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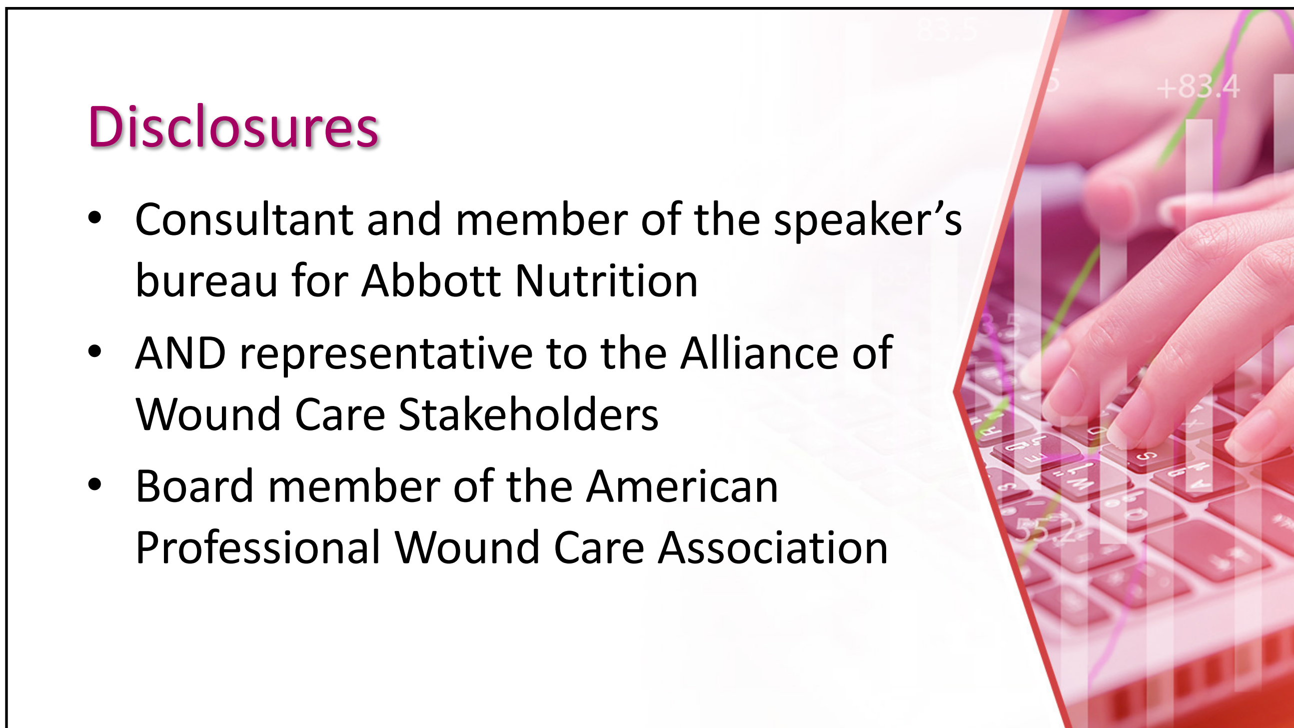

2

Maryland is 1 of 3 Below Average Nursing Home States in the Mid-Atlantic Region

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MARYLAND

2019

Overall Grade	Overall Rank
D	33

Previous Report Card

Overall Grade	Overall Rank
D	33

- Maryland's overall nursing home ranking did not improve nor did it worsen over the last year, making it one of only four states with no change.
- Maryland's nursing homes, once again, spun the wheels of mediocrity, scoring an above average grade in only one reviewed measure while losing ratings ground in nearly half of all measures.
- Despite a nominal decrease in professional nursing hours per resident, Maryland actually posted a better grade in the category when compared to other states, indicating a downward trend in the measure nationally.
- Regulatory problems continued to plague Maryland's nursing homes; 96 percent were cited one or more deficiencies.
- The percentage of Maryland nursing homes with above average direct care staffing levels slumped nearly 50 percent since the last report card; dropping the state a full letter grade in this category.
- Maryland is 1 of 3 below average nursing home states in the Mid-Atlantic Region.

With Proper Care, Nursing Home Patients' Should Not Develop Pressure Sores
Our Bed Sore Lawyers Hold Facilities Accountable
(800)
Nursing Home Law Center LLC

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Today's Agenda

- Describe the physician orders and care areas that frequently lead to concerns in the medical record
- Understand documentation issues surrounding body weight measurement
- Discuss how to implement a minimum of three strategies to improve documentation and patient care

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4

Why Document?

- Professional and legal duty to keep records
- Serves as
  - Communication tool
    - Continuity of care
  - Basis for coding and billing
  - Legal record of care provided

Gutheil TG. Fundamentals of Medical Record Documentation. *Psychiatry (Edgmont)*. 2004;1(3):26-28.

