



## THE IMPORTANCE OF PROPER DOCUMENTATION

If a tree falls and no one hears it, did it make a sound? One potential answer is that it depends on your interpretation of the word “sound”.

A similar question can be asked about documentation... **If there is no documentation, did the action occur?** Unfortunately, in the legal world, there is little room for interpretation. Savvy plaintiff lawyers will always argue that if there is no documentation, the action did not occur. End of story.

Senior living is such a caring business, and we know you and your staff do many great things every day to show you care for your residents; however, at times these things are not documented. We know staff often go above and beyond in providing compassionate care and treatments that may go undocumented for a variety of reasons, including documentation by exception only, lack of time, lack of staff, inadequately trained staff, etc. All understandable reasons.

Unfortunately, we see countless examples of Senior Living claims/lawsuits that prey on the sparse documentation found in the typical resident file.

There are many challenges to ensuring accurate and complete documentation; however, the “we’re a social model, not a medical model” or documentation by exception or “our state doesn’t require this” no longer affords your facility a viable defense. The fundamentals and standard best practices for documentation must be followed at all times in order to protect your facility and employees as well as your residents.

### CONTACT INFORMATION

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## Standard best practices dictate that Senior Living Providers should document the following at a minimum:

### Pre-Move Assessment

This is used to determine overall health and appropriateness for admission. The assessment should include a Physician Statement/Attestation, in addition to an internal nursing head-to-toes assessment (inclusive of a comprehensive Falls Screening Tool).

### Subsequent Assessments

These Internal Assessments should be completed:

- With each hospitalization;
- Quarterly for all residents diagnosed with: Alzheimer's, Dementia, Parkinson's, Diabetes, Congestive Heart Failure, etc.
- Semi-annually for the typical Assisted Living resident.

### Incident Reports

A comprehensive review of unusual events, with or without injury, should be documented on the Incident Report. Determine root cause of incident, and document interventions provided with their effectiveness, and document communications with physician and resident/ family member/ responsible party.

### Resident Change in Condition

This should include a new assessment and Falls Screening along with updates to Plan of Care.

### Medication

Ongoing list of current resident medications and any changes made to treatment plan.

### Weekly Skin Assessments

These are typically performed during bath/shower or ADL time.

### Coordination of Care with Outside Providers

Typically refers to physicians, home health care nurses and therapists, hospice nurses, etc. Document all conversations regarding resident treatments and obtain copy of progress notes and plan of treatment when possible.

### Training of Staff

This should include documentation of orientation, weekly and monthly in-services training of staff with employee signed acknowledgement. Documentation may be either electronic or paper or a combination of both.

### Documentation of Resident Care Discussions

Communication of individual care items, incidents, etc. with resident/family member/responsible party even though it may appear small, slight or quick. **Remember, if it's not documented, it didn't happen.**

### Resident Agreement

Also referred to as a Resident Move-In Agreement, this should be signed by resident/family member/responsible party. The Resident Agreement should include an **Arbitration Agreement** where allowed.

## What to Document and What to Include in Staff Training

- Observations
- Daily Measurements
- Weight
- Vital Signs (blood pressure, pulse and temperature)
- Food Intake
- Fluid Intake
- Sleeping Pattern
- Bathing Pattern
- Walking Record
- Toileting
- Regular Skin Checks
- Safety Issues
- Resident Statements and Complaints
- Unusual Events, Resident Refusals of Care, Medications, etc. (Incident Reports)

## What Kind of Charting?

### Paper or Electronic Health Record (EHR) or both?

- **Electronic Health Record (EHR).** The EHR is a digital version of a resident's paper medical chart. It is designed to ensure that medical charts are complete and accurate. With good EHR software and EHR systems, health care providers will be alerted to any missing, incomplete, or possibly inaccurate medical charts.

An EHR is a real-time record that makes health information available instantly and securely to authorized users. EHRs are built to share medical notes with other health care providers and organizations – such as laboratories, specialists, medical imaging facilities, pharmacies, emergency facilities and workplace clinics – so they contain information from all involved in a resident's care. When used effectively, the EHR automates and streamlines health provider workflow.

The EHR also has the ability to support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management and outcomes reporting. EHRs are stored in a secure, centralized location to help make sure resident medical charts are not misplaced.

Compared with paper records, the use of EHRs can improve resident care tremendously. Benefits include:

1. Reducing the incidence of medical error by improving the accuracy and clarity of medical records and coordination of diagnosis and treatment among health providers.
  2. Making health information instantly accessible, reducing duplication of tests, reducing delays in treatment, and keeping residents (family members/responsible parties) informed to make better decisions.
  3. Enabling residents (family members/responsible parties) to log on to their records to see health trends and other medical information.
- **Paper Health Record.** What should be in a resident's paper chart? The basics, a binder/folder type with dividers for sections, including: face sheet/demographics, advanced directives, H&P, assessments, care plan/service plan, medication records, social services/activities, physician orders/notes, lab, home health, therapy, progress notes, etc.



## Who is Watching the Data and Responding?

Monitoring the documentation through Chart Audits routinely provides a comprehensive picture of the resident at all times and allows the community to stay ahead of any potential issues prior to them happening. This can be the responsibility of the Administrator, Director of Nursing or Executive Director, individually or as a team.

## Replying to State's Statement of Deficiencies

It's important to remember that the Statement of Deficiencies (SOD) becomes public record and is often referenced by plaintiff's attorneys. The Plan of Correction (POC) should clearly define the corrective action taken and preventative measures to ensure continued compliance in the future.

## When to Report a Claim to Your Insurance Carrier?

Things don't always go as planned and when an unfortunate incident takes place that causes harm to a resident and the family is irate and/or has expressed potential litigation or requested medical records, it's time to notify your Insurance Carrier. As a reminder, the quicker you inform your Insurer to a "potential" claim, the faster we can assist with investigation and advise on resolution options.



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