PACAH
Documentation Guidelines for Skilled Care
April 28, 2015
Disclaimer

- The provider and instructor declare that neither has a conflict of interest in presenting this educational offering for the receiving entity.
Objectives

- At completion of this program participants will be able to:
  - Document to demonstrate implementation of the nursing process
  - Document to demonstrate provision of skilled level of care – Why me? Why here? Why now?
  - Avoid common documentation mistakes
  - Establish lines of communication to promote continuity of care
Federal Regulations

- F 514
- In order to obtain and maintain Medicare certification:
  - The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—
    - Complete
    - Accurately documented
    - Readily accessible
    - Systematically organized

“What Makes Us Different, Makes You Better”
Federal Regulations

- F 514, continued
- The clinical record must contain—
  - Sufficient information to identify the resident;
  - A record of the resident’s assessments;
  - The plan of care and services provided;
  - The results of any preadmission screening conducted by the State; and
  - Progress notes.
Nursing 101

- **Nursing Process**
  - Assessment
  - Diagnosis
  - Planning
  - Implementation
  - Evaluation
Nursing 101

- **Critical thinking** is the careful, deliberate determination of what course of action is appropriate, using evidence-based interventions that are grounded in current standards of practice.

- A nurse must use **critical thinking** every single day in his/her practice.
Nursing 101

- Documentation should describe the nurses’ critical thinking process:
  - Assessment of resident conditions, causative factors, and/or risk factors
  - Analysis of potential outcomes or consequences
  - Plan of action
  - Evaluation of resident response to the plan

This documentation answers the “Why me?”
The clinical record must contain:

- Detailed descriptions of changes in condition
- Unusual occurrences
- Evidence of physician and responsible party notification
- **Proof of care provided**
Documentation 101

- **What to Document**
  - **Assessment**—data collection
    - Auscultate, palpate, inspect, percuss
  - **Action**—what did you do with the findings? Physician/family notification?
  - **Response**—how did the resident react?
  - **Evaluation**—were the actions effective? Does the plan need re-evaluated?
Documentation 101

- Document events in chronological order*.
- **Always** be truthful.
- Never chart in advance or prior to providing care.
- Make sure that documentation is keeping with acceptable nursing practice.
- Document only what you are qualified to do.
- Make sure that all paper pages have resident identification*.

* common error
Documentation 101

- Date and time all entries* – use am or pm unless military time is used
- Sign all entries with credentials
- Avoid the use of texting language
- Avoid “red flag” language – “accidentally” or “by mistake”
- Entries must be legible*
  - Sufficient space on flow records
Documentation 101

- Documentation should include **correct anatomical terms***:
  - Buttocks, sacrum, coccyx, butt crack-- OH MY!
  - Superior, inferior, anterior, posterior, medial, lateral, proximal, distal—remember those terms and what they mean??
  - ICD-10 will be here soon and documentation must include correct anatomy or questions regarding claims will arise.
Medicare Requirements

- **Technical Requirements:**
  - Beneficiary is enrolled in Medicare Part A and has available days
  - Beneficiary has had a three-day qualifying hospital stay
  - Skilled care must begin within 30 days after discharge from a hospital or the last covered Medicare day of a SNF stay
Medicare Requirements

- Level of Care Requirements:
  - Requires **physician-ordered** skilled nursing and/or rehabilitation
  - Services must be **daily**
  - Services must be **delivered in a SNF**
  - Services are **reasonable and necessary**
Medicare Requirements

- **Daily Basis**
  - Rehabilitation—PT/OT/ST at least 5 days a week
  - Skilled Nursing—7 days a week
  - Restorative Nursing—at least 6 days a week
So what is skilled care?

- Nature of the service requires skill of a licensed person.
- Skilled service provided directly or under supervision of a licensed nurse or therapist.
- Diagnosis and prognosis do **NOT** determine what is skilled care—it is the care of the resident (service provided) that is the deciding factor.
Skilled Documentation

- **Practical Matter**
  - Considering economy and efficiency, skilled services can only be provided in a SNF
  - **Reasons for a skilled SNF stay:**
    - Intensity of therapy provided
    - Medical complexity
    - Less than the 24 hour/day care would impose safety risks or an adverse impact on the resident’s medical condition.

