Defensive Documentation in Senior Living: A Risk Management Technique

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Disclosures / Disclaimers

This presentation is intended to provide best practice recommendations; however, you should refer to your organization's documentation policies and procedures

This presentation is not intended to be legal advice

Objectives

- Review professional liability risk factors and trends in Senior Living litigation.
- Explore the importance of clinical documentation practices
- Describe defensive and indefensible documentation, which can protect facilities from lawsuits and insurance claims
- Use case studies to identify best practices for credible, defensive documentation, which can protect individuals from criminal charges

Professional Liability Risk Factors and Trends

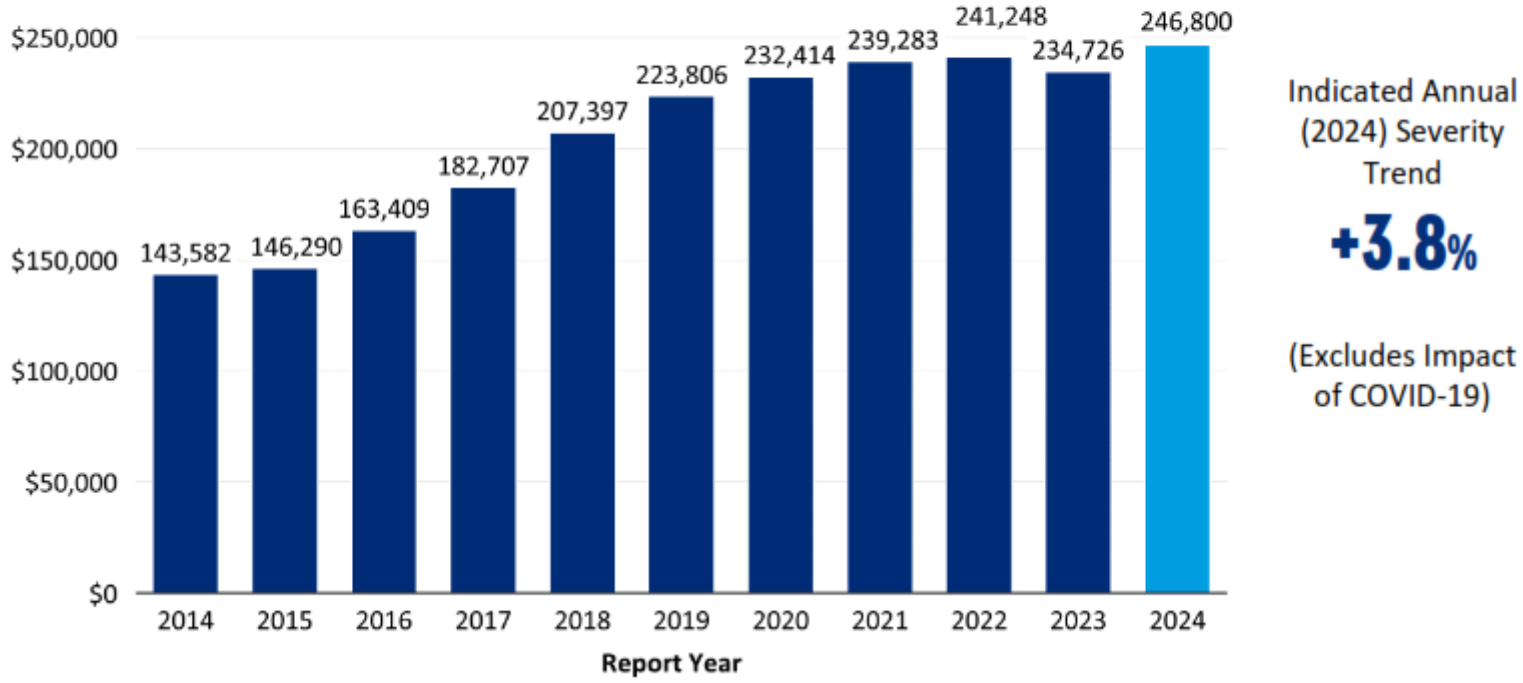
Risky Business

- Healthcare Industry is highly regulated
- Residents enter AL & MC more fragile than in the past
- Senior Living Residents are highly vulnerable
- Occupational Stressors
- Litigious industry
- Staffing Challenges

Average cost of Claims in Senior Living

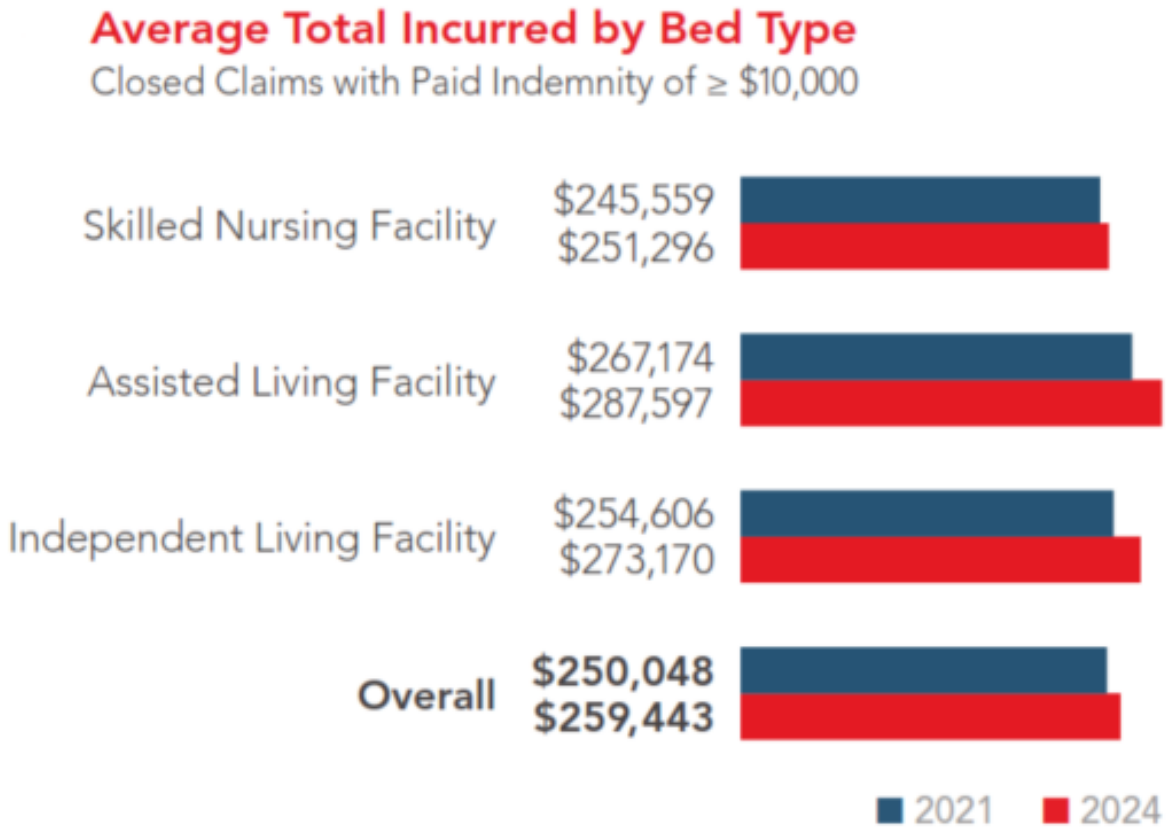
Figure 4 provides the estimated severity for the past ten report years, along with our projected 2024 severity.

Figure 4: Senior Living Severity



Average Cost of Claims

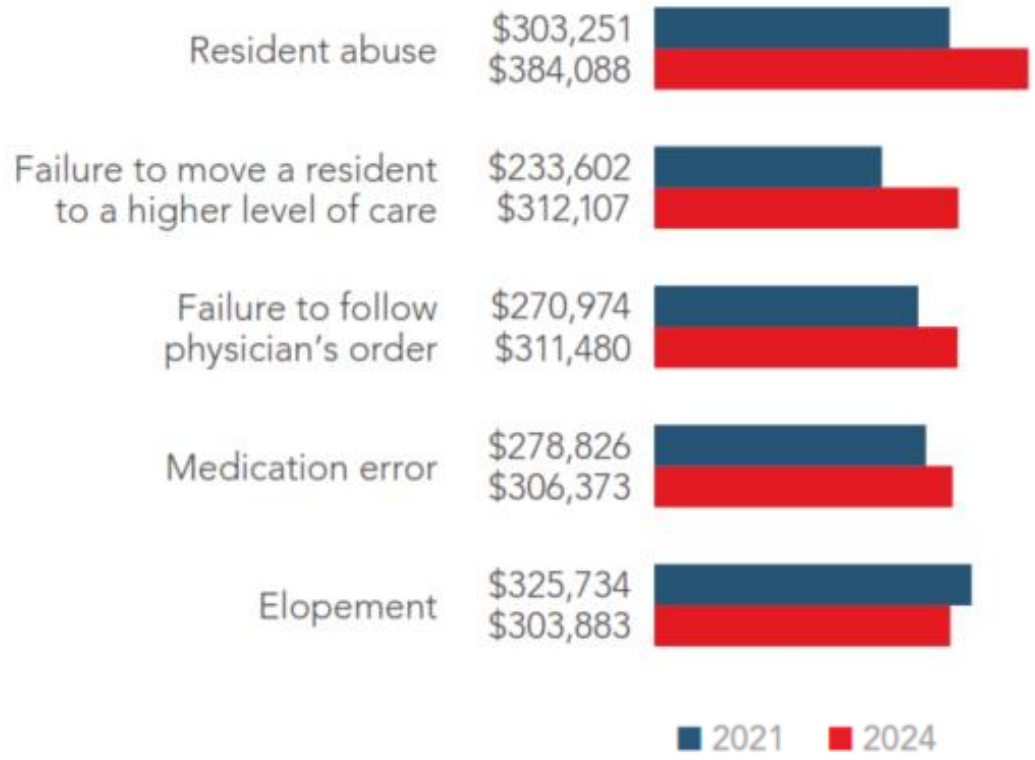
Based on Bed type

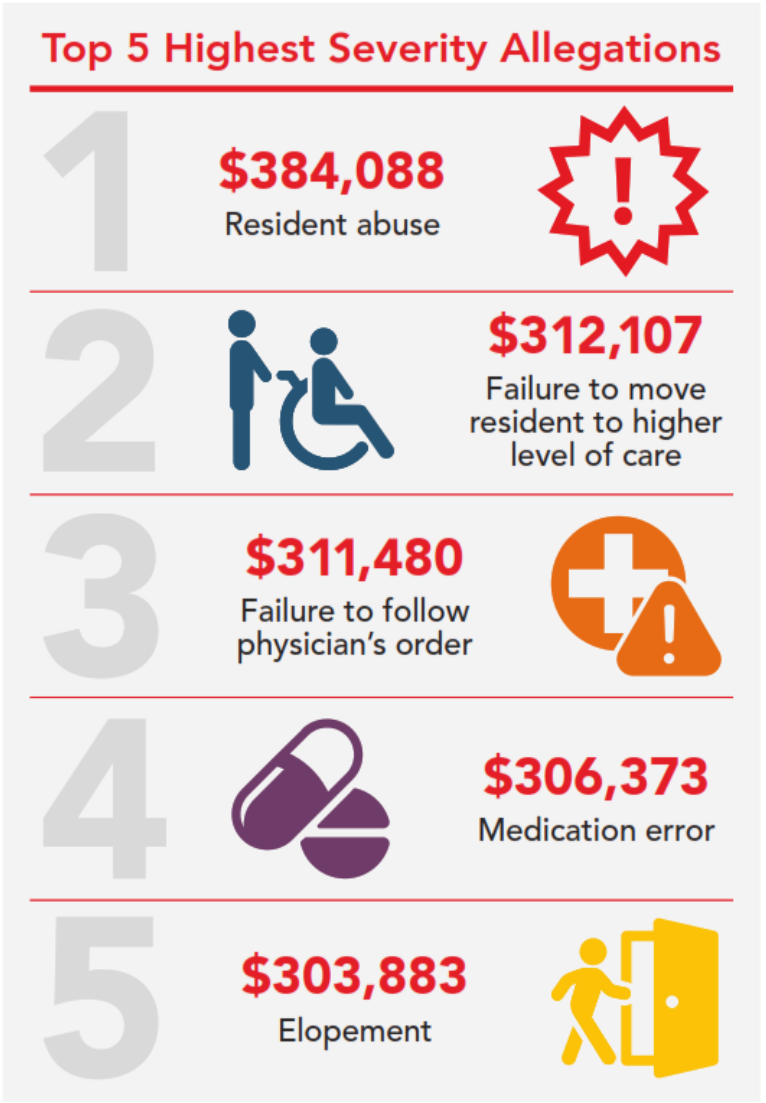


CNA Aging Services Professional Liability Claim Report 12th Edition

Top 5 Causes of Litigation

Based on Severity of Cases





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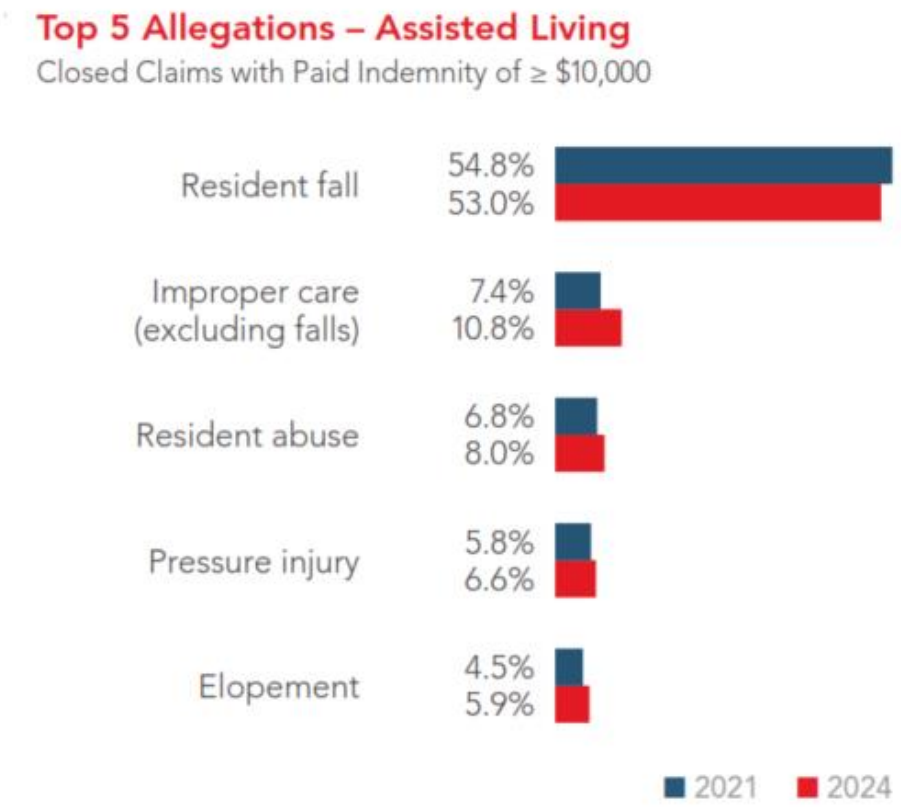
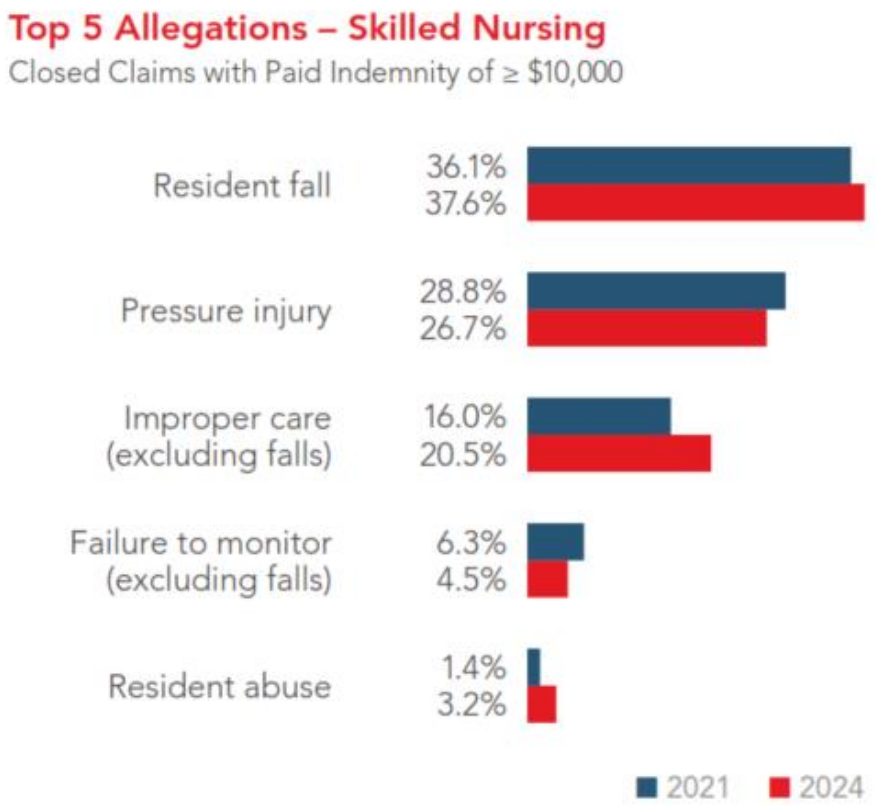
Top 5 Reasons for Litigation

Based on frequency of cases





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Clinical Documentation

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What is Documentation

Who reads documentation?

Assume that clinical documentation will be scrutinized at some point

- Members of the healthcare team
- Regulators (surveyor), credentialing agencies
- Reimbursement services
- Quality improvement monitors
- Residents and families
- Attorneys, judges, juries
- You

Clinical Documentation

Considered a part of the permanent medical record

A legal document that can serve as evidence of the care, treatment and services provided

- If there is no documentation, there is no evidence

Documentation is not optional

It is a legal requirement.

Integral part of resident care responsibilities

Promotes continuity of care

Allows other clinicians to understand the resident's history so they can continue to provide the best possible care and treatment

Supports the resident's diagnosis, justifies treatment, and records response/results of treatment

We can all recite it…
If it's not documented, it didn't happen.

If I didn’t document it… I didn’t do it

Consider this…

Is “not documented not done” true for every situation?

Purposeful Rounding	Turning and Repositioning	Call Lights
What are our policies? How detailed are our Service / Care Plans?	What are our policies? How detailed are our Service / Care Plans?	What are our policies? What do our records show?

