AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines

Documentation in the Long-term Care Record

- General
  - Federal Regulations Pertaining to Clinical Records
  - Purpose of Clinical Records
  - Elimination of Duplication/Redundant Information when Evaluating/Implementing a Documentation System:

- Documentation Content in a Long Term Care Record
  - Admission Record

- Assessments
  - Integrating Facility Assessments with Resident Assessment Instrument RAI) Process
  - Types of Assessments and Requirements
    - Preadmission Assessment
    - Admission Assessment
    - Fall Assessment
    - Skin Assessment
    - Skin at Risk Assessment
    - Actual Skin Problems/Pressure Ulcer
    - Bowel and Bladder Assessment
    - Physical Restraint Assessment
    - Self-Administration of Medication
    - Nutrition Assessment
    - Activities/Recreation/Leisure Interest Assessment
    - Social Service
    - Mental and Psychosocial Functioning
    - Restorative/Rehab Nursing Assessment
    - Rehabilitation Services

- Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) and Care Area Assessment (CAA)

- Care Plan
  - Timeliness
  - Care Conference
  - Admission Care Plan
  - Integrating Acute Problems Into the Care Plan
• Timeliness of Completion of Care Plan
• Authenticating Changes to Care Plan

• Narrative Charts and Summaries
  • Admission/Readmission Note
  • Content of Narrative Charting
  • Nursing and/or Interdisciplinary Summary Charting
  • Integrated vs. Disciplinary Progress Notes

• Medicare Physician Certification
  • Skilled Nursing/Therapy Charting
  • Supporting Documentation for the MDS
  • Therapy Treatment Time
  • Activities of Daily Living (ADL) Charting
  • Mood and Behavior Documentation
  • Hospital Documentation
  • Medicare Certification/Recertification

• Rehabilitative Therapy Documentation

• Physician Documentation
  • Physician Progress Notes
  • Dictated Progress Notes
  • Nurse Practitioner (NP)/Physician Assistant (PA) Documentation
  • History and Physical
  • Other Professional and Consultation Records/Notes
  • Documenting Resident Diagnoses
    1. Supporting Documentation for Diagnoses
    2. Resolving Diagnoses
  • Final Progress Note/Discharge Note/Summary

• Physician Orders
  • Admission Orders
  • Content of an Order
  • Physician Order Recaps/Renewals
  • Telephone Orders
  • Fax Orders
  • Standing Order Policies
  • Authentication/Obtaining Signatures
  • Transcription of Orders and Noting Orders
  • Contacting the Physician to Obtain an Order
  • Discontinuing an Order When a New Order is Obtained
  • Updating/Changing Physician Order Recaps/Renewals After They Have Been Signed
Documentation in long-term care has become increasingly complex as the resident's clinical needs and decision making have become more complex, regulations and surveys more stringent, documentation based payment systems implemented, and litigation/legal
This section creates a foundation for documentation by addressing the minimum content as required by federal regulation for long-term care facilities and fundamental practice standards, but generally does not outline specific content. The tag number for the Federal Condition of Participation is referenced where applicable. Those data elements with an F-tag association are placed in numerical order. Those data elements without an associated F-tag follow in alphabetic order. This section also addresses common documentation issues and concerns and establishes guidelines or provides recommendations on how to handle common problem areas.

As long-term care facilities establish or review their documentation system, the practice guidelines and federal regulations identified below must be taken into consideration. In addition to the federal regulations and professional practice standards, it is imperative to review and incorporate state regulations, accreditation requirements (i.e. JCAHO, CARF), and payer requirements into the documentation systems established. Because documentation systems should be created to meet the needs and unique practices of a long-term care facility or organization, this section does not recommend a specific system. Instead, minimum requirements are established, issues to consider are discussed, and guidelines are provided to assist facilities with implementing or evaluating a documentation system while retaining flexibility in how it can be created. Each facility will need to establish their own documentation guidelines.

Federal Regulations Pertaining to Clinical Records:

Federal regulation (F514) requires that a the facility “must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.”

The guidelines in this document provides the foundation for “professional standards and practices” as established by AHIMA for clinical records/health information systems. Other professional organizations may have additional standards in dealing with documentation unique to a specific discipline. Facilities must always consider State regulations for clinical records and documentation, as they may be more stringent than the Federal regulations.

Purpose of Clinical Records

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 plans of care identified to meet the resident’s identified condition/s, and provides sufficient documentation of the effects of the care provided. Documentation should provide a picture of the resident and their response to treatment, changes in condition, and changes in treatment. While the main purpose of the record is to provide continuity of care, there are other reasons including clinical, administrative, financial, regulatory and legal.

Elimination of Duplication/Redundant Information when Evaluating/Implementing a Documentation System:

One of the most significant problems found in many documentation systems is duplicate or redundant information that is collected in the medical record. Not only is this inefficient, but it potentially creates conflicts and contradiction in the documentation that leads to confusion and could possibly create errors in care and treatment as well as diminishing the credibility of the record. A common problem found in long-term care records is the duplication of information that is collected on different assessments and between disciplines. To address this issue, long-term care facilities should evaluate their entire documentation system looking at the data elements collected by all disciplines and eliminating areas of duplication.
One method to use in evaluating duplication is to create a data dictionary or a list of documentation elements collected in the entire documentation system, identify where it is collected (i.e. what form), how often, and by whom. Once it is known where information is collected and areas of overlap are identified, decisions can be made on elimination of duplicative information. When working with different disciplines, the goal should be creating a system that works together to facilitate the interdisciplinary team approach rather than segregating assessments and documentation into department-specific documents that do not work together but increase the likelihood of contradictions. In addition, it is important when evaluating EHR systems to look for ways to eliminate duplication. EHR systems have great potential for streamlining the documentation process.

**Documentation Content in a Long Term Care Record:**

**Admission Record (F157):**

Every clinical record should have a face sheet or admission record that provides demographic information, responsible party and contacts financial and insurance information, and contact information for outside professionals involved in the resident’s care (i.e. attending physician, alternate physician, etc.). The face sheet should be kept up to date as changes occur. The old face sheet is filed in the overflow folder. Some states have specific field requirements for face sheets such as diagnoses as well as demographic information. The state regulations should be reviewed for this information.

**Assessments:**

It is important to recognize that there are two types of assessments which are referenced, i.e. the Resident Assessment Instrument (RAI) which is the mandated assessment tool (under the Federal Omnibus Budget Reconciliation Act) and those assessments which are required by the nursing facility and/or corporate structure, e.g. Nursing Assessment, Pain Assessment, Elopement Assessment, Dietary Assessment, Social Service Assessment, etc. Assessments are critical to the documentation system in a long-term care record. It is important to recognize that assessments can be documented in a variety of ways but typically fall into two groups – completion of an assessment form or documenting a narrative assessment. Many “assessments” collect information or identify a condition. To be complete, they should also include conclusions, recommendations, recommended interventions. To be an assessment rather than just a data collection tool, the following elements should be in place:

1. Data Collection - data is collected relevant to the issue being assessed.
2. Evaluation - the assessor interprets the data.
3. Conclusion - the assessor comes to a decision as to the clinical conclusions based on the data collected. (Review the state specific practice standards to define who can complete the assessment.)
4. Conclusion -- the assessor interprets and documents their conclusions based on the data collected
5. Plan -- recommendations and follow-up based on resident goals and standards of practice.

**Integrating Facility Assessments with Resident Assessment Instrument (RAI) Process:**

As LTC facilities evaluate their documentation system, one goal should be to create an interdisciplinary assessment process that uses the Resident Assessment Instrument (RAI) as the assessment rather than a supplement. With the regulatory required Minimum Data Set (MDS) and Care Area Assessments (CAAs) as the base assessment tools, other assessments would collect information that supplements and/or supports the comprehensive assessment rather than readdress it. The Centers for Medicare and Medicaid Services
(CMS) position has always been that the MDS is a source document, not requiring additional documentation support. However, various entities both state and private agencies, have identified that supportive documentation is necessary. The Resident Assessment Instrument includes assessments required by the Omnibus Reconciliation Act of 1987 (OBRA) and those required by the Prospective Payment System (PPS). Those residents who are in the facility less than 14 days may not have a Resident Assessment Instrument but will have an Entry Record as a minimum.

OBRA REQUIRED

- Admission (Comprehensive)
- Significant Change (Comprehensive)
- Quarterly Assessment
- Annual (Comprehensive)
- Significant Correction to Prior Comprehensive Assessment
- Significant Correction to Prior Quarterly Assessment

Prospective Payment Required

- 5 day Assessment
- 14 day Assessment
- 30 day Assessment
- 60 day Assessment
- 90 day Assessment
- Other Medicare Required Assessment (OMRA)
- Readmission/Return
- Start of Therapy (SOT)
- End of Therapy (EOT)
- End of Therapy revised (EOT-r)
- Start and End of Therapy
- Change of Therapy (COT)

Other required records/assessments

- Entry record
- Discharge Assessment return anticipated
- Discharge Assessment return not anticipated
- Death in Facility

Types of Assessments (Facility required) and Requirements:

The following assessments represent those required by federal regulation and/or those that have become a standard of practice in the industry. Although many of the assessments may be completed on a separate form, the format either manual or electronic may vary or the assessment may be documented in narrative notes.

