DOCUMENTATION IN HEALTH CARE – AN UNDERESTIMATED ASSET

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September 1, 2008

One of the most powerful and underestimated tools in health care is clear, concise, timely documentation. In the face of increasing severity of illness and escalating co-morbidity, treatment modalities are becoming more complex and technology is playing a much greater role in health care. Another important variable is the rapidly increasing presence of state and federal regulatory entities defining how we provide quality patient care. Many practitioners fail to focus on documentation, because they perceive it as too time consuming in a complex and challenging health care environment.

Impact of State and Federal Regulation

The Department of Health Care Services (DHCS) and the Department of Public Health (DPH) are state agencies with local offices. The mission of DHCS and DPH is to protect and promote the health status of residents on the state level through the financing and delivery of individual health care services. DHCS and DPH provide focused state leadership in public health and health care financing. Their goal is to create a more effective public health infrastructure on the state level. DHCS or DPH will visit health care facilities to investigate patient or family complaints regarding quality of care, to participate in Joint Commission site surveys and to investigate Serious Reportable Adverse Events as defined by the Centers for Medicare and Medicaid Services (CMS), such as stage 3 or 4 pressure ulcers acquired after admission to an acute or long-term care facility.

The Joint Commission on Accreditation of Hospital Organizations is an independent, not-for-profit organization founded in 1951. The mission of this organization is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services, that support performance improvement in health care organizations. The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States and its accreditation and certification is recognized nationwide as a symbol of quality. In 2002, CMS announced the granting of deeming authority for critical access hospitals to the Joint Commission, and announced its continued approval of the Joint Commission as an accrediting body for review of clinical laboratories under federal Clinical Laboratory Improvement Amendments (CLIA) regulations[1], and as a deeming authority for ambulatory surgery centers. In 2006, The Department of Health and Human Services' Centers for Medicare & Medicaid Services granted The Joint Commission deeming authority to accredit durable medical equipment, prosthetics, orthotics and supplies, as provided by the Medicare Modernization Act of 2003. Joint Commission has established National Patient Safety Goals for the following areas:

- Ambulatory
- Behavioral Health Care
- Critical Access Hospital
- Disease-Specific Care
- Home Care
- Hospital
- Laboratory
- Long Term Care
- Office Based Surgery

[1] Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed (http://www.fda.gov/CDRH/clia/)

The Medicare and Medicaid programs were signed into law on July 20, 1965. The mission of Centers for Medicare and Medicaid Services (CMS) is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. CMS seeks to modernize the American health car system. This organization is highly respected and revered by hospitals, because failure to meet CMS regulations can result in revocation of participation in Medicare and Medicaid reimbursement. CMS is divided into four consortiums or business lines:

- Consortium for Medicare Health Plans Operations
- Consortium for Financial management and Fee for Service Operations
- Consortium for Medicaid and Children's Health Operations
- Consortium for quality Improvement and Survey and Certification Operations

CMS has set very high standards of care for hospitals. The organization has announced that beginning October 1, 2008, Medicare will no longer pay the extra cost of treating the following categories of conditions that occur while the patient is in the hospital. Table 1 is a comprehensive list of Serious Reportable Adverse Events or 'Never Events' as defined by CMS.

- Pressure ulcer staged III and IV;
- Falls and trauma;
- Surgical site infection after bariatric surgery for obesity, certain orthopedic procedures and bypass surgery (mediastinitis);
- Vascular-catheter associated infection;
- Administration of incompatible blood;
- Air embolism;
- Foreign object unintentionally retained after surgery

The standards set by each of the above regulatory agencies are designed to promote quality patient care and to optimize patient safety in an extremely complex and

challenging health care setting. Three key variables in meeting these standards are ongoing training, competency and clear, concise, timely documentation.

The Electronic Medical Record

The electronic medical record (EMR) is steadily being implemented throughout the United States. One of the first areas to undergo conversion from paper to EMR documentation is pharmacy. One of the most common errors in health care is medication error. Manual documentation is not only laborious; it opens the door for error and omission. One of the most useful tools of the EMR is medication reconciliation. Medication reconciliation is a process in which a current list of patient medications is generated, reviewed by nursing and physicians and 'reconciled' by the physician. The physician reviews a list of current medications (on admission), prescribes or discontinues medications as indicated, and creates a revised list of medications for discharge. Kramer, et al (2007) found that "Patients who had their medications electronically reconciled reported a greater understanding of the medications they were to take after discharge from the hospital, including medication administration instructions and potential adverse effects." The EMR is used to track and document every aspect of patient care. The advantages are speed, efficiency, built in 'stop-gates' to prevent omissions and an electronic signature. One of the biggest obstacles of manual documentation is the inability to decipher hand-writing.