Defensive & Indefensible Documentation

Protecting facilities against law suits

Healthcare is inherently a risky business

- Death may result despite appropriate care
- Even when we do all the right things…accidents happen

Every incident has the potential of becoming a claim, which is why the documentation of those incidents is vital

All attorneys prove or defend their case based on documentation

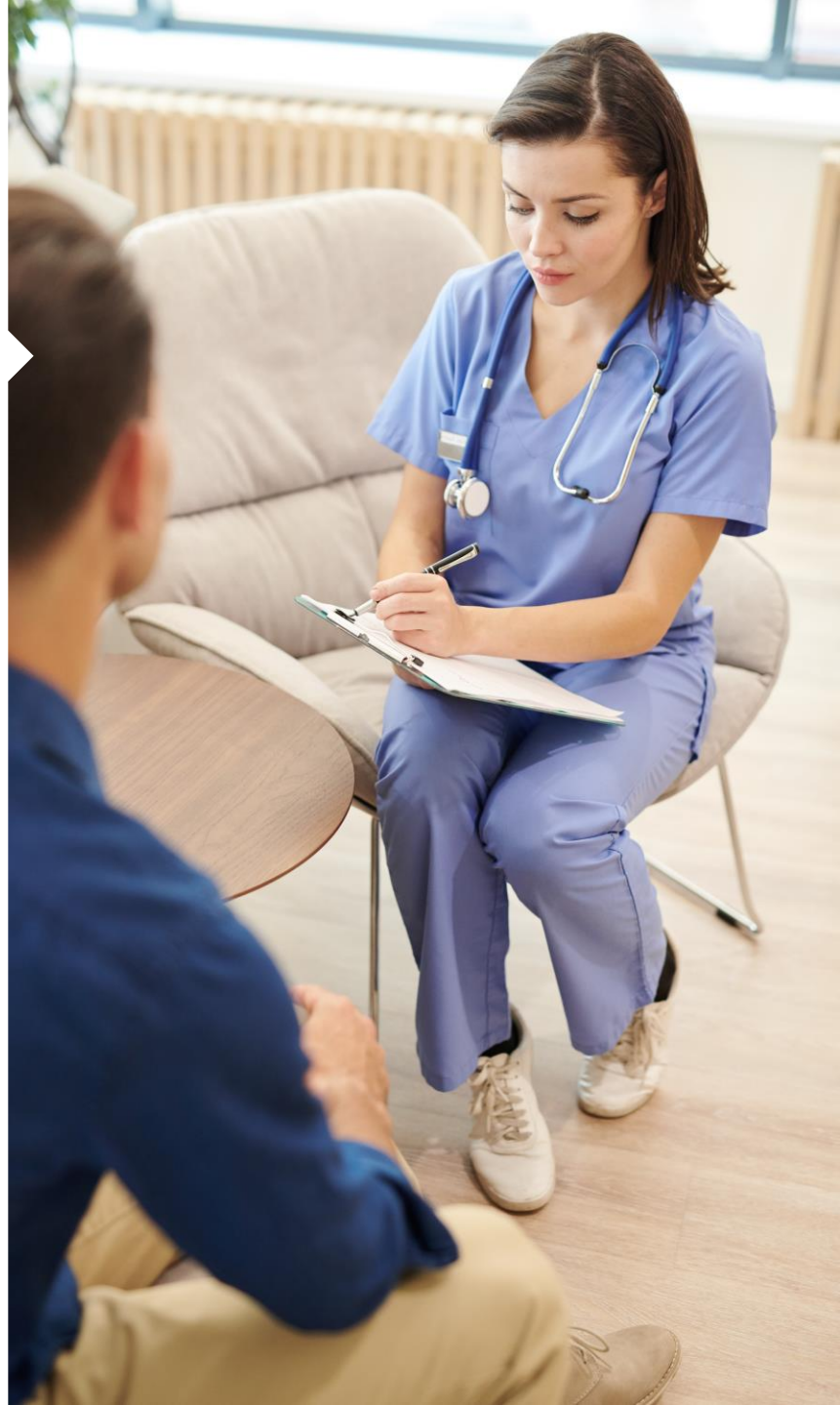
Plaintiff attorneys rely on errors, omissions, inconsistencies, and alterations in nursing documentation to support their case.

Defense attorneys rely on objective, accurate, complete, and timely documentation to successfully defend their case.

Defensive Documentation

Tells a complete story beginning to end

- Charting promptly
- Being consistent with other parts of the medical record
- Meeting standards of care
- Following organizational policies and procedures
- Including patient and family communication and education
- Recording non-adherence
- Not falsifying record
- Documenting provider notification of a change of condition
- Not jumping to conclusions



Additional Records / Reports

In addition to the medical record, facilities have other records that can assist their defense counsel in telling a complete picture of the excellent care they provide their residents

Indefensible Documentation

Misleads the jury to believe care or services provided was unexplained, inappropriate or substandard

- Missing importance pieces of information
- Inconsistent with other parts of the medical record
- Filled with errors
- Backcharting
- Clinical providers practicing outside their cope
- Disparages the work of other clinical providers
- Subjective

35% - 40%

Of lawsuits are “indefensible” because of poor documentation

Objective versus Subjective

Objective

Based on measurable and observable facts. Information we gather with our five senses.

Subjective

Based on or influenced by personal feelings, beliefs, assumptions or opinions. One’s point of view or judgment.