Preadmission Assessment:

Completion of a preadmission assessment is not required by federal regulation, but is commonly completed to determine the needs of the resident and assure that the facility has adequate resources and expertise to provide care. As Medicare reimbursement moved to a prospective payment system partially based on services delivered prior to admission, the
Preadmission assessment has taken on an additional purpose in providing supporting documentation for the MDS. However, with the changeover to the RUGs IV system and the MDS 3.0, services provided prior to admission do not assist in the financial determination but are still reflected on the MDS itself. If the information from the preadmission assessment is used to support other documents in the record including the MDS, it should be incorporated into the legal medical record and meet legal documentation requirements.

Admission Assessment:

An admission or readmission assessment typically incorporates items that would be considered a nursing assessment and physical examination. Although there is not a federal regulation to perform an admission assessment, professional practice standards for the industry indicate that an admission assessment should be completed. State regulations may provide specific detail on information to collect such as vital signs, a review of systems, pain, etc. The purpose of the admission assessment is to collect baseline information on the resident and assist with initiating an initial admission care plan until the MDS, CAAs and care plan process is completed.

Fall Assessment (F323-F324):

The facility must identify each resident at risk for accidents and/or falls and adequately care plan and implement procedures to prevent accidents. Due to the time allowed in completing the RAI, it is recommended that the risk for falls be assessed on admission/readmission. Risk factors may include:

- diagnosis
- fall history
- unsteady gait
- age
- assistance for balance, transfer, walking, wandering
- denial of physical limitation
- orthostatic hypotension
- urinary frequency or incontinence
- infection
- medications
- sensory impairments
- footwear
- confusion/dementia
- delirium or sedation
- sleep disorders
- impulsive behavior or poor judgment

Likewise the physical environment may increase the risks of falls. This may include lack of non-slip surfaces, unfamiliar objects in a walkway and improper lighting.

The care plan should include the risk factors and the interventions to be implemented to try to prevent falls or other accidents. Based on the assessment findings interventions may include but are not limited to:

- assistive devices; such as walker, cane, or wheelchair
- assistances with ambulation
The fall risk should be reassessed with
- Each MDS
- With change in condition, and
- after each fall or “near” fall

The Care Plan should be reviewed after each fall and revised to include a different intervention to try to prevent another fall.

**Skin Assessment (F314):**

Based on the comprehensive assessment the facility must ensure that a resident who enters the facility without a pressure ulcer does not develop pressure ulcers unless the individual’s clinical condition demonstrates they are unavoidable. Residents must receive the necessary treatment and services to promote healing, prevent infection, and prevent new or increasing stage of pressure ulcers from developing. The resident’s skin condition must be reviewed for each MDS including the discharge assessment. Although not a requirement, it is advisable that documentation regarding the resident’s skin condition be provided when the resident departs and returns from a leave of absence, e.g. home visits, out with the family, etc. This provides information as to the presence of absence of bruises and the like which may be determined to be facility acquired if not documented the injury was sustained while out of the facility.

The documentation must support
- the promotion of the prevention of pressure ulcer development.
- the promotion of the healing of pressure ulcers and infections.
- the prevention of the development of additional pressure ulcers.

Tools/ Documents for the identification and documentation of resident’s at risk or with existing pressure ulcers
- Medical Findings (H&P and Discharge Summary)
- Skin Assessment – visual examination of the skin on admission
- Standardized Skin at Risk Assessment such as the Braden or Norton Plus
- Laboratory Work
- Intake and Output Totals
- Resident Assessment Instrument
- Dietician Evaluation

**Skin at Risk Assessment**

The RAI (Resident Assessment Instrument) is the only regulatory required assessment tool and is used to identify risk factors that may be removed or modified. It also identifies a resident who has multi-system organ failure or an end of life condition or who is rejecting
care and promotes identification and evaluation of potential alternatives.

Survey guidelines under F314 refer to a Standardized Risk Assessment such as the Braden Scale or Norton Plus Scale that provides a systematic assessment to identify the degree of risk. The assessment is usually completed

- on admission
- weekly for four weeks after admission/readmission
- quarterly
- with a significant change

The early identification of the risk areas facilitates the prompt implementation of an individualized Care Plan with interventions to stabilize, reduce, or remove the risk factors. Risk Factors include:

- impaired/decreased mobility and decreased functional ability
- co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus
- drugs, such as steroids that may affect wound healing
- impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency
- resident refusal of some aspect of care and treatment
- cognitive impairment
- exposure of skin to urinary and fecal incontinence
- under nourished, malnutrition, and hydration deficit
- weight loss, decline in appetite, cause of decline, medical diagnoses
- a healed ulcer
- pressure points and tissue tolerance
- observation of positioning and pressure sites and devices that may cause pressure

The care plan should include the risk factors and the interventions to be implemented to try to reduce or eliminate risk factors related to skin at risk and/or pressure ulcers. Based on the assessment findings interventions may include but are not limited to:

- protective/preventative Skin Care
- turning and repositioning
- pressure relieving devices on beds and chairs
- encourage ambulation/movement and time out of bed
- nutritional approaches that are specifically designed for adequate nutrition
- pain management
- adequate fluids
- supportive surfaces and pressure redistribution

**Actual Skin Problems/Pressure Ulcer**

A complete review of the resident’s skin must be completed on admission to establish a baseline. In addition there must be an on-going system in place to assess the condition of the skin. This should occur prior to a resident being transferred to another facility, upon resident readmission/return from another facility, prior to the resident leaving the facility for an overnight (or longer) visit with family/friends, and upon return. In addition there should be
a routine monitoring for skin conditions which could occur, for example, at the time of the resident’s shower/bath. Nursing assistants can report observations to the nurse, the charge nurse, nursing supervisor, etc. who would then assess for any abnormal findings.

The documentation of Assessment and Treatment of Pressure Ulcers include:

- identification of the skin’s condition upon admission.
- monitor on an on-going basis throughout the resident’s stay.
- factors that influence the development of the pressure ulcer
- potential for development of additional pressure ulcers
- potential for deterioration of existing pressure ulcers
- Description of ulcer
- Stage of ulcer including if ulcer is unstageable
- Dimensions
- Characteristics of ulcer
- Color of skin surrounding ulcer
- Evidence of infection
- Potential complications
- Presence of pain
- Progress toward healing
- Dressings and treatments
- Description of skin surrounding dressings when dressing does not need to be changed.
- Monitoring on an on-going basis for the presence of complications, change in status of dressing, or a change in the level of pain.

Documentation weekly or with each dressing change can be recorded in a narrative format in the progress notes, on the reverse side of the Treatment Record, or on a specific flow sheet. This charting includes:

- date and time of documentation
- location
- stage – including if unstageable
- dimensions and presence of undermining or tunneling/sinus tract
- exudate, if present (purulent/serous, color, odor, and approximate amount)
- pain, if present (nature, and frequency, episodic or continuous, relief obtained after treatment)
- wound bed: color and type and characteristic of tissues (granulation or necrosis)
- description of wound edges and surrounding tissue (rolled edges, redness, hardness/induration, maceration)
- signs of infection
- response to treatment
- resident’s non-compliance with treatment plan, if applicable
- notify physician of lack of healing or adverse response to treatment

If interventions were either not applicable or not feasible, there should be sufficient documentation from staff and the practitioner of clinically valid reasons why the interventions were not implemented. The total plan of care needs to be re-evaluated to determine if this
was isolated or requires revised approaches.

The MDS 3.0 and CAAs require the use of validated instruments to describe the healing of a pressure ulcer. Clinicians must use the National Pressure Ulcer Advisory Panel guidelines. However, the clinicians may use the Pressure Ulcer Scale for Healing (NPUAP-PUSH) tool. The NPUAP always refers to a healed pressure ulcer as a healed ulcer at the deepest stage of its development (e.g., a healed Stage IV or a healing Stage IV). The NPUAP-PUSH tool documents pressure ulcer healing consistent with the healing process, describes a healing pressure ulcer in terms of three ulcer characteristics, and assigns a numeric value to the characteristics: length (cm) x width (cm), exudate amount, and type of tissue (closed with epithelium; new pink, shiny epithelial tissue; clean, pink or beefy red, shiny, moist granulation tissue; slough tissue; or necrotic, eschar tissue). If a pressure ulcer fails to show some evidence of progress toward healing within 2-4 weeks, the pressure ulcer (including potential complications) and the resident’s overall clinical condition should be reassessed. Re-evaluation of the treatment plan including determining whether to continue or modify the current interventions is also indicated. Results may vary depending on the resident’s condition and interventions/treatments used. The complexity of the resident’s condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment (for example, why some, or all, of the plan’s interventions remain relevant despite little or no apparent healing).

