed the appropriate standard of care and that the decedent's death was unpredictable and not preventable.
- An Atlantic County jury found on behalf of Plaintiff with an award of $1,100,000 in damages.

June 2013, Pennsylvania: $150,000 Settlement

- 87-year-old resident assessed as a significant fall risk, with Posey alarm and floor mats installed in her room. Not even a day after her arrival she was found on her bedroom floor.
- Despite the indication that their initial set up was ineffective, the facility chose against making any alterations to her care plan.
- One month later, an attending nurse obtained orders orders D/C the alarm and fall
- One week later fell, sustained hip and wrist fracture
- Not a surgical candidate due to multiple co-morbities
- Remained bedridden for four months until her death.
- Her estate sued the nursing home and primary care physician for negligence for allowing preventative measures to be removed.
- Plaintiff alleged the nursing home was negligent in failing to provide adequate fall prevention.
- Defendant nursing home settled with the estate for $150,000 but remained as a defendant during the trial. A Philadelphia jury did not find the primary care physician negligent, attributing 100% negligence to the nursing home.

June 2010, Kentucky: $7,120,000 Verdict

- 67-year-old woman with dx rheumatoid arthritis had been admitted for rehabilitation following knee surgery and requested an aide to assist her to the BR
- The aid entered the room, put the woman's legs over the bed, and left claiming she was "too busy" to assist the elderly woman and that she could take herself to the bathroom.
- After attempting to stand, the woman was unable to get to the restroom in time and urinated on herself slipping in the urine and fell, causing knee incision to reopen.
- Resident was transferred to the hospital, requiring resusitation due to significant blood loss

Continued

- Hospitalized x 2 months, requiring multiple surgeries.
- Resident was not able to return to independent living and suffered from recurrent infections.
- She sued the nursing home for negligence, alleging they had staffed their facility with an uncertified aid and covered up documents relating to the fall. The matter continued to trial where a Kentucky Circuit Court jury found for the Plaintiff. She was awarded $7,120,000 for damages

Organized Approach to Medical Record

Record Order

- Information easily retrieved is more likely to be used
- Time is of the essence
- Difference between a good decision and a less desirable one

Organized Approach to Medical Record

Standardize the record order

Use descriptive dividers

Assign someone accountable to maintain the chart order

Chart order is part of staff orientation

Maintain chart order when record is thinned

Limit binders on units and offices storing documents that are filed in the medical record

Documentation Format

Use facility approved standardized format whenever possible some examples:

- Change in condition
- SBAR
- PCC formatted notes

Prompts the nurse to document all the facts, resident assessment

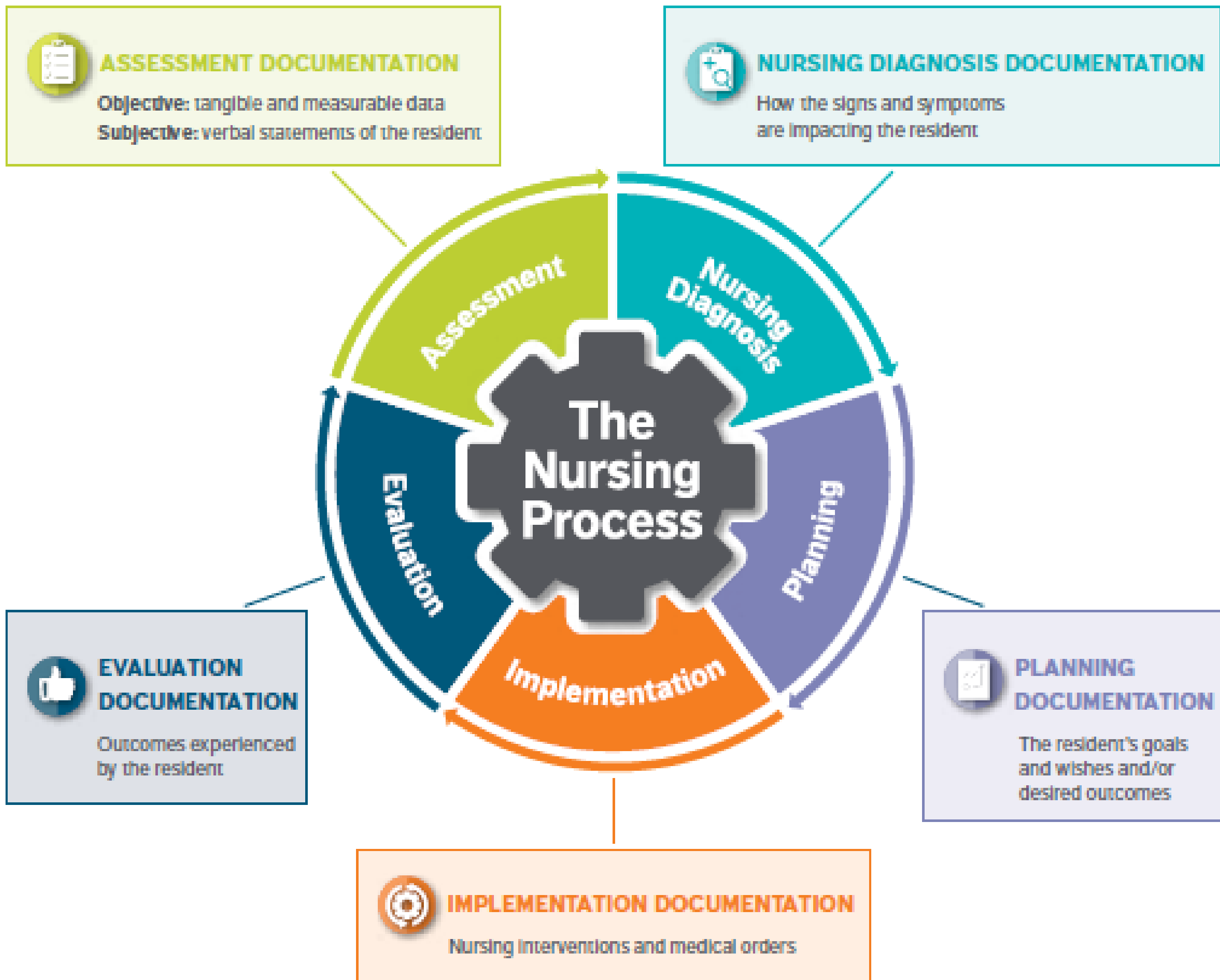
Covers notification of MD and family

Interventions and care plan updates

Documentation and Nursing Process

- “A systematic approach to care using the fundamental principles of critical thinking, client-centered
- Approaches to treatment, goal-oriented tasks, evidence-based practice (EBP) recommendations, and nursing intuition.” (Toney-Butler, 2019).
- **There are five steps: assessment, nursing diagnosis, planning, implementation, and evaluation.**

Link Between Nursing Process and Documentation



Narrative Notes

Keep the nursing process in mind

Use your mental acronym for problem oriented notes

- Details
- Assess, Act
- Response, Report
- Educate,Evaluate

Stop And Watch

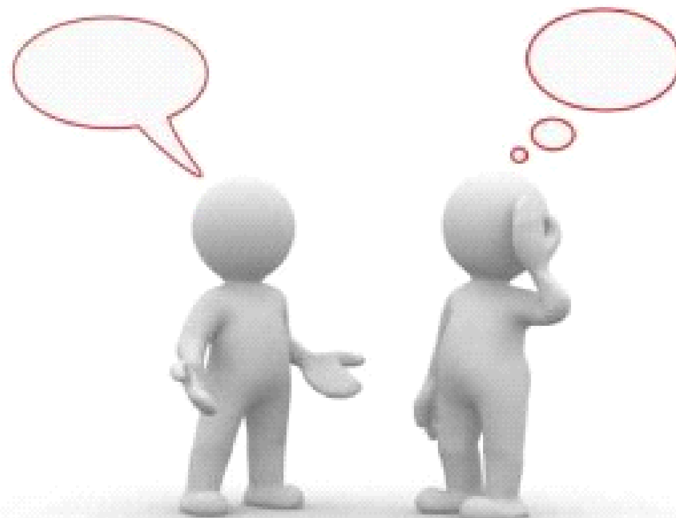
Seems different than usual
Talks less than usual
Overall needs more help than usual
Participating in less activities than usual

Ate less than usual
N
Drank less

Weight change
Agitated or nervous more than usual
Tired, weak, confused or drowsy
Change in skin color or conditin
Help with walking, transferring, toileting more than usual

Nursing Documentation – SBAR

- Situation
- Background
- Assessment
- Response



SBAR

S Situation
Briefly describe the situation.
Give a succinct overview.

