MEDICAL RECORD DOCUMENTATION IN SUPPORT OF THE CRITICAL ELEMENT PATHWAYS

PADONA Annual Convention

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Disclaimer:

The information included in this presentation was current at the time that it was developed. Medicare policy changes frequently so there may be changes to what is included here after this session is completed.

Objectives

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1. Learners will be able to identify the critical element pathways provided by CMS as guides to assist in preparation for survey.
2. Learners will be able to correlate medical record documentation to the critical element pathways.
3. Learners will be able to recognize the guidance provided for the survey process in the critical element pathways.

CMS Survey Process

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CMS Survey Process Requirements

- Nursing home surveys are conducted in accordance with survey protocols and Federal requirements to determine whether a citation of non-compliance appropriate.
- The consolidated Medicare and Medicaid requirements of participation were first published in the Federal Register on February 2, 1989 (54 FR 5316).
- These requirements of participation were recently revised to reflect the changes in practice and theory of service delivery and safety for resident care and were initially effective November 28, 2016.
- Survey protocols and interpretive guidelines serve to clarify and/or explain the intent of the regulations.
- Deficiencies are based on violations of the regulations, which are to be based on observations of the nursing home's performance or practices.

CMS Long Term Care Survey Process

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- The Long Term Care Survey Process (LCTSP) Procedure Guide provides instruction on the procedural and software steps necessary for completing the LTCSP.
- Procedure Guide for all standard surveys of SNFs and NFs, whether freestanding, distinct parts, or dually participating.
- LTCSP steps are organized into seven parts: 1) offsite preparation; 2) facility entrance; 3) initial pool process; 4) sample selection; 5) investigation; 6) ongoing and other survey activities; and 7) potential citations.

CMS LTCSP: Initial Pool Process

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Initial Pool Process

- Completed in the first 8 – 10 hours on site.
- Entails screening all residents in the facility and narrowing down to an initial pool of about eight residents per surveyor.
- Surveyors complete an observation, interview (if appropriate), and **limited record review** for the initial pool residents to help the team further narrow residents from the initial pool to identify residents who should be in the sample.
- Surveyors use the survey software to complete an interview (if possible), observation, and **limited record review** for each initial pool resident.

CMS LTCSP: Sample Selection

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- The expected sample size is based on facility census. At the start of the survey, the offsite selected residents chosen based on **MDS indicators** make up 70% of the expected sample size.
  - Medical record documentation must support the coding of the MDS
  - MDS support documentation must take the next step to not only note the coded item but address it in terms of intervention and monitoring for effectiveness

CMS LTCSP: Documentation

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- Resident who are non-interviewable, refused, or unavailable, record is reviewed for the following information:
  - **Pressure ulcers,**
  - **Dialysis,**
  - **Infections,**
  - **Nutrition** (% weight loss)**,**
  - **Falls** in the last 120 days**,**
  - **ADL decline** in the last 120 days**,**
  - **Low risk bladder and bowel (B&B),**
  - **Unplanned hospitalizations, elopement** and **change of condition** in the last 120 days**.**

CMS LTCSP: Documentation

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- Residents in the initial pool currently receiving **insulin, an anticoagulant, an antipsychotic with a diagnosis of Alzheimer's** or **dementia**, or has an appropriate diagnosis but is not receiving **PASARR Level II** services, will have record reviewed to confirm the information**.**
- Newly admitted residents in the initial pool who did not have an MDS, will have a medical record documentation review completed to identify current **high risk meds** and **hospice.**

CMS LTCSP: Documentation

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- Selection of residents for three closed record review:
  - **D**eath, hospitalization and community discharge
- The survey team may use discharged offsite selected residents, complaint or FRI residents, or another resident who had a concern brought to the attention of the team to replace system-selected residents for the closed record reviews, as long as the discharged offsite selected residents fit the required discharge types.
  - For example, if there is an active **complaint resident** regarding a death, the complaint resident may be reviewed for death even if there is an offsite selected resident

CMS LTCSP: Critical Element Pathways

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- Critical Element Pathways available at:
  https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.htmll