Skin problems/ulcers are listed on the resident’s Care Plan. The interventions and the implementation of these interventions are critical and may include preventative measures. Interventions to treat pressure ulcers may include

- protective/preventative skin care
- turning and repositioning
- pressure relieving devices on beds and chairs
- nutritional supplements
- pain management
- adequate fluids
- supportive surfaces and pressure redistribution
- treatments as ordered by physician
- short term placement of catheter

**Bowel and Bladder Assessment (F315):**

Based on the comprehensive assessment the facility must ensure that a resident who enters without a catheter is not catheterized without medical justification and a resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

**Assessment**

The Admission Nursing Assessment identifies the status of the resident such as:

- continence status as described by resident or by observation
- risks or conditions that may affect continence.
- use of medication that may affect continence.
- environmental factors that might facilitate or impede the ability to access to the toilet, type of clothing, ambulation status and devices, use of restraints, and use of siderails.
- dietary preference.
- hydration status; skin turgor, mucous membranes, weight loss
if catheter present; medical justification for catheter, type and size of catheter, potential for removal, color of urine, flow of urine.

The continence of the resident is usually determined over a period of time, for example, 72 hours. Once the assessment has been completed, the type of urinary incontinence (stress, urge, overflow, mixed, functional or transient), should be determined by the practitioner. Since the type of incontinence is a diagnosis, it can only be determined by the practitioner.

Over the following week, or when the catheter is removed additional data is gathered to include:

- cognitive status
- patterns of incontinent episodes
- voiding patterns
- fluid intake and hydration status
- toileting ability

Based on the initial assessment and the evaluation of ability and patterns, an individualize toileting program is developed for the resident and entered under interventions on the Care Plan. Intervention may include:

- routine incontinence care
- a scheduled toileting program
- habit training, prompted voiding, or
- formal bladder or bowel retraining program.

Progress notes for bladder/bowel retraining programs are usually recorded weekly until the resident has reached the goal or the program is discontinued. Restorative nursing toileting programs that may help the resident regain the ability to toilet self and reduce incontinent are summarized during and/or at conclusion of each assessment reference period.

**Physical Restraint Assessment (F221):**

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The state specific regulations must be referenced to determine if there are any specific requirements related to the use of restraints.

The goal of a facility is to be as restraint free as appropriate. Prior to the use of a physical restraint an assessment must be completed to determine whether a restraint is clinically necessary and assess the resident's bed mobility, ability to transfer between positions, ability to transfer to and from bed or chair, and ability to stand and transfer to the toilet and so forth. The assessment should all include all interventions tried before the use of a restraint was considered. If the nursing staff have determined that a restraint may be appropriate, the practitioner should be contacted and an order for a Physical Therapy/Occupational Therapy evaluation be obtained for the use of the restraint and for the least restrictive device to be used. Once the evaluation has been completed, the recommendations are relayed to the physician for the appropriate order.

The order needs to include the following:

- Type of restraint to be used
- Duration (ex – while in wheelchair, while unattended, to be removed when resident is sitting at the table, removed at least every 2 hours)
- Diagnosis/medical justification for use.

It should be noted that the interpretive guidelines clarify that the justification of the use of the
restraint cannot be based on the request of the family, for safety of the resident, and/or for the convenience of staff.

Once the order has been received, the resident/legal representation must be contacted and a consent for use obtained; after the risks and benefits have been explained to the resident/legal representative.

The restraint/device is included in the resident's Care Plan with the medical symptoms for which the restraint is used. The interventions may include

- method of application
- schedule for release and repositioning
- a plan to reduce the need for the restraint
- alternatives to the restraint; such as lowering the bed, mattress on floor, bed alarms,

Though many state regulations may mandate additional requirements, the facility must reassess the use of the restraint at least quarterly. To evaluate the appropriateness, the facility may use the Physical Restraint CAA to evaluate the appropriateness of restraint use; a form designed for this use or records a narrative note.

Self-Administration of Medication (F176):

If the resident requests to self-administer medications, the interdisciplinary team must determine that it is safe for the resident to self-administer drugs before the resident may exercise that right. The assessment may include:

- cognitive status
- manual dexterity
- eyesight

If it is determined the resident is a suitable candidate for a self-medication program, the physician is contacted for an order.

The Care Plan will reflect the self-medication program and goals. Flowsheets or narrative notes will reflect the resident's progress in the program.

Nutrition Assessment (F325):

The facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels; unless the resident's clinical condition demonstrates that this is not possible. The facility must ensure the resident receives a therapeutic diet when there is a nutritional problem. In addition, the resident must be interviewed to determine food preferences and food allergies that are taken into account when meeting the resident's needs.

The Nutrition Assessment should address these issues and include identification of the factors that put the resident at risk for malnutrition. The Nutritional Assessment may require the expertise of a Registered Dietitian. State regulations may mandate a dietitian's assessment of all residents with identified nutritional problems.

Evidence of review of the CAA for Nutritional status should be present to assess the status of the nutritional needs, the causal factors for decline, and potential for decline or lack of improvement for residents at risk.

The nutritional problem or medically related condition is recorded on the resident's Care Plan.

The interventions may include
therapeutic diet
altered texture of diet
fluid restrictions
altered fluid consistency
periodic review by dietitian
laboratory work

The problem and goals of the Care Plan is reviewed at least quarterly and with significant change using a progress note or reassessment form.

Activities/Recreation/Leisure Interest Assessment (F248):

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests, and the physical, mental, and psychosocial well-being of each resident.

With the implementation of the MDS 3.0 Assessment, the resident's preferences for activities of leisure are evaluated with every comprehensive MDS. Much of this information may be obtained through the resident interview process. The facility should use an Activity Assessment that includes

- resident's lifelong interests
- spirituality
- life roles
- occupation
- relationships
- goals
- strengths
- needs
- activity pursuit patterns and preferences

The Assessment need not duplicate information from other sources, such as the RAI, including the CAAs, assessments by other disciplines, observation, and resident and family interviews. Other sources of relevant information include interviews with the resident or family. The ongoing program of activities should match the skills, abilities, needs, and preferences of each resident with the demands of the activity and the characteristics of the physical, social, and cultural environments. Many facilities are implementing other methods of structuring the environment. These programs such as the Eden Program and Pioneer Network are resident centered. They change the types and locations of activities; however, the interests of resident are central to the programs and related documentation. Care planning involves identification of the resident’s interests, preferences, and abilities; and any issues, concerns, problems, or needs affecting the resident’s involvement/engagement in activities. Information may also be found in the resident’s Care Plan, a separate Activity Plan or on the Activity Participation flow sheet. Activity goals related to the comprehensive care plan should be based on measurable objectives and focused on desired outcomes (e.g., engagement in an activity that matches the resident’s ability, maintaining attention to the activity for a specified period of time, expressing satisfaction with the activity verbally or non-verbally), not merely on attendance at a certain number of activities per week. Progress notes reflect the resident’s participation in the Activity Care Plan, preference for specific activities, interactions with other residents, and progress toward goals should be documented during and/or at conclusion of each assessment reference period.

Social Service (F250):
It is the responsibility of the facility to identify the medically related social service needs of the resident and assure that the needs are met by the appropriate discipline. Clinical records must reflect the social history of the resident and assessment of the emotional, financial, mental, and psychosocial needs.

- Cultural background
- Family dynamics and family support, significant others
- Role in community
- Loss and grief
- Financial concerns
- Support of fraternal organizations or community
- Prior living arrangements

The Care Plan addresses these issues as needs or strengths and interventions to support the goal:

- Visits with clergy
- Visits from fraternal organizations
- Visits with social worker
- Family visits
- Hospice intervention
- Community support
- Mood and behavior issues
- Mental health counseling
- Discharge planning

Progress notes which reflect the resident’s emotion, financial, psychosocial needs, and progress toward goals should be documented during and/or at conclusion of each assessment reference period. A significant change such as a new diagnosis requires a review of the psychosocial needs and a review of the Care Plan. Discharge planning conferences should be arranged, if indicated, to discuss discharge plans, especially if the resident requires ongoing care or a change in their living arrangements on discharge.

**Mental and Psychosocial Functioning (F319-F320):**

Based on the comprehensive assessment the facility must ensure that a resident, who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. (F320) For a resident whose assessment does not reveal a mental or psychosocial adjustment difficulty, there is not a pattern of decreased social interaction and/or increased withdrawal, anger or depressive behaviors, unless the resident’s clinical condition demonstrates that such a pattern is unavoidable.