B Background
Briefly state pertinent history.
What got us to this point?

A Assessment
Summarize the facts.
What do you think is going on?

R Recommendation
What are you asking for?
What needs to happen next?

Situation

- Describe the problem
- Introduce your name, professional title, and work location
- Explains the patient problem in detail.   Can include: patient complaints like body pain, nausea, and difficulty breathing.
- It can also include issues the nurse identified, such as an abnormal blood pressure, bleeding, or change in a patient's level of consciousness.

Background

- Includes information about the patient that the doctor needs to know to help identify the source of the problem and its potential solution.
- This includes the reason the patient was recently seen by the doctor and specific medical history about the patient.
- Only information related to the patient problem is mentioned.

Assessment

- Record what was observed when checking the patient including: information gathered during the physical examination through seeing, hearing, smelling, and touching
- Data obtained from tools and equipment the nurse uses including: vital signs: blood pressure, heart rate, temperature, and respiratory rate, abdominal assessment, surgical wound assessment
- Patient response to specific questions

Recommendation

- Includes nurse suggested solutions to the problem.

- Requests for specific tests, medications, and treatments are made that might help.

- The nurse may also be an advocate by asking the doctor for specific things patients want and explanations about their conditions.

- Physician and family notification

POINT

- Choose a format you can easily remember and with which you are comfortable.
- Limit the subjective information to what the resident says.

What caregivers should chart

- Document in chronological order
- Write so others can read the entry
- Time and date all entries
- Use only truthful, accurate information
- Use only standard abbreviations

What attorneys look for

Evidence that care and services were rendered consistent with the resident's diagnosis

Was the Standard of Care met?

Notes are reviewed for gaps in care or monitoring

- ADL sheets and other flow sheets
- Omissions on MAR/TAR
- Wound flow sheets for wound assessments

What attorneys look for

- Was risk assessed and identified?
- Was there a plan of care in place?
- Was the care plan followed?
- Were policies and procedures followed?
- Was the concern investigated with follow up interventions?
- Who was notified?
- Who was involved in the resident's care?
- Was there timely response and evaluation?
- Was the plan of care updated?

Standard of Care

n. the watchfulness, attention, caution and prudence that a reasonable person in the circumstances would exercise

The Free Dictionary by Farlex

Standard of Care

If a person's actions do not meet this standard of care, then his/her acts fail to meet the duty of care which all people (supposedly) have toward others.

Failure to meet the standard is negligence, and any damages resulting from may be claimed in a lawsuit by the injured party.

The problem is that the "standard" is often a subjective issue upon which reasonable people can differ

Computerized Charting

- Helps improve the accuracy of the documentation
- Legible
- Still need back up paper system
- Notes out of sequence

Content and Value of Entries in the Record

Completeness of an entry is often debated

There is no standard of specific language for documentation

- Reimbursement standards force some specific information but there is no universal format for nursing, social services, dietary, activities, or physician progress notes

POINT

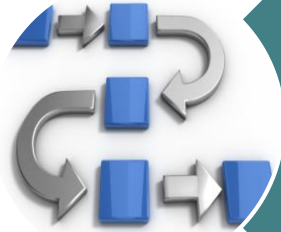
Set expectations for all disciplines about what an entry should contain. Each caregiver should know what is expected when required to make a note in the medical record.

What does the facility administrator expect??

- Entries meet professional standards of care
- Nursing staff follow the nursing process
- Entries are in compliance with the state and federal regulations

What does the Nurse Practice Acts require??

Document and maintain accurate records



Follow the Nursing process

May not Falsify or knowingly make incorrect entries into the patient's record or other related documents.

What is expected by state and federal regulations??

F842 In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are—

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is—

- *(i) To the individual, or their resident representative where permitted by applicable law;*
- *(ii) Required by Law;*
- *(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;*
- *(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.*

483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

483.70(i)(4) Medical records must be retained for—
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain—
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician, nurse, and other licensed professionals progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under 483.50.