The EMR comes with disadvantages as well. Many patients and practitioners express concern that electronic medical records might be hacked and exploited by others. Introduction of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 (known as the Privacy Rule), has created an environment where confidentiality is now

one of the first considerations of medical treatment. Just how many people might have access to all one's medical records is a valid concern. Misuse of private medical information could create problems for people who have conditions they wish to keep private. A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being.

Documentation and Quality Outcomes

Many hospitals are seeking 'Magnet® Status'. "Magnet status is awarded by the American Nurses' Credentialing Center (ANCC) to hospitals that satisfy a set of criteria designed to measure the strength and quality of their professional practice (Kaplow, 2008). To achieve Magnet® Status, a hospital must be identified in the excellent delivery of all services to patients, in the promotion of quality in a milieu that supports professional practice, and in providing a mechanism for the dissemination of "best practices" in patient care services. To reach this goal, a myriad of leadership, cultural and organization factors must converge into a partnership. Hospitals achieving Magnet® status clearly understand and maintain compliance with DHCS/DPH, Joint Commission and CMS standards, because it all boils down to establishing and maintaining quality. Britt et al (2005) developed a conceptual model for translating evidence into clinical practice;

1. Assess need for change in practice;
2. Link problem intervention and outcomes;
3. Synthesize best evidence;

4. Design practice change;
5. Implement and evaluate change in practice;
6. Integrate and maintain change in practice

This simple and straight forward process may be used throughout a health care organization. Brier (2007) conducted a Heart Failure (CHF) Quality Improvement Project in 2003. The components of the program were (1) a comprehensive educational program for nurses about heart failure; (2) extensive coaching of staff by the cardiovascular clinical nurse specialist for heart failure; and (3) documentation tools specific to the CHF population. Results of the project found that a trend toward improved compliance in documenting patient education, a decrease in the readmission rate of patients within 90 days, and a significant difference in nurses' satisfaction with the tools available to them. Goolsby (2006) describes the 'Four C's' regarding malpractice and risk management, (1) Caring, (2) Communication, (3) Competence and (4) Charting (documentation).

Conclusion

Clear, concise, timely documentation promotes compliance with state and federal regulation and most importantly, establishes accountability of health care providers. While manual documentation is cumbersome and often viewed as too time consuming, introduction of the EMR promises to save time allowing health care providers to devote more time to direct patient care and provide clarity, with documentation that is easy to read. It is evident that documentation benefits all involved, whether it be patients, families, health care providers, legal nurse consultants or lawyers. My motto is "You can never document too much, but you can definitely document too little." The EMR

presents the opportunity for documentation to finally gain recognition as a valuable asset to health care providers.

TABLE 1

RELATIONSHIP OF HOSPITAL-ACQUIRED CONDITIONS TO THE NATIONAL QUALITY FORUM'S LIST OF SERIOUS REPORTABLE ADVERSE EVENTS ("NEVER EVENTS")

Current NQF Serious Reportable Adverse Events	CMS' Hospital-Acquired Conditions
Surgical Events	
Surgery on wrong body part	
Surgery on wrong patient	
Wrong surgery on a patient	
Foreign object left in patient after surgery	Current
Post-operative death in normal health patient	
Implantation of wrong egg	
Product or Device Events	
Death/disability associated with use of contaminated drugs, devices or biologics	
Death/disability associated with use of device other than as intended	
Death/disability associated with intravascular air embolism	Current
Patient Protection Events	
Infant discharged to wrong person	
Death/disability due to patient elopement	
Patient suicide or attempted suicide resulting in disability	
Care Management Events	
Death/disability associated with medication error	
Death/disability associated with incompatible blood	Current
Maternal death/disability with low risk delivery	
Death/disability associated with hypoglycemia	Proposed
Death/disability associated with hyperbilirubinemia in neonates	
Stage 3 or 4 pressure ulcers after admission	Current
Death/disability due to spinal manipulative therapy	
Environment Events	
Death/disability associated with electric shock *	Current
Incident due to wrong oxygen or other gas	
Death/disability associated with a burn incurred within facility *	Current
Death/disability associated with a fall within facility *	Current
Death/disability associated with use of restraints within facility	
Criminal Events	
Impersonating a heath care provider (*i.e.*, physician, nurse)	
Abduction of a patient	
Sexual assault of a patient within or on facility grounds	
Death/disability resulting from physical assault within or on facility grounds	

* Death/disability associated with electric shock, burns, or falls within a facility are grouped for purposes of the Hospital-Acquired Conditions into one HAC (http://www.cms.hhs.gov/apps/media/press/factsheet.asp)

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