Assessments used to identify mental and psychosocial functioning include, but not limited to:

- RAI (through the use of the BIMS, PHQ9, and CAMS obtained in the interview process)
- Folstein Mini-mental Status
- Geriatric Depression Scale,
- Cornell Depression Assessment
- ADAS-Cog (Alzheimer Disease Assessment Scale-Cognitive)
- Behavioral Pathology in Alzheimer’s Disease Rating Scale (BEHAVE-AD)
- Blessed Test
- CANTAB - Cambridge Neuropsychological Test Automated Battery
- CERAD (The Consortium to Establish a Registry for Alzheimer's Disease) Clinical and Neuropsychological Tests
- Clock Draw Test
- Cornell Scale for Depression in Dementia (CSDD)
- Geriatric Depression Scale (GDS)
- Mini Mental State Exam (MMSE)
- Neuropsychiatric Inventory (NPI)
- The 7 Minute Screen
- Social History and Evaluation

Restorative/Rehab Nursing Assessment (F317-F318):

The facility must provide care and services to attain or maintain the resident's highest level of independent function. Based on the assessment the facility ensures that a resident who enters without limited range of motion, functional activities of daily living does not experience a decrease in their functional status unless the resident's clinical condition indicates that it is unavoidable.

Assessments may include:

- The RAI
- screens and recommendations by physical, occupational, speech therapists,
- range of motion
- bed mobility, transfer, and ambulation
- self feeding capabilities
- bladder/bowel status
- ADL assessments; grooming, dressing, toileting, hygiene, bathing
- communication

The Care Plan must include the functional deficit, measurable goals, and the restorative training program. The nurse in charge of the nursing restorative program must record progress notes addressing the progress toward goals during and/or at conclusion of each assessment reference period. The state regulations may address the frequency of documentation of the review of the resident’s progress. Many facilities document the resident's progress at least quarterly.

Rehabilitation Services (F406):

The physical, occupation, and speech therapists perform evaluations based on the physician orders. The format of these evaluations is based on their professional standards of practice and will address the resident's physical function in the specific area. The medical diagnosis that supports the medical necessity for skilled therapy services must be provided by the physician either in current documentation in the record or documentation of a newly identified diagnosis made by the physician.

Once the evaluation is complete, the therapist or nurse will notify the physician and obtain an order for the program as outlined by the therapists. Some therapists inform the physician of the program by sending or faxing a copy of the evaluation. Any skilled services must be certified as necessary by the physician/nurse practitioner/physician assistant.
For residents covered by Part B therapy, the physician/nurse practitioner/physician assistant must certify the resident for the services and follow the resident every 30 days as long as the resident is covered by Part B Medicare. At the end of the services the facility must provide the resident with the Notice of Exemption from Non-coverage.

The time spent in therapy and the progress of the resident during this time may be documented on a daily documentation form. Many facilities may use separate log sheets to document the time spent in therapy. These logs should be part of the clinical record. The therapist must include in the note the level of participation of the resident in the program as defined in the plan of treatment. The therapist must write a discharge summary when the program is discontinued.

**Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) and Care Area Assessment (CAA) (F272-F278):**

Each facility must complete a comprehensive assessment that is based on a uniform data set. Facilities must use the MDS, and the CAAs to assess newly admitted residents within 14 days (F273). Using the Assessment Reference Date (ARD) as the base, the facility staff must conduct an annual assessment (no more than every 366 days after last full assessment or more than 92 days after the last quarterly (F275), assess those residents who experience a significant change in status (F274) or when completing a significant correction of a prior full assessment (within 14 days). No less than once every quarter (92 days), facilities must conduct a State specific quarterly review of the resident's status (F276). With implementation of the MDS 3.0, the scheduling the subsequent MDS assessment is based on the assessment reference date (ARD) of the previous assessment. (RAI 2-15 to 2-16)

A comprehensive assessment must be completed within 14 days after the facility has determined that there has been a significant change in the resident’s physical or mental condition (F274). A significant change is defined as a major decline or improvement in the resident’s status that will not normally resolve itself without further intervention by staff or by implementing standard disease related clinical interventions, that has an impact on more than one area of the resident’s health status and requires interdisciplinary review of the plan of care or both.

The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The facility is also responsible for addressing the resident’s needs from the moment of admission.

The MDS is also used to determine the reimbursement level under the prospective payment system for Medicare Part A residents in a SNF. Based on the MDS scoring, a Resource Utilization Group (RUG) is assigned which determines the per diem payment. While on Medicare Part A, the PPS MDS assessment schedule includes a 5, 14, 30, 60, and 90-day assessment. An OMRA (Other Medicare Required Assessment) may also be completed in specific situations for example after all therapies are discontinued but the resident is still receiving skilled nursing services such as wound care. Under the MDS 3.0 requirements, residents who opt to receive Hospice benefits must have a significant change assessment completed when benefits are initiated and on discharge from hospice. In addition to Medicare, many states also use the MDS to determine reimbursement for Medicaid. For complete information on the RAI/MDS schedule for both OBRA and PPS assessments, refer to Chapter 2 of the RAI User's Manual.

**Care Plan (F279):**

The care plan is the foundation that provides direction to the interdisciplinary team and staff on providing care and treatment to the resident. The care plan should be the central focus for the on-going documentation of the residents care, condition, and needs.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be provided to attain or maintain the resident's highest
practicable physical, mental and psychosocial well-being; and any services that would otherwise be required but are not provided due to the resident’s exercise of rights including the right to refuse treatment. The care plan must reflect intermediate steps for each outcome objectives if identification of those steps will enhance the resident’s ability to meet his/her objectives. Facility staff will use these objectives to monitor resident progress. Facilities may need to prioritize their care plan interventions. This should be noted in the clinical record or on the plan of care.

The care plan must be prepared by an interdisciplinary team that includes the attending physician, a registered nurse with the responsibility for the resident and other appropriate staff and disciplines as determined by the resident’s needs and, to the extent practicable, the participation of the resident, the resident’s family or the resident’s legal representative. There should be evidence that the care plan is periodically reviewed by a team of qualified persons after each assessment and as the resident’s status changes.

Timeliness (F280):

A comprehensive care plan must be completed within 7 days of completion of the comprehensive assessment. Completion or updating of the care plan should follow the comprehensive assessment since the assessment provides the foundation or analysis of a problem resulting in the goals and interventions on the care plan. The care plan is reviewed and updated after each scheduled comprehensive assessment – admission, quarterly reviews, annually, and with a significant change in condition. This review must take place within 7 days of completion of the assessment. The care plan must be kept up to date. At any given time; the resident’s care plan should reflect the care the resident is receiving.

Care Conference (F280):

In completing a care plan, the professional disciplines must work together to provide the greatest benefit to the resident. The mechanics of how the interdisciplinary team meets its responsibilities in developing an interdisciplinary care plan (e.g. a face-to-face meeting, teleconference, and written communication) is at the discretion of the facility. The facility should encourage residents, surrogates, and representatives to participate in care planning including encouraging attendance at care planning conferences.

Admission Care Plan:

Upon admission, a brief initial care plan should be developed to carry through until the resident’s comprehensive assessment and care plan have been developed. The care plan should address the primary reason for admission and treatment and the resident’s most immediate care needs. The plan may include self-care deficits, mobility status, nutritional needs, skin conditions, and clinical and/or rehab needs.

Integrating Acute Problems into the Care Plan:

When temporary or acute problems arise, the facility documents an assessment of the problem and implements a plan. It is at the facilities discretion on how the acute problem is incorporated into the care plan. The acute problem can be incorporated into the comprehensive care plan or could be documented on a separate acute or temporary care plan form. If an acute care plan is used, there must be documentation of the problem, interventions and conclusion.

Timeliness of Completion of Care Plan:

The comprehensive care plan should be in the medical record within 7 days after completion of the comprehensive assessment and/or the quarterly assessment. For example, if the care conference were held 7 days after the completion of the comprehensive assessment, the updated care plan would be on the record or available for staff to use on that day.

Authenticating Changes to Care Plan:
Since the care plan is a key document that should be kept up to date at all times, changes are frequently made. Each time there is a change made on the care plan, staff making the change must follow proper legal documentation guidelines and authenticate and date the entry. This includes making a new entry, changing, or discontinuing an entry.

**Narrative Charting and Summaries:**

**Admission/Readmission Note:**

It is a standard of practice to write a note at the time of admission that documents the date and time of admission, how transported, the reason for admission, and the resident’s condition. The narrative note should not repeat information already included in the nursing assessment. The narrative note should provide supplemental information. State regulations may have specific requirements for admission documentation and the time frame for completion.

**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 staff 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 what the resident said or did observations and/or assessments by staff, communications with practitioners and legal representative/s and the resident’s representative, response to interventions/treatment. Good practice indicates that for functional and behavioral objectives the clinical record should document change toward achieving care plan goals.

**Nursing and/or Interdisciplinary Summary Charting:**

Federal regulations do not require the completion of a summary note; however, some states may require a summary per licensure or reimbursement regulations (i.e. monthly, weekly, or periodic summary). If used, the summary documentation provides a mechanism to update 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 not reflected in the care plan, the summary should describe the resident’s status, the reason for the change, and the updates made to the care plan. If flowsheets 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, a note should be written explaining the reason for the change and the updates made to the care plan. The use of a monthly summary note or flow sheet does not preclude staff from maintaining documentation throughout the month that reflects any changes in condition or status.

**Integrated vs. Disciplinary Progress Notes:**

Either integrated or disciplinary progress notes may be used according to the facility’s policies and procedures. There are advantages and disadvantages to each type of progress note. With integrated progress notes, all disciplines document on one progress note form found in one section of the medical record. Disciplinary progress notes separate the narrative notes on different forms based on the specific department or discipline performing the documentation. The integrated progress notes may help to facilitate interdisciplinary communication.

**Medicare Physician Certification:**

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 coverage, the skilled services being delivered, and the on-going 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 and billed to Medicare by documenting that the services were both delivered and medically necessary. The certification for Medicare services can be signed by the Nurse Practitioner or the Physician Assistant working with the physician. However, the attending physician must complete the initial medical assessment (H&P) and sign the admission orders.

Note: Some Fiscal Intermediaries (FI) and other payers may have specific local medical review policies pertaining to MDS and other supporting documentation, content and format. When developing documentation systems for Medicare, it is advisable to check with your payers to determine any specific documentation requirements. Some states also provide payment to nursing facilities for services provided based on the RUGs system. These state agencies may also have additional documentation requirements to determine payment and/or support the data on the MDS. External auditing agencies may be used to determine whether the facility documentation is compliant with these requirements.

**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). Documentation may be more frequent if necessitated by the resident's condition. Those residents receiving skilled services must show evidence in the documentation of the need for daily skilled services being rendered. The content of the documentation is specific to the clinical reasons for coverage and services delivered and should be objective and measurable. Medicare worksheets can be helpful in focusing charting to the specific service delivered, related clinical issues, and the resident's response to care. 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 for charting can vary based on the reason for Medicare coverage and the services delivered – documentation can be written in a narrative format, captured on flow records or graphics, through structured documentation systems such as SOAP, FOCUS, PIE, etc. In addition to documenting daily skilled services, the medical record should also contain documentation supporting the reason for coverage/non-coverage.

**Supporting Documentation for the MDS:**

The Centers for Medicare and Medicaid Services has identified that the RAI/MDS is a source document and does not require supportive documentation, however they have identified that some entities may require additional documentation requirements specific to supporting the MDS. Since the MDS is the basis for determining the payment/RUG class, the medical record documentation should support the answers on the MDS within the time frame established by the assessment reference date. Note: Some case-mix states will stipulate the specific source document that is allowable in supporting the MDS data and/or additional State specific documentation requirements. The following are examples of types of supporting documentation for the MDS.

**Therapy Treatment Time:**

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 assignment level. In addition to treatment time, the RAI manual requires that the physician order for therapy services must include a statement of the frequency, duration, and scope of treatment.

**Activities of Daily Living (ADL) Charting:**
The ADL section of the MDS has an impact on all RUG payment categories for Medicare. The documentation in the medical record should provide support for the scoring on the MDS along with observation and interviews. A facility may utilize ADL charting to collect information from all three shifts during the 7-day observation period. If the staff member assessing the ADL status and completing the MDS disagrees with the supporting documentation based on observations and interviews, a clarification note can be written documenting the rationale for the ADL scoring on the MDS.

Mood and Behavior Documentation:
Mood and behavior scoring on the MDS will affect the Medicare RUG payment category. Because these sections on the MDS require the reporting of the frequency of the mood or behavior problem, the medical record should provide supporting documentation that quantifies the frequency reported.

Hospital Documentation:
With the implementation of the MDS/CAA 3.0 and RUGs IV, the services provided prior to the resident’s admission to the nursing facility cannot be calculated into the RUG assignment. However, the MDS 3.0 does identify those services prior to admission; therefore it is important to obtain supporting documentation from the hospital to justify the MDS. A preadmission assessment that captures hospital services and dates of delivery could also be used to support the MDS. When used in this manner, the preadmission assessment should be considered part of the resident’s permanent record and meet the legal documentation standards.

Medicare Certification/Recertification:
Each resident on Medicare must have a Medicare part A certification/recertification completed and signed by a physician knowledgeable of the residents care and treatment. Depending upon the individual state’s practice standards for Nurse Practitioners and Physician Assistant, the Nurse Practitioner and/or Physician Assistant may sign the certification. The certification/recertification must include the reason for Medicare coverage and the skilled services to be delivered. Certifications are required upon admission, on or prior to day 14, and then every 30 days thereafter, from the date of the previous signature, while the resident continues to be Medicare part A covered. It should be noted that signature stamps are not acceptable for the Medicare certification and the date of the signature must be completed by the physician at the time of signing the certification form. The facility staff may document the specific reasons for the Medicare services being provided but cannot sign and/or date the certification. The certification may be recorded in various formats as long as it contains the specific certification terminology. There is no Federal requirement for a specific form to document the certification.

(Effective with items and services furnished on or after January 1, 2011, §3108 of the Affordable Care Act has added physician assistants (PAs) to the existing authority for physicians, nurse practitioners (NPs), and clinical nurse specialists (CNSs) to perform the required initial certification and periodic recertifications under 42 CFR 424.20, with respect to the skilled nursing facility (SNF) level of care. As is true for the NPs and CNSs, this authority extends solely to those PAs who do not have a direct or indirect employment relationship with the SNF but are working in collaboration with a physician.)

Timely and accurate completion of the Medicare Certification Recertification form is crucial to support Medicare services provided and billed and must indicate the reason for skilled therapy is the reason for the hospitalization. Incomplete or untimely certifications may result in denial of Medicare payment and loss of appeal rights. The reason for skilled services should align with the reason for the hospitalization.

Rehabilitative Therapy Documentation
Rehabilitation Services are provided at the order of the attending physician to improve the physical functioning of the resident, hopefully to allow them to return to the community. The
Rehabilitation Services Assessment should be performed within a reasonable time after the order is received. Once services have been initiated, a progress note must be documented with 14 days and then at least every 30 days as long as the resident is receiving therapy services. The attending physician must certify the assessment and plan of care documented by the therapists. Most therapists utilize a specific government generated form (HCFA 700) for this purpose. This form includes the assessment of the resident’s functional status, the plan of care going forward and a location for the physician’s signature certifying the need for and approval of therapy services. Once the resident has reached their goal a therapy discharge summary is completed. One of the requirements under the PPS system is a calculation of the number of days and minutes of therapy. The clinical record must reflect these dates and times, usually completed through a flow record, whether electronic or in hard copy. Many therapists include a notation as to what the resident’s performance level was for the therapy session as well. In addition, a weekly summary is frequently documented as well. Regardless of the format for documentation, the therapy documentation must support the information identified on the MDS.

Physician Documentation:

Physician Progress Notes: (F386)

The Following is based on the AMDA (American Medical Directors Association) Position Statement:

“Role of the Attending Physician in the Nursing Home” effective March 2003.

Progress notes must be written, signed and dated each time a physician visits a resident. The frequency of each visit is based on a joint physician-facility-developed protocol that is consistent with applicable state and federal regulations (AMDA). Per federal regulations, the resident must be seen at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. (F387)

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required (F387). The subsequent physician visit schedule is established based on the resident’s date of admission. Progress notes should provide documentation to explain medical decisions, enable effective care and should include:

(Per AMDA guidelines):

- An evaluation of the resident’s condition, current status and goals.
- Progress of resident’s response to the treatment regime.
- Status of any acute episodes of illness since the last visit
- Relevant information about significant ongoing, active, or potential problems including reasons for changing or maintaining current treatments or medications
- Plan for addressing relevant medical issues
- Provide diagnoses related to resident problems and interventions (including medications and diagnostic studies)
- Analysis of significant tests and medical rationale for subsequent interventions or decision not to intervene based on those results when the basis for such decisions is not readily apparent
- Documentation of ethical issues and end of life decisions

Dictated Progress Notes:

If a physician dictates a progress note, a brief note should be entered into the record at the time of the visit stating that dictation will follow. At a minimum, the physician should identify the resident’s diagnoses and/or reason for admission. If there has been an acute change in the resident’s condition, the physician should write a note for the medical record in addition to the dictated progress note. The dictated progress note should be received by the facility
and filed in the medical record within 7 days. The facility should have a monitoring system to assure that dictated notes are received within the appropriate time frame. Each dictated note should reflect the date dictated and date typed, including the physician’s signature (manual or electronic).

Nurse Practitioner (NP)/Physician Assistant (PA) Documentation (F388; F390):

Federal regulations allow a NP/PA working with a physician to make every other required physician visit after the initial visit. The NP/PA must write a progress note at the time of the visit and should follow the same guidelines for content as defined above. The federal regulations do not require countersignature by the attending physician; however, state law usually defines the NP/PA authority and should be reviewed to determine if countersignatures are required. Federal regulations allow the physician and nurse practitioner to alternate the required visits, after the initial visit by the attending physician.