What is expected from those who document??

- Document assessments, observations, and interventions
- Communicate with other caregivers, practitioners, and family members
- No Blank spaces in nurses' notes
- No references to risk management-incident report completed, or called nurse attorney
- Date, time, sign name to all entries

3 C's of Documentation

Be Concise

- Liability is not prevented by writing down everything, but by the choice of words and information they contain

Be Correct

- Report on only facts, no opinions

Be Cautious

- Choose your words correctly and convey the appropriate information
- Care *not* documented is care not given

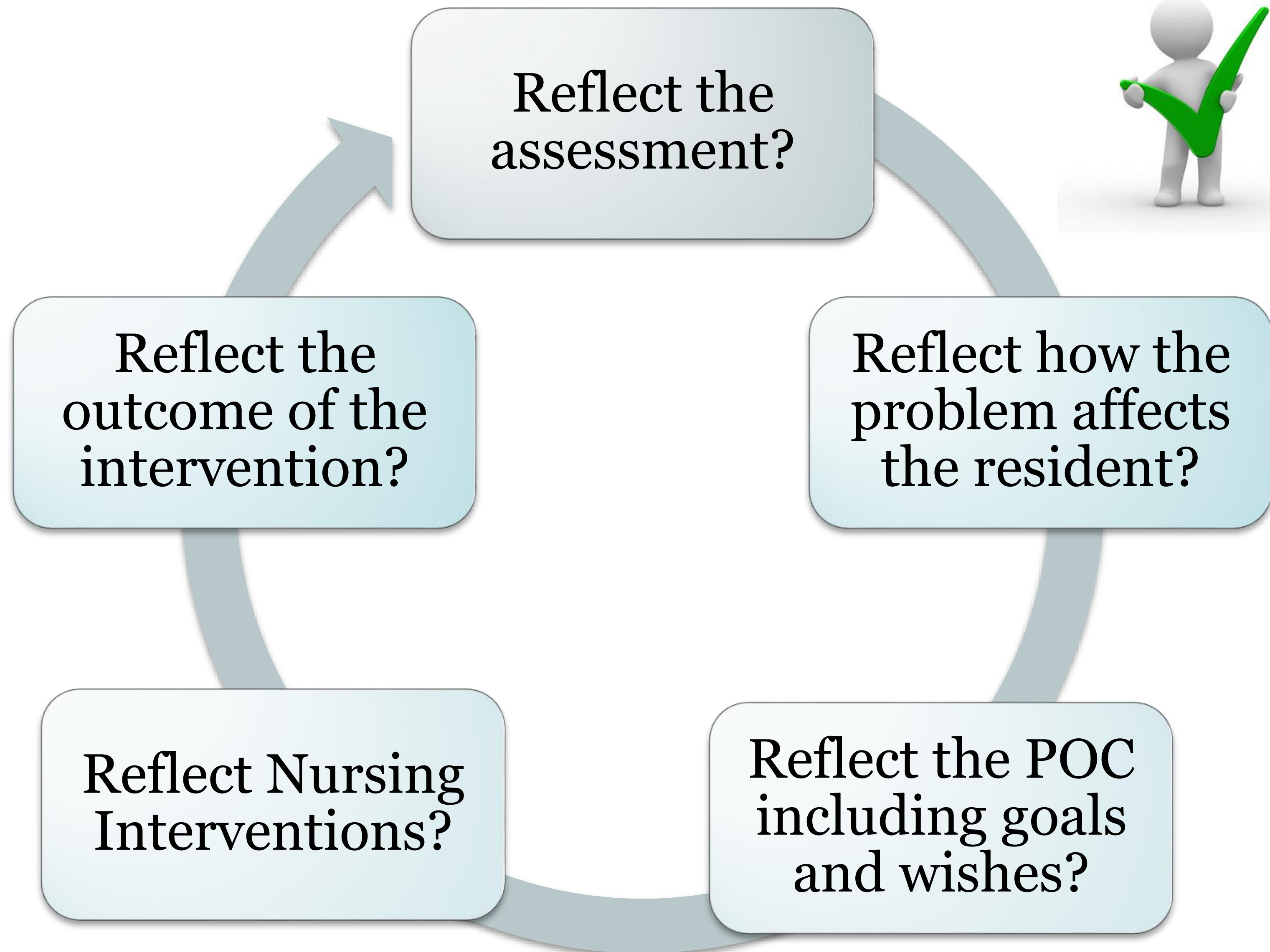
What should documentation do?

