

Quality Assurance Update

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ment implications if the reviewer cannot read the medical record.

What should you do to protect your department from the Cryptographer?

- Teach your staff “If it isn’t legible, it isn’t done”.
- If the entry is illegible, it should be rewritten in the next available space and noted as such.

The Better-Late-Than-Never

This creature prefers to write its notes weeks after the event. Several weeks of notes are written at the same time, with the same pen in the same handwriting. Entries contain the same information with minimal change because the creature is embellishing on scantily remembered facts. The more time that passes, the less reliable and more dangerous this species becomes.

What can you do to protect your department from the Better-Late-Than-Never?

- Teach your staff to document as treatment is provided (Point of Service documentation).
- Build documentation time into every day and use the time for documentation and not other activities.

The Replicator (aka, The Copycat, The Parrot)

This creature inhabits every department. Have you seen entries like this before?

“Progress made”. “Continue with plan of care”. “Training is ongoing”.

They just copy a previous entry. Treatment after treatment or week after week, the entries are the same. *What progress has been made? Continue the focus on what part of the plan of care? Training of who- on what- is ongoing- and for how long?* If no progress towards goals was made, then perhaps the goals and interventions need to be reevaluated. Reimbursement will be denied if the documentation from this creature is pulled for medical review.

What can you do to protect your department from the Replicator?

- Conduct peer reviews of documentation during department meetings looking for entries that do not support progress or medical necessity of treatment.
- As part of the review process, select one area of improvement (goal writing, progress reports, CPT coding) to focus on each month.



The Overlooker

This species never reads previous notes or notes from other disciplines. They create dangerous situations of contradictions that can cause denied payment or legal ramifications.

For example:

“9/10/07, Resident admitted to hospital per nursing note. Therapy note dated 9/11/07 makes no mention of the hospitalization but does indicate that therapy will continue at next session”.

“8/22/07, Discipline one therapy note at 8:00 am indicates that patient is out of bed in chair, transfers with min assist, highly motivated to return home and asks for exercises to do independently. 8/22/07, Discipline two therapy note at 9:00 am indicates that patient is uncooperative making negative comments about therapy being useless and refuses all treatment. 8/22/07, Discipline three nursing note indicates that patient to X-ray at 9:00 am.”

What can you do to protect your department from the Overlooker?

- Provide daily updates to staff on patient status within the facility (discharges, clinical changes).
- During peer reviews, look for contradictory information between disciplines, including nursing, physician and other therapy disciplines.

In summary, substandard documentation can be suggestive of substandard care. The question in the surveyor’s, lawyer’s or insurance company’s mind will be, “If this therapist cannot clearly document, what kind of care are they providing?”

The best way to avoid a documentation jungle at your facility is to:

- Orient staff at hire and annually on “best practice” documentation using EnduraCare approved materials and facility policies and procedures.
- Conduct audits of new employee documentation for one month to ensure compliance with “best practice”.
- Request site visits or documentation desk audits by your Director of Education and Compliance (DEC).
- Conduct regular peer audit reviews of documentation to maintain good documentation habits.

Contact your supervisor for more information on EnduraCare documentation standards, peer review or to schedule a desk audit by your DEC.

References:

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