- *Keep this all in mind when documenting skilled care*...
Skilled Documentation

- Skilled care may be necessary to improve a resident’s current condition, or to prevent or slow further deterioration of the resident’s condition.
Skilled Documentation

- Goals of Skilled Documentation:
  - Substantiate daily skilled care
  - Record treatments, therapies and resident response
  - Communicate between disciplines and facilitate continuity of care
Skilled Documentation

Example:

Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the resident’s condition is complicated by circulatory deficiency, areas of desensitization, or open wounds. The documentation needs to support the severity of the circulatory condition that requires skilled care.
Skilled Documentation

- So...
  - Would the documentation from this case all come from the physical therapist?
  - How would nursing be involved with the skilled documentation for this resident?
  - How does everyone stay on the same page?
Skilled Documentation

- **Answers...**
  - The PT could not be responsible for all of the documentation for this resident. Nursing sees the wound during dressing changes. Nursing should be assessing the circulatory status.
  - Nursing and therapy need to **communicate** about what is happening with this resident.
  - **One more question...** Since the resident is skilled for therapy, only the therapy documentation counts, right?
Skilled Documentation

- **WRONG!!**
  - Nursing assessment of the circulation and wound status is an important part of the resident’s skilled care.
Example of Nursing Documentation:

- 8:00 AM  left leg red and warm to touch.  2+ pitting edema present in left leg from knee to toes. Unable to palpate left pedal pulse. Resident states “tingling” feeling in left foot. Dressing changed to stasis ulcer left lateral calf—large amount serosanguinous drainage present. Dr. Smith updated at 8:15 AM regarding change in circulatory status.
Skilled Documentation

- The medical record is expected to provide:
  - Communication
    - Among ALL members of the care team regarding the:
      - Development of the plan of care
      - Course of care and treatment
      - Outcomes of the:
        - Skilled observations
        - Assessments and/or treatments
        - Training
Skilled Documentation

- The resident’s medical record must document as appropriate:
  - The history and physical exam
  - The skilled services provided
  - The resident’s response to the skilled services
  - Plans for future care
  - Detailed rationale explaining the need for skilled care
  - Complexity of the service to be performed
  - Any other pertinent characteristics of the resident
Skilled Documentation

- Always document **objectively**
  - Avoid terms such as:
    - “normal’
    - “good”
    - “resident had a good night/day”
    - “appears”
    - “seems”
    - “generalized weakness”
    - “voiced no complaints”
Skilled Documentation

- The following terminology **does not** sufficiently describe the reaction of the resident to his/her skilled care:
  - Tolerated treatment well
  - Continue with POC
  - Remains stable

- This type of documentation does not provide a clear picture of the results of the treatment, nor the “next steps” that are planned.
Skilled Documentation

- If you document information such as:
  - “wound healing” or
  - “condition improved”

  - Be sure to state facts that support your documentation.
  - Give exact measurements and state the observations supporting the opinion.
  - “As evidenced by…”
Skilled Documentation

- **Examples of Nursing Documentation:**
  - Left lateral calf wound healing as evidenced by decrease in size and amount of drainage from last week. Wound now 0.2 cm x 0.5 cm. No drainage at this time.
  - Condition improving as evidenced by now able to ambulate entire distance to dining room for meals with no rest periods required.
Skilled Documentation

- **Direct Skilled Nursing Services to Residents**
  - Considered skilled when so inherently complex that they can be safely and effectively performed **ONLY** by, or under the supervision of, a registered nurse or a licensed practical nurse.
  - If the service can be safely and effectively performed by an **unskilled** person, it is **NOT** considered to be a skilled nursing service, even if a nurse provides the service.
Examples of direct skilled nursing services:

- Intravenous or intramuscular injections and intravenous feedings
- Enteral feeding that compromises at least 26% of daily calorie requirements and provides at least 501 milliliters of fluid per day
- Naso-pharyngeal and tracheotomy aspiration
- Insertion, sterile irrigation, and replacement of suprapubic catheters
Skilled Documentation

- **Examples of direct skilled nursing services:**
  - Application of dressings involving prescription medications and aseptic technique
  - Treatment of pressure ulcers, Stage III or worse, or a widespread skin disorder
  - Heat treatments which have been specifically ordered by a physician as part of active treatment **AND** which require observation by skilled nursing personnel to evaluate the resident’s progress adequately
Examples of direct skilled nursing services:

- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel such as the institution and supervision of bowel and bladder training

- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy
Examples of direct skilled nursing services:

- Care of a colostomy during the early post-operative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the resident’s medical record.
Skilled Documentation

- **Nursing Documentation to Support Skilled Rehab**
  - Physical therapy
  - Occupational therapy
  - Speech therapy

- Many residents receive skilled services provided by therapy in a SNF.
Skilled Documentation

- If the resident is receiving therapy, nursing documentation should be **consistent** with therapy documentation.
- Read what the therapist has written before writing your notes.
- Ask questions if you need clarification or do not understand the therapy terminology.
Skilled Documentation

- **Conflicting documentation** between nursing and therapy is a significant legal and financial issue.
- This commonly occurs because nurses do not read therapy notes and therapists do not read nurses’ notes.
- Therapy documentation should be available for review by the nurses.
Example of Conflicting Documentation:

**Therapy**—resident ambulated 50 feet with contact guard. Resident able to wash hair and upper body in shower today.

**Nursing**—resident unable to walk due to non-weight bearing status. Total care provided by nurse aide this AM.
Nursing Documentation to Support Therapy

Nursing documentation must contain nursing observations about **functional** ability. How did the resident do when—

- Walking to and from the bathroom, dining room, activities
- Getting dressed and undressed, bathing skills
- Toileting skills
- Eating food and drinking fluids
Skilled Documentation

- If nursing is going to document on resident carryover from therapy, who else needs to know what goals the resident is working toward in therapy?

- The Nursing Assistants!
Skilled Documentation

- **Nursing Documentation to Support Therapy**
  - Lengths of stay are becoming shorter due to insurance companies dictating how much coverage is provided before the resident is discharged.
  - If the insurance companies are successful in this venture, do you not think that CMS will follow suit in order to save money?
Skilled Documentation

- **Nursing Documentation to Support Therapy**
  - So how do we know what the residents are doing in therapy?
  - **COMMUNICATION**
    - Therapists should participate in shift-to-shift report
    - Nurses and nurse aides need to be communicating about functional abilities
    - Nursing and therapy should discuss resident goals and progress made during therapy sessions and outside of the therapy gym.
Example of Nursing Documentation

11:00 PM Resident receiving OT to assist with bed mobility, transfers and locomotion in wheelchair. Resident was able to pull self to sitting position with correct use of enabler bars and minimal verbal cues. Resident assisted by 2 caregivers when transferring to wheelchair. Needed assist of one to place left leg in position on leg rest. Able to propel wheelchair to doorway of room.
Skilled Documentation

- Do you have to worry about what therapy is documenting??
  - “Company to Pay $3.5M to Settle Rehab Billing Complaint”
  - “Chain Agrees to Pay $38 Million to Settle False Claims Act Allegations Relating to the Provision of Substandard Nursing Care and Medically Unnecessary Rehabilitation Therapy”
  - “SNF Agrees to Pay $1.3 Million to Resolve Allegations that it Submitted False Claims for Rehabilitation Therapy”
Skilled Documentation

- Indirect Skilled Services
  - Management and evaluation of the care plan
  - Skilled observation and assessment of patient condition
  - Teaching and training activities
Skilled Documentation

- **Management and Evaluation of the Care Plan**
  - Development of the care plan
  - Management of the care plan
  - Evaluation of the care plan.....based on the
    - Physician’s orders
    - **Supporting documentation**
Management and evaluation of the care plan:

- Develop initial plan of care
  - Initiate plan of care within 24 hours of admission

- Implement plan of care
  - Physician’s orders and nursing measures

- Evaluate plan of care
  - Is it working? Have there been changes in the resident’s condition?