- Support good decisions
- Provide evidence of tangible, measureable actions
- Indicate well being of the resident
- Stay within the law and scope of practice
- Work within your facility policies and procedures

Characteristics of Good Documentation

- Complete, accurate and timely
- Full name and title of author
- Accessible and systematic
- Sequential, logical order
- No blank areas or lines
- Secured and Confidential
- Implementation of the Care Plan
- Every problem should show a response

Does the documentation….



Charting guidelines

- Time
- Legality
- Content
- Recording
- Construction

Guidelines – Time

- Chart in a timely manner
- Follow facility policy regarding documentation frequency
- Date and time each entry
- Chart in chronological order
- Never document interventions before carrying them out

Guidelines-Legality

- Document in a legally prudent manner
- Chart any actions taken to resolve a problem and notification of responsible party
- Chart resident non-compliance
- Chart resident responses and reactions
- Document actions taken in response to questionable treatment or orders
- Don't chart staffing problems or disputes

Guideline – Content

- Chart appropriate data
- Be specific, accurate and complete
- Report the facts, avoid assumptions, personal opinions and biased statements
- Support subjective data w/ objective data
- Record all resident and family education
- Record everything done for the resident including discharge planning

Guidelines – Recording

- Chart on the right resident
- Use the appropriate form and format
- Write neatly and legibly in black ink
- Sign each entry, full name and credentials
- Do not leave blank lines or spaces

Guidelines- Construction

Rules of Construction

- #1 Conceive the Whole Note First
  - Engage brain before putting pen in gear
  - Know purpose for writing
  - Group information in a logical manner
  - Write for the reader

Rules of Construction

#2 Admit or Omit Nothing at Random

- Have a reason for everything you write
- Include all relevant material
- Analyze the [event, facts, circumstances] in terms of
  - Clinical Implications
  - Stakeholders
  - Effects in Law

Rules of Construction

#3 Follow a Logical Order

- Chronological is a good rule of thumb
- Multiple or Interactive Events?
  - Pick an order and stick to it!
  - E.G., Physical Assessment – Head to Toe
  - SBAR
  - MDS Section by MDS Section

Rules of Construction

- #4 Choose the Right Words
  - Customary language (Plain English)
  - Use only Approved Abbreviations
  - Common Definitions
  - Use correct medical terminology
  - Avoid meaningless terms and repetition
  - Use correct spelling, punctuation and grammar
  - Style, e.g., “resident” instead of “patient”

Rules of Construction

- No Ambiguous Words
  - Moderate
  - Sufficient
  - Essential
  - Reasonable
  - Appropriate
  - Adequate
  - Good
  - Functional
  - Proper

Rules of Construction

- No Indefinite Pronouns
  - It
  - Them
  - These
  - Those
  - This
  - Their

Rules of Construction

- Use Technical Words Correctly
- Adhere to Rules of Grammar
- Use Simple Declarative Sentences
- Use Active Voice
- Document Conclusions only with Supporting Facts

Correction of Errors

- Make corrections in legally acceptable manner
- Make corrections promptly
- Make late entries appropriately
- NEVER alter a resident's legal medical record
- Do NOT discard or destroy any pages of a medical record
- NEVER document a task or care that was not provided

Process of Correcting Errors

- Draw single line thru entry made in error
- Write “error’ next to entry
- Enter “date” correction was made
- Enter your initials next to entry
- Enter statement to correct entry made in error
- Computerized charting- use late entry and strike out features of software

Negative Impact on Medical Record Integrity

- Omissions
- Wrong dates
- Missing Pages
- Multiple repeats of same document
- Instructing that the record be changed
- Meds/Tx not signed out according to protocol

Consequences of Inconsistent and Inaccurate Entries

- Statute of Limitations
- Punitive damages
- License Revocation
- Criminal Conviction
- Willful Material Omission
- Willful Material Falsification
- False Claims Act
- Presumption that care is not done

Refusal of medication, treatment, nutrition, fluids

- Date and time
- Type of refusal
- Potential complications and adverse effects reviewed
- Notification of family and physician, with time
- Resident's cognitive status
- Alternative treatment discussed and offered
- Chronic refusals identified in interdisciplinary care plan
- Advance directive status
- Risk, Consequences and Benefits

Documentation of Resident Refusals: example

03/09/18 7:00AM Resident refused to get out of bed this morning. Would not allow morning care or turning and positioning. Explained to the resident the importance of position change.