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The Old Adage…

- If it wasn't documented, it wasn't done
  - Still holds true today
- Electronic Health Records (EHR)
- Handwritten records
- Combination of both

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The Three "*I*"s of Poor Documentation

- Incomplete
- Illogical
- Illegible

Let's look at an example of each

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Avoid Meaningless Words and Phrases

- Weight is better this week
  - Eating more this week
- Wound is improving or healing
- Describe the wound thoroughly
  - Size
  - Color
  - Odor
  - Drainage
  - What you see and feel

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Wound Documentation

- Not every wound is a pressure injury
- *Present on admission* documentation requires a real head-to-toe examination
- Keep your dimensions consistent
  - Length x width x depth
- Know your anatomy
  - Buttocks, sacrum, coccyx are different
  - Know your left from your right

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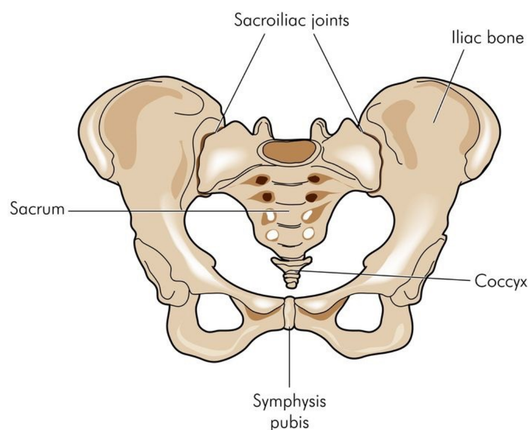
Sacrum or Coccyx



- The sacrum is a large, flat triangular-shaped bone located below L5 and in between the hip bones.
- The coccyx is the tailbone and is located just below the sacrum.
- The coccyx is closer to the anus and only protrudes while seated making it harder to palpate.

Eidelson SG. Spinal Anatomy: The Sacrum and Coccyx. Spine Universe. Available at https://www.spineuniverse.com/anatomy/sacrum-coccyx

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Intake & Output Records (I & Os)

- *Intake:* all the liquids consumed, either orally, enterally or intravenously, in a 24-hour period
- *Output:* mainly urine output, although other loses such as excessive sweating or vomiting also are considerations

Ling WW, Ling, LP. Improvement in Documentation of Intake and Output Chart. Intl Jrnl of Public Health Research Special Issue 2011, pp (152-162. Available at http://journalarticle.ukm.my/3549/1/special%2520issue%25202011_22.pdf.

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I & Os and Incontinence

- Simply writing the word *incontinent* across the entire output section makes no sense
- In this case, only intake is being recorded
- If that is the intention, it should be indicated in the physician's order
- Evaluate policy on I & Os
  - Who, when, how long

11

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3- Day Calorie Counts

- Ordered for patients suspected of eating poorly
- Labor intense
- Readily available anthropometric and biochemical data may be as good an indicator of inadequate dietary intake

Breslow RA, Sorkin J. Comparison of One-Day and Three-Day Calorie Counts in Hospitalized Patients: A Pilot Study. Jrnl of the Am Geriatrics Society. 41. 923-7. 10.1111/j.1532-5415.1993.tb06756.x.

12

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Weight Records

- Often make no sense
- Stated weight vs. measured weight
- Scale calibration
- Casts, positioning devices, blankets, diapers can all cause discrepancies
- Evaluate policy on weights
  - Who, when, how long

Collins N, Friedrich L. Why Worry About Body Weight Measurements? OWM Vol 55 Issue 11. Available at https://www.o-wm.com/content/why-worry-about-body-weight-measurements.

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Fluid Balance and Weight

- One liter of fluid weighs 2.2 pounds
- Cannot explain all weight change by edema or diuretic usage
- Use logic!
  - For someone to lose 10 pounds of weight due to fluids that would be 4.5 liters

https://www.reference.com/science/many-pounds-liter-water-weigh-1e026674d8fac3c1

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Weight is Erroneous

- March 4 179.4 pounds
- March 10 157.9 pounds OUTLIER
- March 11 181.0 pounds
- March 25 179.9 pounds
- Note on March 10: Measured weight today reflects loss of 21.5 pounds in past week. Based on meal intake of >75% of all meals, no nausea or vomiting, and no change of medical condition this seems questionable. Will weigh again tomorrow to determine accuracy.

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Weight is Erroneous (contd.)

- Note on March 11: Weight today reflects consistency with baseline weight. Will disregard weight on March 10 as an outlier and continue to monitor weekly weights for four additional weeks to confirm trend.

