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Wound Care Documentation Across the Multidisciplinary Team

Neely Tolbert Sullivan MPT, CLT-LANA, CDP

Speaker Bio

- Neely Sullivan, PT, CLT-LANA, has worked with diverse client populations ranging from pediatric to geriatric in a variety of clinical settings. These experiences and multiple courses on the topic have allowed her to treat and develop client care programs for clients living with lymphedema and wounds. She has served in multiple levels of regional and corporate management positions. In these positions, Neely has developed policies and worked closely with interdisciplinary teams to ensure that clients living with lymphedema and/or wounds have the opportunity to attain their highest level of function and quality of life. She is a certified lymphedema therapist and has most recently been responsible for the identification, implementation, and evaluation of clinical programs in long-term care settings. Neely currently provides educational support to 13,000+ therapists nationwide as an Education Specialist for Select Rehabilitation. Neely has lectured nationally and at the state level on the topics of Lymphedema and Wound Care Management. She has authored publications focusing on edema and lymphedema management.

- Presenter Disclosure: Financial: Neely Sullivan has received an honorarium for presenting this course. Non-financial: Neely Sullivan has no relevant non-financial relationships to disclose.

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Learning Outcomes

After this course, participants will be able to:

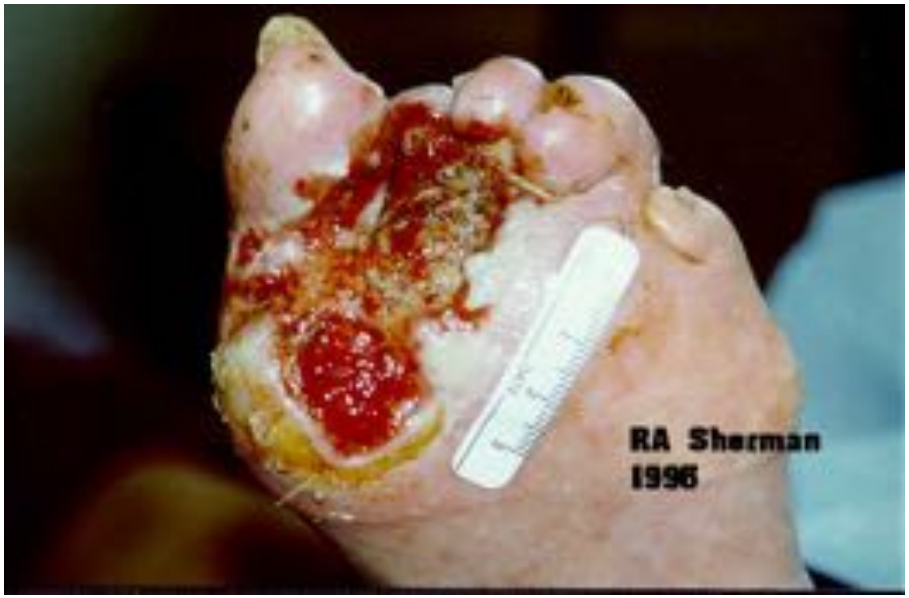
- