Disclosures

(Marlene Foreman) has no real or perceived conflicts of interest that relate to this presentation.

Objectives

- Objective 1 State the various documentation forms available to nurses.
- Objective 2 Apply legal guidelines related to documentation regardless of form or system used.
- Objective 3 Utilize appropriate documentation to validate patient condition for reimbursement, auditors, and quality/research data collection.
Objectives

- Objective 4 Describe CMS requirements for admission, certification, recertification, discharge, revocation, and transfers.

DOCUMENTATION FORMS

- 1. Paper forms
- 2. Electronic medical records
- 3. SOAPIER, PIE, SPAR, etc.
- 4. General information

Legal Issues Related to Documentation

- Nurse Practice Act
- Do Not Use abbreviations, acronyms, etc
Legal Issues

- Documentation issues that may lead to litigation
- HIPAA and HITECH issues
- Event or Incident Reports

VALIDATING PATIENT CONDITION

- "Paint the Picture"
- Use of Checked boxes, lists, etc.
- Document changes over time

VALIDATING PATIENT CONDITION

- Use of scales, labs, and other data to validate changes
- Documentation supporting changes in level of care
- HPNA and NHPCO guidelines related to documentation
CMS REQUIREMENTS

- Issues related to admissions
- Issues related to certification and recertification
- Issues related to revocation and discharge

CMS REQUIREMENTS

- Issues related to transfers
- State variations

Case Studies

- You are the charge nurse (RN) on the evening shift. The physician’s order reads "Medication X 01.25 mg hs" and it was sent to the pharmacy.
  - What is wrong with this order?
  - Who should you call to clarify the order?
  - What is the pharmacist’s role in clarifying this order?
  - What is the nurse’s role in clarifying this order?
CASE STUDIES

- You are listening to report at the beginning of your shift. The nurse on the previous shift tells you that Mr. Y in Room 3 fell and hit his arm on the bed. She stated that the fall was documented in the record and that the record also notes that an Event Report was filed.
- What should you tell this nurse?
- Who else should be notified of this chart entry?
- What are the legal issues related to documenting an event report in the chart?

CASE STUDIES

- You are reading the CMS Regulations regarding admissions. You realize that your newly admitted patient was with another hospice 3 years ago for 7 months.
- What is this patient’s benefit period when she becomes your patient?
- Do you need to complete a Face to Face Encounter before admitting the patient?

Questions

1. What is the appropriate way to note an error in a chart?
2. You realize that an entry was omitted on yesterday’s documentation. What is the most acceptable way to rectify this situation?
3. When are you required to perform a Face to Face Encounter?
4. Your patient is seeking aggressive treatment. What is the proper term to use when the patient removes himself from hospice services?
QUESTIONS

5. You note that your physician still uses cc’s and gms when writing orders. Are these acceptable abbreviations?

6. Your state regulations state that the RN must reassess the patient at least every 14 days and the CMS regulations state 15 days. Which regulation are you mandated to follow?

References


REFERENCES

- HPNA Position Statements: Evidence Based Practice, April 2008.