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More Common – The Slow Decline

- March 4 179.4 pounds
- March 10 176.9 pounds
- March 17 175.1 pounds
- March 25 168.5 pounds
- March 31 171.6 pounds

Net loss of 7.8 pounds or 4.4%

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The Slow Decline (contd.)

- Documentation should include more than net loss
  - Look for root cause
  - Examine meal/snack intake
  - Interview (if possible)
    - Use quotation marks for things patient tells you
  - Make a plan

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Data Collection v. Intervention

- Weigh weekly
  - Reweigh
  - Monitor weights
- Speak to MD/PA
  - Discuss at care plan meeting
- Get labs
- Continue to monitor
  - Follow prn

This is not a plan.

This is data collection.

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Interventions Must Address Root Cause

- **Poor appetite**
  - Small, frequent meals
  - Cultural and favorite foods
  - Fortified foods to get "more bang for the bite"
- **Dry mouth**
  - Provide ice chips, popsicles, or moistened swabs
  - Keep lips moistened with petroleum jelly or lip balm
- **Mouth pain**
  - Soft and bland , non-irritating foods
- **Constipation**
  - Add extra fiber as tolerated (start slow and gradually increase)
  - Serve additional liquids – prune juice can be helpful to some
- **Diarrhea**
  - Avoid "trigger foods" that stimulate the bowels/ diarrhea (simple sugars, sugar alcohols, caffeine, alcohol, high fiber, and gas producing foods)
  - Add fluids and electrolytes to prevent dehydration with diarrhea
- **Nausea or vomiting**
  - Serve bland foods (crackers, toast)
  - Limit sights, sounds, smells that trigger nausea/vomiting
- **Altered taste and smell**
  - Plastic silverware if taste is metallic
  - Experiment with seasonings/flavoring (lemon juice, vinegar, herbs, etc)

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Positive or Insidious Weight Loss?

[redacted] CENTER
DIETARY PROGRESS NOTE

RESIDENT NAME: [redacted] ADMISSION DATE 3/9/[redacted] MR# [redacted]

PHYSICIAN [redacted] DATE 11/9/[redacted]
PREVIOUS DIET ORDER: Pureed CURRENT DIETRDER Mech Soft
SUPPLEMENT / SNACKS: House Shake
WT 112.7 WT CHANGE SINCE LAST REVIEW 11.8% wt ↓ IBW 98%
USUALWT 127 HT 58.8"
WOUNDS / SKIN: no skin tear.
FEEDS SELF: ASSIST W / MEALS: ✓ TOTAL FEED TUBE FED
LABS: No New labs work.

SUMMARY: Resident has wt ↓ of 11.8% since last review. will talk to P.A about wt ↓ loss but, her IBW Range is 81%-101% - so (+) wt ↓ loss [redacted] 11/9/[redacted]

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Things That Make Me Go Hmmmm

- Precise meal percentages e.g. 76.8% of dinner
- Eating in the nursing home while out at the hospital
- Height of 5’8” in hospital and 5’4” in the long-term care facility

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Beware of Copy/Paste

- Propagating errors
- Chronology errors
- “Note bloat”
- Provenance should be preserved

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What Does This Say?

Coumadin
Avandia

25 U/hr
25 cc/hr

24

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Abbreviations Can Cause Confusion

- MVI
  - Multi-vitamin
  - Multi vitamin injection/infusion
  - Motor vehicle incident
  - Mitral valve insufficiency
  - Major vascular injury
  - Malaria vaccine initiative

All Acronyms. Available at https://www.allacronyms.com/_medical/MVI

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Steps for Improving Documentation

- Identify your weak areas
  - Chart audits
  - Peer reviews and/or consultants
- Review policies for weak areas
  - Eliminate unnecessary orders unless the reason for obtaining data is clear
- Revise data collection forms and tools

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Develop Good Charting Habits

- Verify orders and information for yourself
- Document who you spoke with
  - "Daughter" or "daughter Eileen Jones"
  - "Notified doctor's office"
- Do not use work email for personal use or personal commentary on workplace
- Understand Charting by Exception (CBE)

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Records Play a Key Role in Litigation

- Health records assist in:
  - Reconstructing events
  - Establishing times and dates
  - Refreshing long faded memories
  - Resolving conflicts in testimony
- Plaintiffs look for breaches in the standard of care

HIROC. Strategies for Improving Documentation: Lessons from Medical-Legal Claims. Available at https://www.hiroc.com/getmedia/9b3d1ed1-b2e1-45fc-ae18-bfc998177d15/Documentation-Guide-2017.pdf.aspx.

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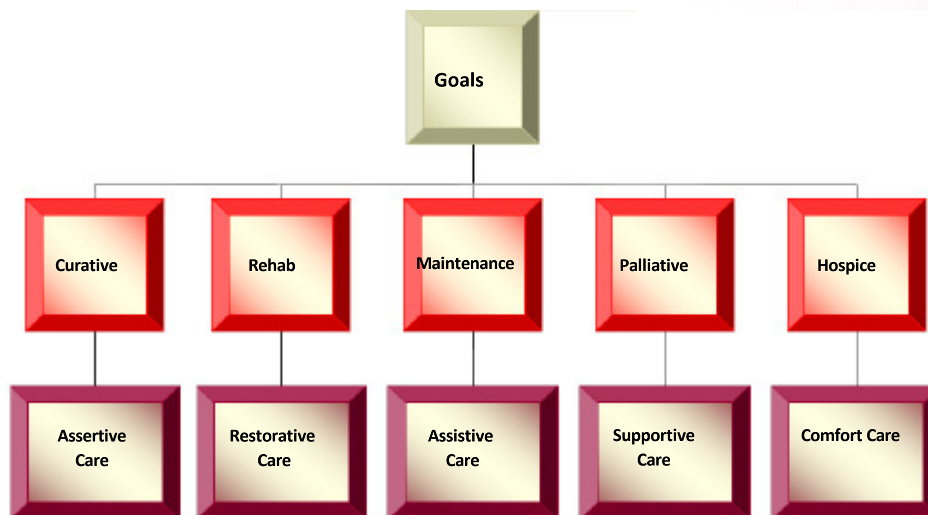
Document Your Realistic Goals



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Addressing Weight Loss at End of Life

- Adequate nutritional intake is often difficult, if not impossible, for the person at end of life
- Starving people generally want food; dying people do not
- Help family members understand this change in metabolism
  - avoid the use of the word *starvation*

Hospice Patients Alliance. Food, Nutrition, Artificial Feeding Methods, Constipation, and Other Considerations. Available at http://www.hospicepatients.org/hospic28.html.

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Documenting Declining Body Weight

- Weight loss is anticipated
- Communicated to family and team
- Discussion on enteral nutrition
- Hospice services does not mean discontinuation of nutrition care

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Hospice and Palliative Care Differ

	Hospice	Palliative Care
Stage	End-of-Life	Any stage of illness
Life expectancy	< 6 months	As long as necessary
Care or treatment	Comfort or relief	Curative treatment OK
Focus	To provide comfort, care & support for terminally ill	To provide relief from discomforts, symptoms, and stress of a serious illness

NIH National Institute on Aging website. What Are Palliative Care and Hospice Care? Available at https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care.

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Coordinating Care

- 87 yo female admitted May 5
- Records showed skin intact on nursing assessment May 5
- RD assessment done May 13 stated skin intact
- Nursing note May 11 showed stage 2 pressure injury on sacrum

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Thoughts…

- RD copied admission note but didn't read any further
- Adequacy of RD hours
- Wound care team???

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The Story Continues…

- No nutrition issues noted so next nutrition note was due quarterly (about August 11)
- In the interim, patient lost 22 pounds, was eating poorly, sacrum progressed to Stage 3 and two new wounds developed

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Nutrition Quarterly Note

- RD note on August 18
- “Rt. Sleeping during visit. No new labs available. Weight loss noted. Will recommend HS. Will encourage good intake. Will continue to monitor.”

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Wound Care Weekly Note

- Wound care nurse note on August 19
- “Called NP. Orders received for collagenase, MVI, vitamin C, zinc x 4 weeks, and amino acids + HMB BID.”

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Confusion Continues…

- Next RD note September 7
- Mentions MVI, vitamin C and zinc but not amino acids + HMB
- Order sheet shows amino acids + HMB but not on MAR
- Did patient get amino acids + HMB or not?
  - Breach in standard of care
  - Depositions (2 years post) show different responses
    - Should amino acids + HMB go on the MAR?

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Action Plan

- Conduct chart audits regularly
- Identify the common orders and care areas in your facility that cause problems
- Review your policies and forms and revise as needed
- Make an individual pledge to have good charting habits

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Adequate Or Not?

- RDN records the following entry into the medical record: “Spoke with daughter. Does not want TF.”
- Is this documentation adequate and sufficient?

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Inadequate!

- This example of documentation does not include
  - which daughter
  - the method of contact
  - if any education was provided
  - the plan instead of TF

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The Final Question

- Ask yourself this:
  - if another practitioner (e.g. RDN) had to step in and take over the care of this patient, does the record provide sufficient information for the seamless delivery of safe and competent care?

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Thanks for Attending!

Let's discuss…

More questions?

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/lightbulbheath

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