Documentation of Resident Refusal

03/09/18 7:15AM Information relayed to Dr. Jones during rounds. New orders received for clinical social worker to visit. Orders noted, referral appointment made. Daughter Ann made aware of care refused and stated she understood and would visit this afternoon.

Documentation of Resident Refusal final note example

03/09/18 8:30AM Resident continues to refuse to be turned and positioned. Would not accept breakfast or hydration. Referred refusal to care plan team.

Point to Remember

Don’t state that the resident is noncompliant or refusing care without supporting your active role in meeting the needs of the resident.

Characteristics of Good Documentation for Dietary

- Document calorie needs
- Document needed fluid intake
- Document obstacles meeting the caloric and fluid intake
- Efforts required by caregivers to reach the caloric and fluid intake goals

Dietary Example

- Resident needs a 2,000 calorie regular diet with ethnic preferences of rice and tea with each meal. She has a history of fluctuating weight of approx. 10lbs. supported by the facility. She refuses meals often. Supplemental milkshakes have been added to her diet. We have requested the family bring favorite foods from home. We are unable to to meet the requirements of food and fluid intake due to the personal choice of the resident. The physician has been notified and the family has been involved in our efforts."

What are the problems with these entries?

Discrepancies and inaccuracies in recorded weights:

Date	Record	Weight
10/27/00	Nursing Notes	189.9 lbs
10/31/00	ADL Progress Note	165.9 lbs
11/7/00	Medication Record	189 lbs.
11/24/00	MDS	189 lbs.
12/19/00	Medication Record	129.6 lbs.
12/22/00	MDS	165 lbs.
1/2/01	MDS	165 lbs.
1/2/01	Medication Record	128.2 lbs.
1/9/01	ADL Progress Note	123 lbs
1/15/01	Dietary Progress Note	128 lbs.

(This also had a notation that admission weight of 165 lbs was "incorrect.")

Admission

- Admission process sets the stage for how other care givers interact with the resident
- Establishes baseline assessment and sets the stage for all future documentation
- Establishes the baseline plan of care to educate the resident and family
- Provides snapshot of the resident’s condition upon arrival

Interdisciplinary Admission Assessment

- Assessment and physical observation is key in determining the residents needs and response to baseline plan of care
- How you assess and describe the resident on the day of admission will guide all other care givers
- Identifies risk areas
- Provides baseline to establish the initial plan of care

Medical Record Entry Example

05/06/02 2:00PM 82 yr. old female admitted to Room 63.   Alert, but confused x3.

Improved Medical Record Entry

- 05/06/02 2:00PM 82 yr. female admitted to Room 63. She is alert, knows she is not at home and asks if she is still at the hospital. Stated it is about Christmas time, and she must buy the children some presents. Stated her name was Mrs. Smith when asked.

Listen to the Resident

- Comments during the admission process such as “I have to get home to feed the dogs.”
- When does the bus come?
  - What should be part of the initial care plan?

Listen to the Family

- “We could not get her to eat anything.”
- “She falls every day at home.”
- “She would not take all of her medications at home.”
    - What should the above statements prompt you to do?