Revised December 2017

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- Medical record documentation includes:
  - All portions of the medical record: all disciplines, diagnostic reports, assessments, progress notes, physician orders, etc.
  - Care Plans
  - Restorative nursing documentation
  - Bathing and toileting schedules and documentation
  - Behavior monitoring records
  - MDS Assessments
- If an area is of concern for the surveyors and there is not a critical element pathway, it will be evaluated

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Where to begin with medical record documentation

- Evaluate previous medical record documentation deficiencies, recommendations or concerns from 2567
- Review medical record documentation deficiencies being cited in facilities in your field office area
- Review medical record documentation deficiencies being cited in the state

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Before addressing the critical element pathways:

- Evaluate the federal regulatory requirements (F tags)
  - Regulation intent
  - Definitions in the regulation
  - Interpretive guidance for the regulation
  - Investigative summary and probes
  - Key elements of noncompliance (new section added to some F tags)
  - Potential tags for additional investigation

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Sufficient and Competent Nurse Staffing

- Facility Assessment correlating to the actual staffing levels
- Addressing changes in resident condition to prevent/avoid negative outcomes or harm
- Addressing actual negative outcomes using standard of practice/care and adhering to policies/procedures/protocols
- Focus on hospitalizations and determination if they could have been avoided by earlier recognition of condition changes
- Evaluation of the need for position change alarms and included in care plan
- Evaluation of devices used to ensure they are not restraints

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Sufficient and Competent Nurse Staffing

- Addressing pain management and behavioral changes with care planning
- Care plan for residents who prefer to eat in their rooms and who prefer to have medications administered with meals
- Addressing resident preferences in the care plan for waking, bathing and going to sleep as well as preferred name
- Competency evaluations and documented education
- Routine communication of resident care needs and changes to caregivers
- Addressing specific items associated with the resident diagnoses/condition

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QAA and QAPI (F865, F867 and F868)

- Documentation includes the written QAPI plan (F865) (which is not in the medical record) and potentially the minutes
  - Plans of action are identified, developed and implemented to correct identified quality deficiencies (F867)?
  - QAPI committee demonstrates “good faith attempts” to identify and correct quality deficiencies
    - Systematically investigates and analyzes concerns and adverse events
    - Identifies deviations from standards
    - Addresses with corrective action and monitors for effectiveness

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Freedom from Neglect

- Documentation reveals that standards of care/practice are followed in daily resident care
- Facility policies, procedures and protocols are noted in documented resident care
- Is resident care documentation evaluated to ensure that missing documentation does not reveal missed care?
- Does medical record documentation of resident care correlate to the care plan/plan of care for the resident ?
- Documentation verbiage

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- Freedom from Abuse
- Documentation reveals that standards of care/practice are followed in daily resident care
- Facility policies, procedures and protocols are noted in documented resident care
- Residents do not appear with injuries that have not been addressed in the medical record
- Event reports correlate to medical record documentation of injuries
- Resident physical injuries documented include description of injury and resident statement of how injury occurred
- Behavior and pain documentation before and after the physical injuries

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Freedom from Abuse

- Significant changes in resident behavior/pain/status among caregivers noted in documentation
- Documentation verbiage
- Medication administration – especially pain and sedatives
- Notification of attending physician and representative of physical injuries
- Monitoring and addressing changes in condition

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Hospitalization

- MDS coding and support documentation for resident status and changes between assessments
- Care plan addressing signs and symptoms to monitor demonstrating exacerbation of medical conditions
- Physician's orders for treatment related to changes in condition that may have prevented hospitalization
- Notification of physician/physician extender and timeliness
- Notation of signs and symptoms and documentation of management interventions with evaluation of effectiveness

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Hospitalization

- Progressive change in condition or emergent and management
  - Mental status changes
  - Pain level changes
  - Physical distress/symptoms
  - Behavioral/mood changes
  - Changes in previous status
- Change in condition addressed based on standards of practice/care and monitoring for effectiveness of treatment
- Does care provided and transfer to hospital reflect resident preference?
- Documentation upon return addresses the rationale for transfer and current status
- Care plan evaluated ad adjusted based on the changes upon readmission