- Change plan of care
  - Have new problems been identified?
Management and evaluation of the care plan:

Remember, the plan of care was created to meet the resident’s skilled needs by—

- Promoting recovery
- Meeting medical needs
- Providing medical safety

NOTE: The care plan must reflect frequent adjustments with weekly evaluation of goals documented.
Skilled Documentation

- Are **Nurses** responsible for the care plan??
  - **YES!**
    - Develop **measurable** goals
    - **Individualized** interventions
    - Evaluate, evaluate, evaluate and change, change, change that care plan!
Skilled Documentation

- What type of care and assessment would nursing be providing for this resident?
- What goals might be appropriate for this resident?
- What interventions would be part of this resident’s care plan?
- What are you going to document?
Skilled Documentation

- Example of Nursing Assessment
  - Cardiac assessment
  - Respiratory assessment
  - Skin assessment
  - Neurological assessment
Scenario #1:

An 81 year-old woman, who is aphasic and confused, suffers from hemiplegia, CHF, and a-fib. She has suffered a CVA, is now incontinent, and has a Stage II pressure ulcer on her coccyx. She is unable to communicate and make her needs known.
Example of Nursing Documentation:

7:15 AM AP-99, irregular. R-28. SPO2 92% on O2 3 LPM via nasal cannula. Rhonchi present in all lung fields bilaterally. Unable to express self verbally, not able to follow simple commands. Total dependence on two caregivers for repositioning in bed. Stage II area on coccyx noted to be 2 cm x 2.2 cm x 0.1 cm. Dr. Brown notified of assessment findings. New orders received for change in wound care and STAT chest x-ray. Daughter Shelly Smith notified of change in condition.
Skilled Documentation

- Example of Care Plan Documentation:
  - Goals
    - No signs of infection Stage II pressure ulcer on coccyx
    - No signs/symptoms of cardiac or respiratory distress as evidenced by absence of chest pain, dyspnea
    - Will be able to answer simple questions by nodding head with yes or no response
Skilled Documentation

- **Example of Care Plan Documentation:**
  - **Interventions**
    - Auscultate breath sounds q shift and PRN
    - Auscultate heart sounds q shift and PRN
    - Assess pulse oximetry q shift and PRN
    - Administer nebulizer treatments as ordered
    - Administer oxygen as ordered via nasal cannula
    - Turn and reposition q hour while in bed
    - Pressure redistribution mattress and cushion
    - Provide orientation to surroundings
    - Keep communication simple
    - Ask only yes/no questions
Skilled Documentation

- Even though no specific service provided to this resident is skilled, her condition requires **daily skilled nursing involvement** to manage a plan for the total care needed, to observe her progress, and to evaluate the need for changes in her treatment plan.

- The **medical condition** of the resident must be described and documented to support the goals and the need for skilled nursing services.
A primary need of a nonambulatory resident may be frequent changes of position in order to avoid development of pressure ulcers. However, since changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such turning and repositioning is obviously necessary.
Skilled Documentation

- The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel.

- So, no chance that this is a skilled service, correct?
Skilled Documentation

- But…
  - Although the act of turning a resident normally is not a skilled service, for some residents, the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities.
  - The reasons why skilled nursing or skilled rehab personnel are essential must be documented in the resident’s record.
Example of Nursing Documentation

2:00 PM  Education provided to day shift nurse aides and resident’s daughter Mary Lou Jones on positioning techniques to prevent pressure ulcer development. Resident’s skin extremely fragile due to long-term steroid use. Nurse positioned resident on left side with wedge pillow behind back, pillow between knees. Nurse aides performed return demonstration of positioning while maintaining skin safety. Daughter stated she was afraid she would hurt her mother when moving her. One on one education provided to daughter on position changes and skin safety. Daughter stated she will try again tomorrow.
Scenario #2:

A resident is recovering from pneumonia, is lethargic, disoriented, has residual chest congestion, and is confined to bed as a result of her debilitated condition. To decrease the congestion, the MD has ordered frequent changes in position, coughing and deep breathing.
Skilled Documentation

- **Example:**
  - While the residual chest congestion alone would not represent a high risk factor, the resident’s immobility and confusion represent complicating factors, which, when coupled with the chest congestion, could create a high probability of relapse.
  
  - In this situation, skilled oversight of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the resident’s medical safety.
Example of Nursing Documentation:

9:15 PM Resident more alert this evening, oriented to person and place. Wheezes present in base of left lung. Resident turned and repositioned every hour while in bed. Able to follow simple command of taking a deep breath, which was performed five times. Deep productive cough with thick white sputum. Nebulizer treatment administered as ordered. Lung sounds clear post-treatment.
Skilled Documentation

- Documenting Respiratory Therapy
  - Assess lung sounds pre- and post-treatment
    - Clear
    - Diminished
    - Crackles
    - Wheezes
    - bronchospasms
  - O2 saturation pre- and post-treatment
  - Respiratory rate pre- and post-treatment
Skilled Documentation

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<td><strong>Total Number of Minutes</strong></td>
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</tbody>
</table>
Respiratory Therapy

Documentation should also include:

- Minutes spent with the resident to perform assessments before, during, and after treatment as well as time it takes to prepare the medication and equipment as well as to *educate* the resident to participate in the delivery of the treatment.

- Is this all part of the care plan?
Skilled Documentation

- Paint the picture of the care that you are providing.
  - Use the nursing process
  - Use your critical thinking skills
  - Document accurately and professionally
  - Initiate/evaluate the care plan
  - Take credit for the care you are providing
Observation and Assessment of Resident’s Condition

These are skilled services when the likelihood of a change in a resident’s condition requires skilled nursing to identify and evaluate the need for possible modification or treatment or initiation of additional medical procedures, until the resident’s condition is essentially stabilized.
Scenario #3:

A resident with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medications, such as Digoxin and Lasix.
Skilled Documentation

- **Cardiac assessment:**
  - Pulse rate, rhythm
  - Presence of peripheral edema
  - Monitoring daily weights/rapid weight gain
  - Medications—new, adjustments in dose, resident response
  - Lung sounds
  - Presence of cyanosis, dyspnea
  - Coughing, pulmonary congestion
  - Presence of diaphoresis
Skilled Documentation

- **Respiratory assessment:**
  - Dyspnea, cyanosis
  - Lung sounds
  - Productive cough, sputum production
  - Respiration depth and rate
  - Presence of chest pain
  - Vital signs including oxygen saturation
  - Sternal retraction, distended neck veins
  - Results of chest x-ray, labs
Example of Nursing Documentation:

9:50 PM  T-100.2  P-96, irregular and thready.  R-32 with dyspnea.  Continues on O2 at 2 LPM via nasal cannula continuously.  BP-188/85.  Lung sounds with scattered rhonchi bilaterally.  Dry non-productive cough.  3+ pitting edema bilateral ankles and feet.  Educated resident on the importance of keeping legs elevated when sitting in chair. States her chest hurts when she takes a deep breath. Resident stated she is nauseated and has not been able to eat. Also stated that her vision has become blurry today. Notified Dr. Brown of assessment findings. New order to D/C Digoxin, obtain STAT dig level, STAT chest x-ray. Physician stated to notify him with any new changes in condition and he will examine resident in the AM.
Skilled Documentation

- **Example of Nursing Documentation:**
  - 12:05 AM  Chest x-ray results received—moderate CHF present.  Dig level high at 3.2 ng/mL.  Dr. Brown notified of all results—new order for Lasix 40 mg. IV now and daily in the AM
Scenario #4:

- A resident has undergone peripheral vascular disease treatment involving revascularization (bypass) with open and necrotic areas of skin on the involved extremity.

What would you assess?

What would you document?
Skilled Documentation

- **Wound Assessment**
  - Drainage/odor
  - Response to treatment/interventions
  - Measurements
  - Description of wound characteristics
Skilled Documentation

- Circulatory Assessment
  - Presence of peripheral pulses
  - Temperature of involved extremities
Skilled Documentation

- **Example of Nursing Documentation:**
  - 10:45 AM  Wound #1 posterior left calf has large amount green drainage with foul odor. Wound #1 Measures 3.2 cm x 1.4 cm. Wound bed beefy red after cleansing. Wound #2 posterior left calf 100% necrotic, measuring 1.7 cm x 2.3 cm. Popliteal and pedal pulses weak left leg. Left leg cool to touch.
Example of Nursing Documentation:

- 9:05 AM  Resident medicated with Vicodin 5/300 one tab before scheduled therapy session at 10:00 AM
- 1:15 PM  Resident stated she has pain 8/10 in right hip that radiates into right knee.  Medicated with Vicodin 5/300 one tab at 1:10 PM.  Resident ambulated from chair to doorway in room before lunch.  Transported in wheelchair to dining room.
Continued—

2:10 PM  Resident states pain level improved, now 3/10 with no radiation. Transferred to bed from wheelchair with assist of one for rest period.

8:25 PM  Resident washed upper body with set-up. Needed assist with legs and perineal care. Dressing changed to right hip—incision well-approximated, no drainage present. Wound cleansed and dry dressing applied.
Scenario #5:

A resident with congestive heart failure may require close observation to detect signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medications that serve as indicators for adjusting therapeutic measures.

Let’s say this resident is admitted, but did not develop a further acute episode or complication.
Skilled Documentation

- Scenario #5 (cont.):
  - The skilled observation services for this resident are still covered so long as there was a reasonable probability for such a complication or further acute episode.
  - Reasonable probability means that a potential complication or further acute episode was likely (greater than 50% chance).
  - **Documentation** must support this!
  - Physician documentation must support this as well.
Skilled Documentation

- Assessment/Documentation:
  - Abnormal/fluctuating vital signs
  - Weight changes
  - Edema
  - Symptoms of drug toxicity
  - Abnormal/fluctuating lab values
  - Respiratory changes on auscultation
    - ALL justify skilled observation and assessment
Skilled Documentation

Example of Nursing Documentation:

- Tuesday 10:00 AM  Weight 165 pounds. No edema present in lower extremities. Lung sounds clear on auscultation. Due to recent hospitalization for CHF, will continue to assess lung sounds and monitor weights daily.

- Wednesday 9:45 AM  Weight 169 pounds. 1+ pitting edema right lower extremity, 2+ pitting edema left lower extremity. Slight wheezes present in left lung. Resident stated he is “very tired.” Dr. Smith notified, new orders for chest x-ray and increase in Lasix from 40 mg daily to Lasix 40 mg twice daily.
However...

Observation and assessment by a nurse is NOT reasonable and necessary to the treatment of illness or injury where these characteristics are part of a longstanding pattern of the resident’s “waxing and waning” condition which by themselves do not require skilled services and there is no attempt to change the treatment to resolve them.
Skilled Documentation

- **Teaching and Training Activities**
  - Those that require *skilled* nursing personnel
  - Teaching a resident how to manage their treatment regime
  - Nurses are teachers, all the time, no matter who the resident is
Skilled Documentation

- Teaching and Training Activities
  - Teaching self-administration of injectable medications or a complex range of medications
  - Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot care precautions
  - Teaching self-administration of nebulizers/inhalers to a resident
Skilled Documentation

- Teaching and Training Activities
  - Gait training and prosthesis care for a resident who has had a recent leg amputation
  - Teaching residents how to care for a recent colostomy or ileostomy
  - Teaching how to perform self-catheterization
  - Teaching how to self-administer tube feedings
  - Teaching how to care for and maintain central venous or peripheral intravenous lines
Teaching and Training Activities

- Teaching the use and care of braces, splints and orthotics, and any associated skin care
- Teaching the proper care of any specialized dressings or skin treatments
Skilled Documentation