History and Physical:

Although there is not a Federal regulation which requires the completion of a history and physical at the time of admission or on a periodic basis thereafter, facility policies requiring an H&P should be developed based on state regulations and applicable accreditation standards. The Federal requirements mandate that the H&P must be performed and documented by the attending physician.

The physician must assess a new admission in a timely fashion (based on a joint physician-facility-developed protocol) and document the results of that assessment and plan of care in the medical record. The note should include information to support the admission to the facility in determining the level of care:

- History and Physical
- An assessment of Current condition or issues
- Treatment goals and plan of care
- Rehabilitation potential
- Diagnoses

Other Professional and Consultation Records/Notes:

If the resident requires a consultation with a specialist, services in an emergency room or a specialty center such as dialysis center, the medical record must contain documentation of the visit, progress note, and recommendations. For consultations that occur out of the facility, a separate referral/consultation record can be sent to the physician to obtain documentation for the resident’s long-term care record.

Findings and Recommendations of the consultant must be communicated to the Attending Physician. Facility policy will determine this procedure. If the nurse calls the physician with this information, then the nurse will document results of that communication. Some facilities require physician’s to sign off on consultant reports.

Documenting Resident Diagnoses:

The medical record contains a record of the resident’s medical diagnoses. The diagnosis list should include the on-set date for the diagnosis if known (if on-set date not known use the date from physician supporting documentation), a statement of the diagnosis, the applicable ICD-9-CM code, and resolve date. If a section is included on the Diagnosis list containing source document where diagnosis signed by physician was found, then physician will not need to sign Diagnosis List. The MDS 3.0 requires that the physician must document the resident’s diagnosis/es within 60 days of the assessment reference date. This documentation can be found in the H&P, progress notes, physician orders, etc. If the diagnosis list is used to support the use of the diagnosis on the MDS, the physician must verify the diagnoses. The diagnoses identified on the MDS not only must be documented
within the previous 60 days but must be considered active during the past 7 days. Whether
the diagnosis is ‘active’ is determined by whether the condition is being monitored, treated,
etc. during the previous 7 days.

Supporting Documentation for Diagnoses:
The diagnoses recorded in the resident’s medical record must be supported by physician
documentation. Supporting documentation includes written progress notes, transfer forms,
hospital documentation (i.e. H&P, discharge summary), consultation reports, etc. that have
been signed by the physician. If a more specific diagnosis is needed, the physician must be
consulted and provide supporting documentation. Clinical staff (i.e. nursing or therapy)
cannot diagnose or determine a more specific diagnosis without consulting with the
physician and obtaining supporting documentation. This is frequently documented through
the use of a verbal order.

Resolving Diagnoses:
On a regular basis (i.e. quarterly with each care conference, at the time of physician visits,
etc.), the diagnosis list should be reviewed and diagnoses resolved that are no longer
current. If a diagnosis has resolved the physician must provide supporting documentation
that, the diagnosis is no longer active unless the condition is self-limiting such as a UTI
(Urinary Tract Infection) or URI (Upper Respiratory Infection).

Final Progress Note/Discharge Note/Summary F283:
As determined by facility policy, the physician’s final note should include a recapitulation of
the resident’s stay, final diagnosis, rehabilitation potential and prognosis, if appropriate, and
disposition of the resident.

In the event of the resident’s death, the physician must complete and sign the Death
Certificate as defined by State protocol. It should be noted that the requirements regarding
the completion and registering of birth and death certificates are governed by state law
therefore each state may have differences in the requirements.

Physician Orders:

Admission Orders: (F271)
At the time a resident is admitted, the facility must have physician orders for the resident’s
immediate care. These orders should include, at a minimum, the resident’s diet, medications
(if necessary), and routine care to maintain or improve the resident’s functional abilities until
the staff can conduct a comprehensive assessment and develop a comprehensive
interdisciplinary care plan. At the time that the transfer orders are confirmed with the
attending physician, the physician may add or delete some of the orders provided via the
transfer document. These should be documented, as appropriate, following documentation
standards.

Content of an Order:
A physician order should include the drug or treatment and a correlating medical diagnosis
or reason. For a medication order, the route of administration, dosage, frequency, strength,
and reason for administration should be documented in the text of the order. For parenteral
or enteral nutrition therapy include all required components – fluid, amount, flow rate,
pump/gravity/bolus use, etc. For some orders such as antibiotics, a stop date is also
necessary.

Physician Order Recaps/Renewals:
On a regular basis (often 30 days or as required by state law), the current set of physician
orders are compiled for the attending physician to review and renew. F386 requires the physician to review the orders at the time of the physician visit.

The current orders should be recapped on a physician order record, signed and dated by the physician or their designee. Physician order recap or renewal should not be completed via a review of the medication and treatment records with a blanket statement to renew all orders. After the physician has reviewed and renewed the orders, a nurse should review the orders for changes and note the signed orders.

**Telephone Orders:**

Orders received by telephone should be countersigned by the physician within the required time frame as defined by state law. There should be indication that the verbal order was read back and verified with the physician. In absence of a state law, facility policy should define the time frame for countersignature (e.g. 14 days). Federal regulations do not specify a timeframe for countersignature by the physician.

**Fax Orders: (F386)**

Orders received and signed via fax may be accepted until the original is provided. At that time, the fax copy may be destroyed. As identified in the Interpretative Guidelines, when fax is used as a means of communication with the physician, both the physician’s office and the facility should retain the fax documents as part of the resident's medical record. The physician’s office should be able to produce the order with the original signature upon request unless the physician returns the original signed fax to the facility. All faxed information must be clearly identified with the resident’s name and medical record number. It should be noted that some older fax machines utilize paper which can deteriorate in time. This should be photocopied and the photocopy placed on the resident's record.

**Standing Order Policies:**

Standing order policies should be used with discretion. Legend drugs should not be included on standing orders nor should standing orders be used in place of notification to the physician of a change in status. (Note: Some states do not allow the use of standing orders.)

**Authentication/Obtaining Signatures:**

Orders must be countersigned within the required period of time usually determined by state law or facility policy. Federal regulations do not define a time period in which telephone orders are to be authenticated, however, state regulations frequently address the timeframe necessary for signature of the order. All orders must be signed by the authorizing physician. No physician will authorize through their signature an order that was given/written by another physician. Various methods for authenticating orders is acceptable – see legal documentation section for acceptable methods, NP and PA countersignature.

**Transcription of Orders and Noting Orders:**

Transcription of orders, such as telephone orders, is a responsibility of professional nurses (RN, LPN/LVN per the scope of practice defined by State law/practice acts), but can be delegated to a trained individual if allowed by state law or practice acts. If the transcription process is delegated, the nurse still must sign off on the order and retain responsibility for accurate transcription. When a telephone or fax order is transcribed into the medical record, it should be transcribed verbatim as given from the physician.

Physician orders (recaps/renewals, telephone/verbal, or fax orders, etc.) are to be noted by a licensed nurse by writing "noted", dating and signing with name and title.

**Contacting the physician to obtain an order:**

Nurses, therapists or other professionals designated to take orders must first contact the
physician to obtain the order. Each resident’s medical care must be supervised by a licensed physician (F385). Licensed nurses are not authorized to independently write physician orders without the explicit direction of or by the attending physician. It is not acceptable to create/write a telephone order, implement the order and then send the order for signature without contacting the physician. The exception would be for a nurse practitioner or physician assistant who has the authority by law and scope of practice to write orders on behalf of a physician.

Discontinuing an order when a new order is obtained:

When a physician changes a physician order that is currently in place, the original order must be discontinued first and a new order written that reflects the change.

Updating/changing physician order recaps/renewals after they have been signed:

Once the physician has signed the physician order recap/renewals changes or updates may not be made to the signed document. For example, new orders should not be added to the recap after the physician has signed the document.

Processing physician orders after hospitalization – "resume previous orders":

Upon a return from a hospital stay or readmission, when an order to "resume all previous orders" is given, the attending physician should be contacted to review the previous orders to assure that they are still appropriate and would not conflict with any new orders. Some states may not allow the use of "resume all previous order" statements.

Verification of hospital orders with attending physician:

All hospital orders should be reviewed and authorized by the resident’s attending physician at the time of admission or shortly there after.

Accepting orders from a Nurse Practitioner (NP)/Physician Assistant (PA):

Orders should only be accepted from a nurse practitioner or physician assistant if the state practice acts allows the NP or PA to give orders or prescribe and the attending physician has given authorization through a scope of care agreement. Both the scope of care agreement with the attending physician and a copy of the NP/PA’s license should be kept on file by the facility.

Accepting orders from Specialists or Consultants:

As a general rule orders from a physician other than the attending (specialist, consulting physician, etc.) should be reviewed with the attending physician prior to implementation unless the attending physician has given previous written direction to accept the specialist/consultant order(s).

Pharmacy Drug Review: (F428. F431)

A review of the resident’s drug regimen is required to be completed on a monthly basis by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician and the Director of Nursing. The reports made by the pharmacist must be acted upon. Documentation in the record must reflect the physician’s response to the recommendations made by the pharmacist.

Antipsychotic Drug Therapy (F329):

At a minimum, the medical record documentation should include documentation that supports the assessment of the condition, identifies the specific condition as diagnosed including the statement of the manifestation. The assessment should include the
documentation of the behavioral manifestation, signs and symptoms, identification of underlying causes(s) including adverse consequences of medications. The assessment should clearly identify the medical necessity for the use of the psychoactive drug/s, including the consideration of the resident’s risk/benefits, total treatment plan and other medications/conditions. As part of the assessment, risk benefits. Non-pharmacological interventions (such as behavioral interventions) are considered, evaluated and used when indicated, instead of, or in addition to, medication.

Physician orders for psychoactive drug therapy should include the reason for the medication which should be related to the diagnosispecific condition based on assessment. The physician order or documentation in another location in the medical record should identify the manifestation to be monitored.

Residents receiving psychoactive drug therapy should receive continuous monitoring and assessment which includes:

- Evaluation of a resident’s signs and symptoms, in order to identify the underlying cause(s), including adverse consequences of medications;
- Frequency and monitoring of the medication to identify effectiveness and adverse consequences will be carried out to include periodic planned evaluation of progress, review of adverse consequences, continued need at least quarterly, unless regulations specify otherwise.

If psychopharmacological medications are used as an emergency measure, adjunctive approaches, such as behavioral interventions and techniques should be considered and implemented as appropriate. Longer term management options should be discussed with the resident and/or representative(s).

**Dose Reduction Schedules and Documentation (F329):**

For residents who receive antipsychotic drugs, the record should contain documentation of the interdisciplinary behavioral interventions, the documentation of the evaluation of the data related to the behavior/s and medication side effects as well as the efforts to gradually reduce the medication dosage unless contraindicated.

Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a gradual dose reduction in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a gradual dose reduction must be attempted annually, unless clinically contraindicated. If clinically contraindicated, documentation by the physician should provide justification as to why the drug must continue to be used and why the dose of the drug is clinically appropriate. The justification should include a diagnosis (along with description of symptoms), a discussion of the differential psychiatric and medical diagnoses, a description of the justification for the choice of a particular treatment or treatments, and a discussion of why the present dosage is necessary to manage the symptoms of the resident. The information does not have to be found in the physician’s progress notes, but must be included as part of the resident’s clinical record.

**Medication and Treatment Records:**

Medication and treatment records (MARs and TARs) are derived from the physician orders and document the delivery of ordered services. Nurses place their initials in the blocks of the MARs and TARs form when medication or treatment has been administered. Based on physician orders, there should be no gaps noted in this documentation.

Also, the medical record should contain a legend that matches staff initials with full signature and credential. Some facilities choose to do this as a separate master list as opposed to legends on each form in the medical record. This Master Signature List should be updated with new staff hires. Each master list however must then be filed in each resident’s medical record.
Any medications or treatments given on a PRN (as needed) basis must be initialed, and information pertaining to the need for the PRN, documented either on the back of the MAR/TAR or elsewhere in the chart as defined by facility policy. Separate nurses’ note may also be required. For electronic records; the Medication and Treatment Records may only have the initials on the MAR/TAR either on view or print. The legal medical record must be able to be identified with the electronic system to verify the initials against the full name, title and effective dates.

Narcotics will require additional tracking and logging procedures.

Nurses will circle or otherwise indicate which medications or treatments were NOT administered. This would then require a documented explanation as to why the order could not be carried out.

Facilities utilizing electronic medication administration records (e-MARs) may have the ability to perform audit functions at the end of med passes to insure that all required documentation is in place.

Starting new Medication/Treatment Records upon Readmission/Hospital Return:

To eliminate possible errors in transcription or administration of medications and treatments, new medication and treatment records should be initiated with a return from the hospital rather than continuing on the previous record. The new medication and treatment records would be based on the new orders received after hospitalization.

Flow Sheets/Flow Records:

Although flowsheets or records are not recommended to replace summary or narrative charting, they are helpful tools in recording many clinical data or service delivery.

Service Delivery Records:

ADL (Activities of Daily Living) Flowsheets and NAR (Nursing Assistant Record) Flowsheets:

There is no federal requirement to maintain ADL flowsheets or Nursing Assistant flowsheets to document delivery of resident care services however they may be used to provide supportive documentation for the coding on the MDS. Their use should be based on facility/company standards or State requirements. If ADL/NAR flowsheets are used, it is best if they are tailored to the resident’s care plan. ADL flowsheets can be either documented by nursing after consultation with direct care staff or by the nursing assistant providing care. If the nursing assistant completes the flowsheets, there should be a system to monitor completion every shift. Unless utilizing an electronic care tracking program, flow sheets are the easiest way to document amount of care rendered to the resident. ADL scores are critically important to scoring the ADL section of the MDS correctly and consequently for maximizing reimbursement. Scoring on the ADL flowsheets should be consistent with the scoring on the MDS to increase consistency in data collection and assessment.

ADL flow charts a part of electronic legal health record will include a system for verifying initials, full name and title, dates of entries on view and print.

Other Clinical Flow Records:

There are many different clinical flowsheets used to assist in data collection and assessment. Examples of clinical flowsheets include injection site rotation, intake and output, pressure ulcer flowsheets, Medicare flowsheets etc. Facility discretion rather than federal regulations usually dictate when clinical flowsheets are used.

Labs and Special Reports: (F504, F510)

All laboratory, radiology, and diagnostic services must be ordered by the attending physician (F504, F510). Orders for labs, x-rays and other diagnostic tests should include specific tests
and the rationale for the diagnostic test requested. The rationale should be either an established diagnosis or current signs/symptoms. One should not accept rule out statements for the rationale. A report of the findings for all laboratory, radiology or special diagnostic services must be retained in the medical record. The physician must be promptly notified of the results of the laboratory findings (F505) and findings from radiology or other diagnostic services (F512). When labs or studies are received, a nurse must review the report and notify the physician of any abnormal results as dictated by facility policy. The nurse will then initial and date the report and note any communication or orders from the physician (if using an EHR, the system should have an electronic equivalent to the nurse initials and date to signify review). The physician will document the clinical significance of the abnormal findings, especially if it establishes a new diagnosis. If there are abnormal lab results but the physician decides not to treat the resident, a notation should be made in the clinical record (i.e. nurses notes) documenting the physician’s decision and reason for this decision.

Consents, Acknowledgements and Notices:

Informed Consent for Use of a Restraint (F221):

When a restraint is being considered for a resident, the facility must obtain informed consent from the resident or their legal surrogate/representative. The facility must explain the potential risks and benefits of using a restraint, the risks and benefits of not using a restraint, and alternatives to restraint all within the context of the resident’s condition and circumstances. Informed consent should include an explanation of how the restraint would treat the resident’s medical symptoms, assist the resident in attaining/maintaining his or her highest practicable level of physical or psychological well-being, and explain the negative outcomes of restraint use. In the case of a resident who is incapable of making a decision, the legal surrogate or representative may exercise the right based on the same information that would have been provided to the resident.

Consent, Notice and Authorization to Use/Release Clinical Records (F164):

Prior to the release of personal or clinical records an authorization must be obtained. See section 4.9 on confidentiality and release of information. Under the HIPAA final privacy rule, the facility must provide the resident with a written Notice of Privacy Practices. In addition, the facility must provide the resident with a Privacy Act Statement which describes the collection and use of the Resident Assessment Instrument information. (See RAI Users Manual Chapter 1-14)

Notice of Bedhold Policy and Readmission (F205):

The nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bedhold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility. The bedhold policy is usually given to the resident and family/responsible party at the time of admission. In addition, (F205) requires that the facility provide a bedhold notice at the time of transfer. It should be noted that the bedhold status of the resident does not impact the completion of the Discharge Assessment nor should it impact whether the resident’s record is closed or remains ‘open’. The timing of the closure of the clinical record is determined by the facility’s policy, e.g. the chart remains open for ‘X’ days after the resident is admitted to the hospital.

In cases of emergency transfer, notice “at time of transfer” means the family, surrogate, or representative are provided with written notification within 24 hours of the transfer. The requirement is met if the resident’s copy of the notice is sent with other papers accompanying the resident to the hospital.

Notice of Legal Rights and Services (F156):

Prior to or upon admission the facility must provide a written description of the resident’s
legal rights and the items and services provided to the resident.