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Accidents

- MDS coding from the most recent assessment and support documentation to determine resident status
- Event reports addressing:
  - Physical injuries
  - Elopements
  - Entrapments
  - Aberrations from facility policy such as smoking policy
  - Resident altercations
  - Falls
  - Medication errors
- Care plan addresses each of these as applicable

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Accidents

- Care plan addresses level of assistance/supervision required by resident and documentation reveals that it was delivered
- Progress notes address behaviors before and after the accident and if unusual for resident that they were noted and addressed i.e. new wandering before an elopement
- Resident altercations
  - Staff response to changes in mental status and/or mood of involved residents
  - Staff response to pre-altercation behaviors that may have been indicative of potential for altercation such as yelling at other resident
  - Care plan for potential of altercations with pre-altercation behaviors to monitor

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Accidents

- Resident falls
  - Fall prevention interventions care planned and documented
  - Regular and routine IDT evaluation of resident related to fall risk
  - Orders for and referral to rehabilitation therapy
  - Evaluation of fall prevention interventions to ensure that they are not restraints, are the least restrictive and are effective
  - Documentation at the time of the fall of the condition of the resident, location of the resident and addressing interventions

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Accidents

- Entrapment/Safety
  - Assistance required with bed mobility and transfers is care planned and documented and correlates to MDS coding in section G
  - Are physical restraints identified, evaluated and addressed in care plan and documentation per standards and policies?
  - Bed rails and other devices are included in the care plan, documented in progress notes and meet standards of care and facility policies
    - Safety checks
    - Bed measurements
    - Application and removal
    - Entrapment evaluation

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Accidents

- Areas that should be addressed in documentation include:
  - Assistive devices for function in the care plan and documented
  - Medical equipment needs such as oxygen, IV pumps and lifts should be care planned and documented as used
  - Resident ability to safely manage poisonous materials
  - Resident noted wandering or exit seeking should be included in the care plan and documented at the time along with how it was addressed and if that was effective

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Infection Prevention and Control

- Isolation: documentation of the type and why used should be included in progress notes, care plan, orders and MDS
- Signs and symptoms of the infection and treatment
- Timeliness of antibiotic initiation from time of results of positive culture
- Evaluation of effectiveness of antibiotic use
- Documentation of evaluation for adverse effects following resident immunizations

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Physical Restraints

- Documentation of change in status/medical symptoms or need leading to the need for the restraint device
- Evaluation of all devices used for/with residents to ensure that they do/do not meet the criteria for physical restraints
- Care plan all restraints and document: chemical and physical
  - Device used - Frequency and duration
  - Symptoms of decline to monitor for negative outcome
  - Interventions to attempt to prevent use of restraints

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Physical Restraints

- Consent forms for use of restraints
- Routine evaluation of restraints for effectiveness, potential to eliminate and that it is least restrictive device
- Resident response to restraint use
- Complications potentially associated with restraint use
- Addressing standards of practice/care and facility policy for restraint use and documentation

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Pressure Ulcer/Injury

- MDS assessment sections M, K, G, J and H for resident current status
- Physician's orders for wound treatment and initiation of treatment
- Admission skin evaluation/assessment
- Frequency of skin evaluations/assessments and risk assessments following admission
- Documentation that identified risk factors are addressed
- Documentation of monitoring effectiveness of skin at risk interventions and effectiveness of wound treatments
- Diagnosis that is relevant to development of pressure ulcer/injury

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Pressure Ulcer/Injury

- Documentation of wound treatments at the ordered frequency and duration
- Documentation of pain management related to the wound treatments/wound care
- Documentation of resident tolerance of wound treatment and prevention interventions
- Care plan should include:
  - Pressure relief devices used
  - Repositioning schedule
  - Wound treatment
  - Frequency of risk assessments

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Pain Recognition and Management

- Timeliness of implementation of pain management interventions from time of MD orders
- Relevant diagnosis that would result in pain
- Evaluation of pain risk, tolerable levels and interventions that are/have been effective to manage pain on admission and routinely and how resident expresses pain
- Documentation of resident expressions of pain and how it was addressed
- Effectiveness of pain management program including both pharmacological and non-pharmacological interventions