Change of Status

- A decline in resident status is “one in which the resident status will not normally resolve itself without further intervention. Includes the resident’s medical status, functional abilities or psychosocial status
    - Complete Change in status assessment
    - Involve the appropriate health professional
    - Notify the family and physician
    - Update the Plan of Care
    - Document

What Nurse and Personal Care aides can do

Report when they notice changes in the resident

- Appetite
- Elimination
- Sleeping
- Communication
- Behavior changes

Physician Notification and Orders

- Accident resulting in injury
- Significant change in physical, mental or psychosocial status
- Need to alter treatment
- Transfer or discharge
- Keep all orders, including phone orders in chronological order
- Cross check all orders against the plan of care to ensure appropriate care is administered

Treatment and Medication Records

- No gaps and omissions
- Gaps in these records can cause serous consequences
- Omissions/ Gaps makes record appear as though treatment was not provided consistently
- Only the staff member preparing and administering the medication or treatment is to record the administration.
- Document resident refusals- record reason
- Document explanation or risk, benefits and consequences of refusal

Therapy Notes

- Review for inconsistencies with the nurse's notes
- Nursing notes should support reasons why the resident is receiving therapy services
  - "Seems weaker. At risk for falls, need to monitor."
  - Nurse's notes: "Ambulating independently throughout halls."

Wounds

Risk Identification
Implementation of Preventative Measures
Regular Wound Assessment and Documentation
Implementation of Care Plan
Documentation Interventions Implemented
Notification change in wound status
Alternative Measures offered and implemented
Changes to treatment and care plan if ineffective
Resident education
Revision to the plan of care
Standard of Care Followed

Dressing changed on R buttock pressure injury. Analgesic administered 45 min. prior to dressing change and no s/s of pain during procedure. Wound bed beefy red with moderate amount of clear drainage. Free of foul odor. Wound bed cleaned with normal saline. Collagen applied to wound bed and covered with bordered foam dressing. Peri wound area intact and light pink in color. Resident using trapeze bar to reposition self when in bed, along with one staff weight-bearing assist to move legs. Heel protectors on. Gel cushion in place in w/c. Incontinent of urine. Peri care provided & barrier cream applied. Resident consumed 75% during breakfast and lunch.

Falls

Identification of Risk

Interventions based on Risk factors

Implementation of Interventions

Plan of Care Implemented Conduct investigation- root cause of fall

New intervention implemented after each fall

Documentation of interventions in place

Record event in record with assessment and intervention

Post fall monitoring

Notification of family and physician

Revise and Update Plan of Care

Observed resident laying on back approx. 3ft from bed at 14:00. Pulse rapid and bounding at 94 BPM. Respirations 24. BP elevated at 168/96. Resident encouraged to take a few slow, deep breaths, and respiratory rate dropped to 20. Right leg is shorter than left leg and is externally rotated. Right leg stabilized with pillows to prevent movement. No additional injuries found. Neuro checks initiated. PERLA. No change in cognition or level of consciousness. Resident stated, “I was just trying to pee and got so dizzy. What have I done to myself? Help me. Help me. Help me.” Nurse and CNA consoled resident and assured him the ambulance would arrive soon. Resident squeezed writer’s hand and stated “Ok, ok, thank you.” Resident covered with warm blanket. Physician notified of the fall and assessment of the injury @ 14:05. EMS called @ 14:08 and arrived @ 14:30. EMS transferred resident to backboard and left facility @ 14:40. Responsible party notified and thanked writer for helping the resident.

Frequent "forgotten" documentation

- Resident comments and quotes
- Family member phone calls and comments
- Telephone Calls
- Telephone and Verbal orders
- Incidents
- Resident requests
- Other calls pertinent to resident care (follow up appointments)

Documentation DONT's

- Do not pre-date or make entries in advance
- Do not leave any blank lines.
- Do not back-date a late entry
- Do not document assumptions or personal feelings
- NEVER sign an entry employee did not make themselves
- Do not utilize texts or emails that are not encrypted and HIPAA compliant
- Do not use vague terms

Suggestions for Personal Improvement

- Check the forms available for charting
- Know your facility policy and procedures
- Do not use ambiguous words for one day
- Write conclusions only with supporting facts
- Write short declarative sentences in active voice
- Give performance feedback to caregivers on their notes

Suggestions for Personal Improvement

- Notes should support team effort and acknowledges obstacles to care recommendations
- Eliminate duplicate documentation
- Document the facts, not opinion
- Use quotation marks and document exactly what is said
- Correct documentation errors with proper procedures
- The employee signing entries should only sign those he or she makes
- Document in real time
- If a late entry needs to be documented, use the date and time it is being entered

Questions

Thank you for your attention and opportunity to conduct this presentation

Providing Balance Between *CARE* and *FINANACIAL STABILITY*

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