- Teaching and Training Activities
  - Diabetic
  - Ostomy care
  - Suprapubic catheter
  - Self catheterization
  - Wound care
  - Tube feedings
  - Medication administration
  - Stump care
Skilled Documentation

- Teaching and Training Activities
  - Assess readiness to learn
  - Identify barriers to learning
  - Type of instruction or teaching activity provided
  - Response to instructions
  - Return demonstration
  - Who was taught—resident/caregiver
Skilled Documentation

- **IMPORTANT POINT:**
  - The documentation **MUST** thoroughly describe all efforts that have been made to educate the resident and/or caregiver **AND** their responses to training. The documentation should also describe the reason for the failure of any educational attempts, if applicable.
Scenario #6:

A newly diagnosed diabetic resident is seen today in order to learn how to self-administer her own insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions. Even though she voices understanding of the nutritional principles of her diabetic diet, she expresses dissatisfaction with her food choices and refuses to comply with the education she is receiving. She continues to refuse, even when educated on the potential adverse consequences.

What are you going to teach this resident and what will you document?
Example of Nursing Documentation:

10:25 AM Educated resident and husband on the importance of daily foot inspections. Provided resident with hand mirror and demonstrated how mirror can be used to inspect soles of feet. Educated resident/husband on importance of reporting any breaks in skin immediately to physician. Resident was able to hold mirror and stated she was able to see the bottom of her foot. Resident verbalized understanding by stating she would call the doctor right away if she saw any cuts or open areas on her feet.
Skilled Documentation

- **Documentation** must include the resident’s response to the recommended treatment plan as well as all educational attempts made.

- Teaching and training activities should include **return demonstrations** and the resident and/or caregiver repeating the steps back to the nurse to ensure understanding.
Skilled Documentation

- Audits—Internal and External
  - Do medical records substantiate daily skilled nursing or rehab care provided?
  - Does therapy time billed correspond accurately with therapy time documented in clinical record?
Skilled Documentation

- Audits—Internal and External

  - Do “reasonable and necessary” services qualify as skilled services?
  - Does documentation show resident participation in therapy?
  - Is there measurable evidence of resident progress toward goals?
MDS

- The **daily payment rate** is set by items coded on the MDS
- **Resource Utilization Groups (RUGs)** are assigned and set the daily rate of payment for a specific number of days in the **skilled** benefit period.
- The MDS is coded according to the **supporting documentation** present in the clinical record.
Medical Reviews

It is inevitable that some type of medical review will occur:

- **FI/MAC**—Fiscal Intermediary/Medicare Administrative Contractor
- **RAC**—Recovery Audit Contractor
- **ADR**—Additional Development Request
- **CERT**—Comprehensive Error Rate Testing
- **ZPIC**—Zone Program Integrity Contractors
There are MILLIONS of dollars denied every year and this number will continue to grow...

Why? Because we all too often do not adequately capture the care provided to the residents.

We PROVIDE the care, PAY for the care, but are not CAPTURING the care in the clinical record.

OUTCOME=facility receives inadequate or NO payment for care provided.
Skilled Documentation

- **Increase in Denials of Payments**
  - Denials due to **conflict** between nursing, rehabilitation and MDS documentation.
  - Lack of **documentation** by nursing of medical complexity that supports the need to receive skilled services.
Skilled Documentation

Fraud and Abuse

- Audit reveals **incomplete documentation** for skilled care.
- CMS takes the position that any claims made for payment were **false claims**.
- This can result in demands for refunds and possible allegations of fraud.
Skilled Documentation

- Recommendations--
  - Educate staff on skilled documentation
  - Don’t just tell staff—explain WHY and what the ramifications could be
  - Review documentation on a regular basis and provide re-education as needed
  - Have an effective Triple Check process in place
Bibliography

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QUESTIONS?

Linda K. Lewis, MPM, RN, CNHA, RAC-CT
Director of Clinical Consulting Services
voice: 412-635-6270 | cell: 724-712-0387
e-mail: Linda.Lewis@actcpas.com

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