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Pain Recognition and Management

- Frequency of pain evaluation
- Care plan should include:
  - Activities that elicit pain
  - Pain management interventions
  - Frequency of pain monitoring
  - Tolerable level of pain
  - How resident expresses pain
  - Pain prevention methods
- MDS coding and CAA documentation for sections G, J, O, C, K and L for resident status

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Unnecessary Medications/Psychotropic Medications/ Medication Regimen

- Documentation reveals standards of practice/care
- Documentation reveals signs and symptoms that indicate use and that other interventions have been ineffective
  - Signs and symptoms or related causes are persistent or clinically significant (for example with a functional decline) to warrant initiation and continuation
  - Actual benefit is documented and outweighs the adverse consequences
- Documentation of monitoring of potential adverse effects and if present, they were addressed
- Documentation of evaluation of resident need for each classification of medications at the time of symptoms and as needed thereafter

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Unnecessary Medications/Psychotropic Medications/ Medication Regimen

- Care plan should include:
  - Symptoms requiring medication
  - Signs of effectiveness of medications
  - Non-pharmacological interventions attempted before medication
  - Frequency of evaluations for necessity and effectiveness

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Specialized Rehabilitation or Restorative Services

- Most recent MDS assessment coding in sections G, C, H, J and O
- Rehabilitation therapy treatment that does not initiate until there is a physician's order for treatment
- Relevant diagnosis to support functional mobility decline and the need for rehabilitation or restorative services
- Documentation of carry over of compensatory strategies from treatment services into daily care

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Specialized Rehabilitation or Restorative Services

- Effectiveness of pain management prior to treatment
- Resident refusals to attend treatment services and how this was addressed
- Care plan should include:
  - Assistance level with functional mobility
  - Premedication before/after treatment
  - Approaches used in treatment that should be extended to daily care

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Dementia Care

- Treatment and care reflects standards of practice
- Care is person centered and individualized
- Non-pharmacological interventions used to attain well-being
- Documentation reflects resident preferences and maximizes resident dignity
- Care plan should include:
  - Resident individualized care goals
  - Person centered preferences for care and well-being
  - Environmental modifications required
  - Residents current level of function and cognition
  - Approaches to attain and maintain function and well-being

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Respiratory Care

- Documentation to demonstrate care delivery based on diagnosis, symptoms and physician orders
- Relevant diagnoses related to the respiratory care needs
- Documentation of respiratory care delivery based on standards of practice
- Assessments/evaluations to support the delivery of respiratory care services
- Documentation of signs and symptoms when prn treatments are provided
- Care plan should include:
  - Signs and symptoms of exacerbation
  - Frequency of evaluations
  - Equipment required for resident care
  - Frequency and duration of treatments
  - Adverse reactions to treatments

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Dialysis Care

- Documentation of monitoring of renal signs and symptoms
- Documentation of monitoring and care of dialysis access site
- Monitoring of lab work, weights and vital signs between dialysis sessions
- Documentation of monitoring for adverse reactions to dialysis including complications such as hemorrhage, infection at access site, hypotension
- Care plan should include:
  - Who to call with concerns
  - Signs and symptoms of condition change
  - Complications to observe for
  - Average levels for measurements
  - Location of dialysis treatment
  - Resident preparations for dialysis

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Tube Feeding Status

- Relevant diagnosis supporting the need for the tube feeding
- Documentation of evaluation of tube placement, residual and delivery of feeding and flushes per physician orders
- Documentation of pleasure feedings or other feedings prior to tube feeding
- Resident tube feeding tolerance and safety measures
- Evaluation of tube stoma site
- Care plan should include:
  - Physical measure parameters - Type of feeding and how administered
  - Frequency of feedings - Amount of feedings
  - Safety interventions such as elevating head of bed