**Notice Before Transfer (F203):**

Before a facility involuntarily discharges or transfers a resident, an Advance notice must be given to the resident or family member/responsible representative, which includes:

- A copy of the facility bed hold policy
- The reason for transfer/discharge
- Effective date of transfer/discharge
- Location to which the resident is transferred or discharged
- Statement that the resident has the right to appeal the action to the state
- Name, address and telephone number of the state long term care ombudsman
- For nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals
- For nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

**Notice prior to change of room or roommate (F247):**

The resident must be notified prior to a change in the resident's room or roommate and this notification should be documented in the clinical record. Following the room change, the clinical record should include documentation related to the resident's adjustment to the room or roommate change. The facility staff should make every reasonable effort to accommodate the resident’s preferences.

**Advance Directives (F155-156):**

The resident has the right to formulate an advanced directive. The facility must inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and, at the individual’s option, formulate an advance directive. A written description of the facility’s policies to implement advanced directives and applicable state laws must be provided to the resident or representative. A copy of the advanced directive should be retained in the medical record. Some states have chosen to utilize the Physician Orders for Life Sustaining Treatment (POLST) or Medical Orders for Life Sustaining Treatment (MOLST) as the approved method for documenting the resident's wishes for treatment. This is a specific format for documenting the individual’s wishes for end of life care. The form is to be accepted by all health care providers.

**DNR Order vs. Advance Directives:**

Physician orders for a DNR status must be consistent with the advance directives of the resident. Some states utilize the MOST/POLST forms to document the resident's wishes. In the absence of a state law, the facility should obtain the resident’s advance directives prior to a code status/resuscitation order from the physician.

**Discharge Documentation:**

**Discharge Order (F202):**

The resident's physician must document that a transfer or discharge is necessary. This documentation is usually obtained via a physician order prior to discharge or transfer.

**Discharge Note:**
As a standard, a brief narrative note should be written at the time of discharge, including the date and time of discharge, the resident’s disposition, condition of the resident at discharge, instruction, or training provided, where discharged to, and the individual taking responsibility for the resident.

**Discharge Summary (F283 and F284):**

For planned discharges (i.e. discharges home or to another facility), federal regulations require that the facility complete a discharge summary that includes: (1) recapitulation of the resident’s stay, (2) a final summary of the resident’s status based on the comprehensive assessment, and (3) a post-discharge plan of care. The post-discharge plan of care serves as discharge instructions for a resident discharging home or as the transfer form for a resident discharging to another health care facility. Minimum content for the post-discharge plan of care includes a description of the resident and family’s preference for care, how the resident and family will access the services, and how care should be coordinated if continuing treatment involves multiple care givers. Specific resident needs after discharge, such as personal care, sterile dressings, and therapy, as well as a description of resident/care giver education needs to enable the resident/care giver to meet needs after discharge. The format for these documents is not mandated. Depending on facility policy, a copy if the summary may be given to the resident when discharged from the facility.

**Transfer Form:**

A transfer form must be completed when transferring the resident to the hospital or to another health care facility. This transfer forms should include the resident’s status, reason for transfer, medications, etc. Date elements that should be contained in a Transfer form would include, but not limited to, the following:

- Basic demographic information
- Financial information (Medicare number, Medicaid number)
- Next of kin and/or responsible party contact information (name, address, phone, relationship)
- Facility’s name, address, phone number and contact person
- Code status of the resident
- Description of the problem, condition of the resident necessitating the transfer
- Medications and when they were last provided
- Functional status of the resident

Many facilities will also send copies of information from the clinical record with the resident to the accepting facility. Some of these items may include, but not limited to, copies of the current orders, medication record, last 3 days of nurse’s notes, most recent physician note, advanced directive, power of attorney, etc. The original of the Transfer form should be sent with the resident to accepting facility while the copy (carbon) would be retained in the clinical record.

**Physician’s Discharge Summary vs. Discharge Record:**

Federal regulations do not require the completion of a physician’s discharge summary for every discharge. However, State regulations should be reviewed to determine the physician’s responsibility for documentation upon discharge. Some states may identify the content of the discharge summary as well as the timeline and responsibility for completion. At a minimum, a discharge record should be completed which includes the date and time of discharge, disposition, prognosis and rehabilitation potential (if applicable), final diagnoses, cause of death and to where the resident was discharged.

The RAI 3.0 requires that a Discharge Assessment be completed within 14 days of the resident’s discharge from the facility. If the resident expires in the facility, a Death in Facility
record must be completed. If the resident is discharged in less than 14 days from admission, the record may contain only the Entry Record. Any portion of the MDS which has been completed should be part of the clinical record and a notation written identifying why the MDS was not completed.

Post Discharge Plan of Care (F284):

There must be a plan for the resident’s treatment, if necessary, after their discharge home. This may include visits by a home health agency, outpatient rehabilitation or care provided by the family. This plan should be documented in laymen’s terms, including the medications to be received by the resident. The original of this information is provided to the resident with a verbal explanation of the care needs. The resident and/or responsible party should sign the form verifying that the information has been provided and their understanding of the information. A copy of this information is retained on the clinical record. The accrediting standards require a follow-up contact with the resident and/or responsible party to verify that the resident is progressing as anticipated.

Agreements

Admission Agreement

Upon admission an Admission Agreement which would contain a Consent to Treat must be completed, signed and dated by the patient or legal representative and a representative of the facility. The patient should receive a copy; the original will be placed in medical record.

Financial Agreement

Upon admission a Financial Agreement which identifies the financial obligations of the resident with regard to the stay in the facility and changes which could be incurred, including terms of payment and any interest rate or late charges on overdue accounts. The Financial Agreement must be signed by the patient or his legal representative. The patient should receive a copy, the original will be placed in the medical record (or business office files).

Advanced Beneficiary Notice

Generic Notice

Two days prior to termination of Medicare Benefits, a Notice of Termination of Benefits (Generic notice) must be completed, issued to the patient or their legal representative, and signed and dated by the patient (representative) and the facility staff member. A corresponding progress note should be documented in the medical record which identifies the person who was notified and that they understood the implication of the notice and their right to appeal the notice. A copy should be given to the patient. The original should be maintained in the medical record. The physician should be notified of patients being terminated from Medicare benefits.

Detailed Notice of Termination of Medicare Benefits

On the occasion that a patient or their representative appeals the decision to terminate Medicare Benefits a “Detailed Notice” will be completed and issued to the patient. This notice will contain the specific reason or rationale, based on the Medicare Criteria for Skilled Services, why the patient no longer qualifies for Medicare Benefits. A copy of this notice will be sent along with copies of the record as requested by the QIO for review. A copy will be retained in the Medical Record.
Documentation Systems/Formats

Most facilities utilize the narrative format when documenting in the clinical record, though this is only one of the many options available. It is important to utilize a system which provides the information to meet the needs of the facility and allow the staff to document efficiently and effectively. Following is a brief overview of the formats available. As this is an overview, more detailed information on each system should be researched through various resources, e.g., Charting Made Incredibly Easy, Mosby's Surefire Documentation, etc.

- **NARRATIVE**: Used in the majority of institutions, narrative charting is essentially staff recording data using progress notes, with flow sheets supplementing the notes. Narrative charting does not follow a specific outline and follows the thought process of the staff member documenting.

- **PROBLEM ORIENTED MEDICAL RECORD (POMR)**: Used in many health care institutions, the POMR system follows a problem list format, identifying all areas impacting the patient/resident, both positive and negative. The notes and all documentation refer back to the problem list, utilizing the “SOAP” (Subjective, Objective, Assessment, Plan), SOAPIE (Intervention, Evaluation) and/or SOAPIER (Revision) format.

- **PROBLEM/INTERVENTION/EVALUATION (PIE)**: Organizes information according to the residents' problems to simplify the documentation system. Utilizing flow sheets which have been designed for daily documentation supplemented with structured narrative documentation. This system also integrates the care plan into the daily documentation.

- **FOCUS**: Organized into patient centered topics, the FOCUS system encourages integrating assessment data to evaluate the resident's condition on an ongoing basis. Utilized principally in acute care settings, it is best used where the procedures are repetitive. Progress notes are written utilizing the DAR (data, action, response) format.

- **CHARTING BY EXCEPTION (CBE)**: Developed by nurses, this system requires the development and use of practice standards or protocols for each body system. The forms utilized in the documenting are developed following the specific guidelines. Developing the standards and forms eliminates the need to document in narrative format standard nursing care. Staff would check off those areas on the flow sheet through which the resident has met the established standard/protocol and then writes a narrative note when the resident’s condition deviates from the established standard.

- **FLOW SHEET, ASSESSMENT, CONCISE, TIMELY (FACT)**: Developed to help eliminate irrelevant data, repetitive notes and inconsistencies and to reduce the amount of time required to document. Flow sheets are designed to address the redundant activities in caring for a resident. The narrative documentation utilizes the DAR format of the FOCUS charting system.

- **CORE**: this system focuses on the nursing process. Specifically the CORE framework uses the data base, care plan, flow sheets, progress notes and discharge summary to chart the resident’s needs and progress. Progress notes follow the DAE (data, action, evaluation/response) for each problem.