Objective Documentation

Gather objective information with your five senses; Quantify observations

Palpated a pea size lump, red in color, warm to touch

Observed a yellow tint to the skin

Resident heart rate of 84 bpm

Upon auscultation, expiratory wheezing heard throughout the lungs

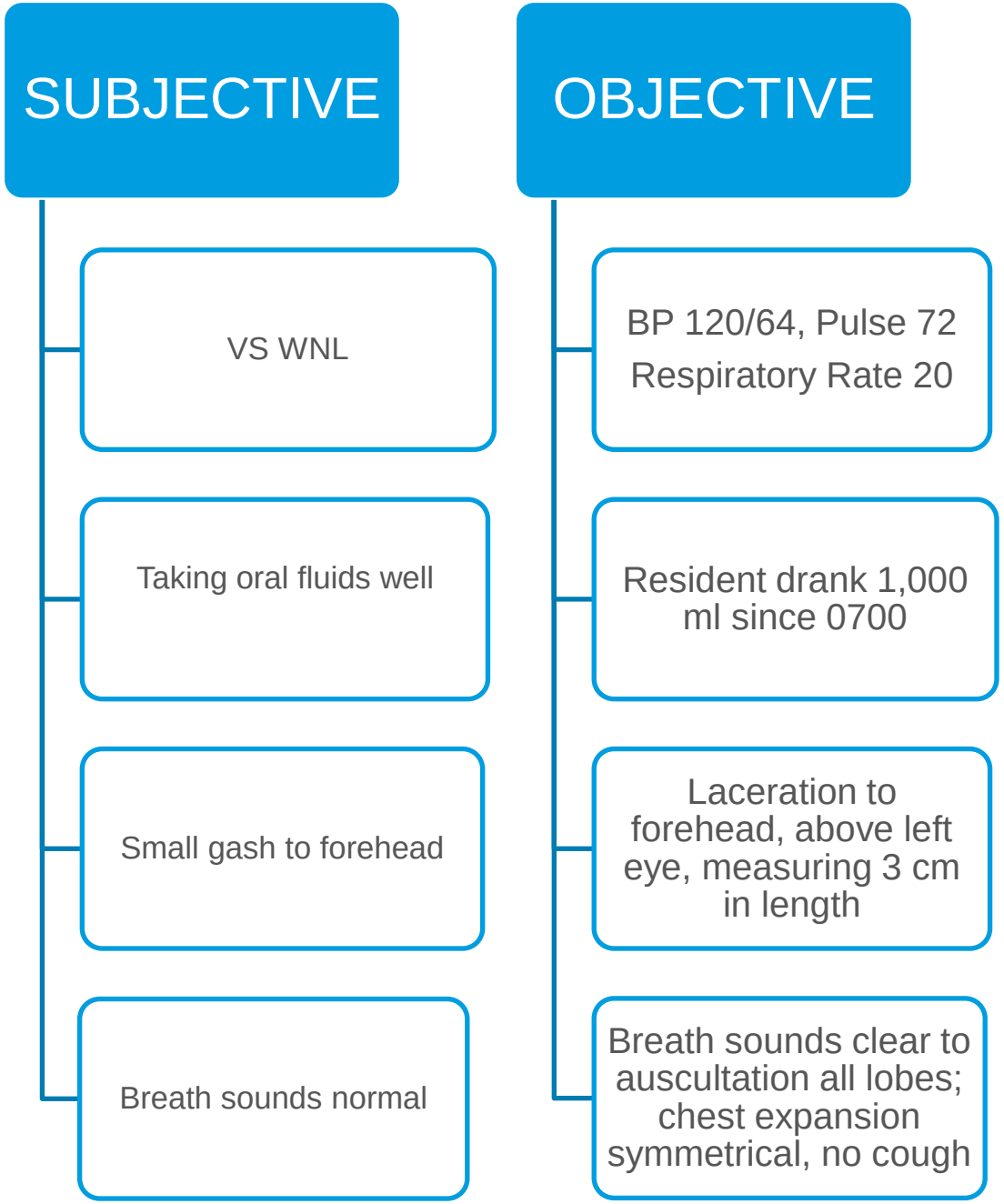
Urine was dark amber in color with a strong, rancid odor

Subjective Documentation

Involves verbal statements from others

- Subjective data is
  - Helpful in gaining context and details of the clinical story.
  - Information provided by a resident (or other individual) from the resident's viewpoint or the viewpoint of a second party.

- When documenting subjective data:
  - The documentation should be included in quotation marks and start with verbiage such as, "The resident reports…" or "The resident's wife states…"
    - For example: The resident reports, "I feel dizzy when I get out of bed."


SUBJECTIVE
OBJECTIVE
VS WNL
BP 120/64, Pulse 72
Respiratory Rate 20
Taking oral fluids well
Resident drank 1,000 ml since 0700
Small gash to forehead
Laceration to forehead, above left eye, measuring 3 cm in length
Breath sounds normal
Breath sounds clear to auscultation all lobes; chest expansion symmetrical, no cough

Defensive Documentation

Just the Facts….