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Urinary Catheter or UTI

- Care related to the urinary catheter reflecting standards of practice
- Evaluation of continued need for urinary catheter
- Relevant diagnosis for use: urinary obstruction/neurogenic bladder
- Description of the urine: color, consistency, flow, etc.
- Evaluation of the meatus at the catheter insertion site
- Resident tolerance/related behaviors/removal attempts
- Care plan should include:
  - Catheter size
  - Frequency of change
  - Signs and symptoms of complications
  - Expected duration for use
  - Catheter care instructions
  - Diagnosis for use

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Urinary Catheter or UTI

- Signs and symptoms of the UTI
- Demonstration of effectiveness of treatment or exacerbation
- Initiation of treatment with physician orders
- Non-pharmacologic interventions for treatment
- Care plan should include:
  - Signs and symptoms to monitor
  - Pharmacologic and non-pharmacologic treatment
  - Expected duration of treatment and symptoms
  - Prevention interventions for caregivers

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Bladder of Bowel Incontinence

- MDS assessment coding for sections C, G and H and CAAs
- Documentation of timely interventions to prevent or reduce
- Effectiveness of interventions
- Skin integrity
- Resident tolerance of interventions and acceptance
- Care plan should include:
  - Toileting device used
  - Assistive devices required
  - Incontinence products used
  - Frequency and type of toileting program
  - Assist level required
  - Skin concerns to monitor

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Communication and Sensory Problems

- Method for communication of needs
- Effectiveness of communication and sensory devices
- Diagnoses that are related to the communication/sensory problems
- Care plan should include:
  - Specific communication and sensory problems
  - Devices used to assist resident and where they are maintained
  - Environmental factors affecting resident communication and sensory problems
  - Treatment being provided
  - Frequency of evaluation of communication and sensory problems

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Behavioral and Emotional Status

- Any signs and symptoms of distress and how staff address
- Adhering to instructions provided with the PASARR level II
- Ensuring resident rights and dignity with treatment interventions
- Evaluation of treatment interventions to ensure they do not meet criteria for restraints
- Implementation, monitoring and effectiveness of non-pharmacological treatment interventions
- Care plan should include:
  - Signs of distress - Non-Pharmacologic treatment interventions
  - Risk factors to monitor - Symptoms of decline

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Activities of Daily Living

- MDS assessment evaluation of sections C, E, G, F, J and O
- Resident self-performance and support provided during self care tasks and functional mobility
- Referral to rehabilitation or Restorative services when there has been a change in the resident status
- Care plan should include:
  - Level of assistance required
  - Devices required for functional mobility
  - Environmental approaches to ADLs
  - Compensatory strategies from treatment to be completed in daily care

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Discharge

- Documented discharge plan with information about the location
- Discharge education that initiates on day of admission using lay terms
- Resident demonstration of understanding/comprehension of discharge instructions with return demonstration when applicable
- Addressing progress toward discharge plan and achievement of goals related to discharge plan
- Discussions with resident related to discharge plan and progression toward the plan
- Involvement of representatives in the preparations for discharge, including education

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Discharge

- Documentation of expected equipment needs for discharge location and resident specific needs
- Documented specific discharge instructions
- Information on discharge to the primary care physician
- Care plan should include:
  - Discharge plan - Equipment needs
  - Community contacts required - Education required
  - Any changes to the discharge plan or the needs for discharge

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Hospice and End of Life Care

- Comfort care interventions implemented included skin evaluations, positioning, range of motion, suctioning, pain management, nutrition and hydration, etc.
- Referral to rehabilitation therapy to attain/maintain comfort
- Measurements and care delivery not being provided to maintain comfort
- Physical signs and symptoms assessed/evaluated
- Care plan should include:
  - Comfort measures to be provided
  - Care not to be provided
  - Signs and symptoms to monitor as a change in status
  - Advance directive
  - Care requirements
  - Hospice provider

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Death

- Physical status changes approaching the time of death
- Assessments/evaluations of critical elements
- Care delivery to address medical/physical needs while maintaining rights, dignity and preferences
- Addressing and implementing comfort care measures
- Notification of attending physician and representative
- Addressing pertinent items from the care plan

Questions

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QUESTIONS

Thank You

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