FACTUAL

ACCURATE

COMPLETE

TIMELY

Factual

FACT

- State Relevant Facts – who, what, when, where, how, why
  - Avoid bias, personal opinions and value judgments
- Describe Behaviors
  - Don’t label people or draw conclusions
- Be Objective
  - Don’t allow emotions or subjective opinions to influence documentation
- Clearly Identify Subjective Information
  - Including relevant subjective information helps tell a complete story
  - Use Quotations
  - Do not include subjective statements without supporting facts

Accurate

FACT

- Be truthful
  - Avoid assumptions
- Be precise & specific
  - Avoid vague statements
- Review entries for continuity
  - Avoid copy/paste charting
- Review your documentation
  - Inconsistencies, inaccuracies, incorrect information, confusion in chronology (unclear story) and poor grammar, spelling, and punctuation will damage the medical records credibility

Complete

FACT

- Tell the whole story
  - Who was there
  - Assessment of the resident
  - Who was notified
  - What recommendations were given by the provider
  - What facility policies / procedural workflows were followed
  - Follow-up actions performed
  - Do not leave questions unanswered
- Complete EVERY section
  - ADLs, % meals consumed
- Be clear, concise and well organized
- How much detail will depend on organization policy
  - Follow your organization’s policy related to confidentiality and HIPAA
  - The more you put in the medical record, the less you have to rely on memory

Timely

FACT

- Complete documentation as soon as practicable, follow facility policy
  - NEVER document in advance
- Document in chronological order
  - Avoid (or minimize) late entries, addendums, and clarification notes
- Date and time are critical in establishing a timely response
  - Computer entries are automatically date-and-time stamped; if your entry refers to earlier events, note the time to which you are referring
- Failing to comply with timely documentation:
  - May cause you to forget key pieces of information
  - Jeopardizes the integrity of the record

Audit Trails

Reveal

Who accessed the record

When the record was accessed

What changes were made

How long entries were open

Copy-Paste Usage

Late Entries & Edits

Why it Matters

Regulatory Compliance

Legal Protection & Liability

Fraud Detection

Words to Avoid in EMRs

These words and phrases can imply substandard performance or wrong-doing

- Unnecessary, unintentionally, unfortunate, unsupervised, undesirable, unsatisfactory, unexplainably
- Mishandled, misjudged, misinterpretation, miscalculate, mistake
- Inadequate, incorrect, inappropriate, insufficient
- Bad, defective, negligent, accidently
- Understaffed, short-staffed
- **Other words to avoid**…**found** (use observed or noted), somehow, appears, seems, problem, wrong, accidental, erroneously, fault, mix-up, awful, faulty, sloppy, excessive, blame, careless, error, terrible, oops
- **Phrases to avoid**… within normal range, within normal limits, all needs met, looks worse, seems to be, not usual self, appears to be, will continue monitor, safety maintained, shows signs of improvement

Test Your Knowledge:
Apply the Principles of Defensive Documentation

4

Turn Subjective Bias into Facts

Avoid Drawing Conclusions, Labeling People or Behavior, and Personal Opinions

Resident is non-compliant	Resident noted to be eating a Snickers candy bar; resident stated, “I don’t care if my blood sugar goes up, just adjust my insulin.”
Resident is rude and disrespectful	When entering resident’s room, resident stated, “Get the heck out of my room. I’m sick and tired of you coming in here; get out and leave me alone.”
Resident appears nervous and confused	Resident appears nervous and confused as evidenced by fidgeting of hands, pacing up and down hallway, repeatedly asking, “Why am I here? Where did my daughter go? I need a ride home”.

Turn Assumptions into Known Facts

Avoid Drawing Conclusions, Assumptions and Personal Opinions

Resident fell from bed (unwitnessed)	Nurse was making rounds at 1100 and observed resident on the floor, leaning against the side of her bed, in a sitting position with her legs extended in front of her.
Resident's right arm appears broken	Resident states, "I fell trying to get out of bed." Resident's right forearm slightly swollen compared to her left forearm. Right forearm has no discoloration or obvious deformity noted. Resident states increased pain when moving her right arm, rates pain 4/10 with no movement, pain increases to 9/10 with any movement.

Common Documentation Pitfalls

❌ **Vague documentation:** *Resident had a fall. Nurse and CNA assisted resident to chair. PCP and daughter notified.*

✅ **Specific details:** *At 0700, resident observed on the floor next to the bed in sitting position. Resident stated, 'I lost my balance.' Resident denies pain and no apparent injuries noted. Resident able to stand with minimal assist, two-person assist with gait belt to chair provided with nurse and CNA. Dr. Sam Jones, PCP, notified via phone at 0710, no new orders received. Daughter Sally Smith notified via phone at 0712."*)

❌ **Missing follow-up:** *Resident reported pain. PRN pain medication administered.*

✅ **Complete entry**: *At 1015, resident reported to right leg pain to CNA. Upon nurse assessment, no apparent injury noted and resident rated pain 4/10. PRN Tylenol 650 mg administered at 1025 per physician order. Resident repositioned with two-person assist and pillows placed for comfort. Pain reassessed at 1100, resident verbalized relief and denies pain at this time.*

What would you document?

Fall	Elopement	Medication	Choking

What would you document?

Falls

- Who was there
- Assessment
- **Immediate action taken**
- Everyone that was notified
- Recommendations from provider
- Updates to care/service plans
- Facility protocols initiated
- **Cause**

Elopement

- Who was there
- Assessment
- **Immediate action taken**
- Everyone that was notified
- Recommendations from provider
- Updates to care/service plans
- **Facility protocols initiated**
- Follow-up
- **Cause**

Medication

- Who was there
- Assessment
- **Immediate action taken**
- Everyone that was notified
- **Recommendations from provider**
- Updates to care/service plans
- Facility protocols initiated
- Follow-up
- **Cause**

Choking

- Who was there
- **Assessment**
- **Immediate action taken**
- Everyone that was notified
- Recommendations from provider
- Updates to care/service plans
- Facility protocols initiated
- Follow-up
- **Cause**

What would you document?

Wound	Abuse	Moving to a Higher Level of Care	Change of Condition

What would you document?

Wound

- Who was there
- Assessment
- **Immediate action taken**
- Everyone that was notified
- **Recommendations from provider**
- Updates to care/service plans
- Facility protocols initiated
- Follow-up
- **Cause**

Abuse

- Who was there
- Assessment
- **Immediate action taken**
- **Everyone that was notified**
- Recommendations from provider
- Updates to care/service plans
- Facility protocols initiated
- Follow-up
- Cause

Moving to a Higher Level of Care

- Who was there
- **Assessment**
- **Immediate action taken**
- **Everyone that was notified**
- Recommendations from provider
- Updates to care/service plans
- Facility protocols initiated
- Follow-up
- Cause

Change of Condition

- Who was there
- **Assessment**
Immediate action taken
- **Everyone that was notified**
- **Recommendations from provider**
- Updates to care/service plans
- Facility protocols initiated
- Follow-up
- Cause

Criminal charges against nurses & caregivers

How could charges have been prevented with defensive documentation practices?

2023 Pennsylvania

- Two nurses working at a Rehabilitation and Nursing Center were charged with felony neglect of a care-depend person and misdemeanor tampering with or fabricating evidence after a resident passed following two recent falls
- Grand Jury investigation revealed that neither nurse followed protocol in how they responded to the man's condition
- "Charged due to omitting and misstating information on the resident's medical chart"
- Neglecting to follow facility's policy for follow up care following a resident fall

https://www.attorneygeneral.gov/taking-action/ag-henry-charges-two-nurses-with-neglect-after-resident-died-at-dauphin-county-facility/

Criminal charges against nurses & caregivers

How could charges have been prevented with defensive documentation practices?

2022 Unknown state

- A nurse working at a long-term care facility was charged with second-degree reckless manslaughter after a medication error – infused narcotics instead of an antibiotic
- There were many system issues that lead to this error
- Nurse documented that the resident was “tolerating the antibiotic”
- Documentation by another nurse 2 hours later that the resident was “awake, alert, and oriented”

https://home.ecri.org/blogs/ismp-alerts-and-articles-library/another-case-of-nursing-criminalization-long-term-care-ltc-must-improve-systems-not-blame-nurses-part-i

Criminal charges against nurses & caregivers

How could charges have been prevented with defensive documentation practices?

2017 Michigan

- Two caregivers were charged following the elopement of a resident who later died due to exposure to the elements
- One was charged due to falsifying the medical record by stating she had performed q 30 minute visual bed checks while the resident was not in the facility

https://www.mcknightsseniorliving.com/news/2-caregivers-charged-with-felonies-after-resident-freezes-to-death/#:~:text=Two%20former%20caregivers%20at%20a,to%20comment%20for%20the%20media.

Criminal charges against nurses & caregivers

How could charges have been prevented with defensive documentation practices?

2017 Arkansas

- A nurse at a long-term care facility was charge with assault after several unintentional medication errors

https://www.mcknightsseniorliving.com/news/2-caregivers-charged-with-felonies-after-resident-freezes-to-death/#:~:text=Two%20former%20caregivers%20at%20a,to%20comment%20for%20the%20media.

Clinical Documentation, Telling the Healthcare Story

FACT

- Does your documentation **accurately represent the resident's experience** during their stay in your facility?
- Does your documentation convey the **essential clinical information** related to the resident’s diagnosis, treatment (plan of care), and outcomes (response to treatment, change in condition)?
- Would you want a resident or resident’s family to read it?
- Would you want to read it aloud at a deposition or in a courtroom?
- Four years from now, would it **help you remember** the excellent care and services you provided to the resident?

Questions & Comments

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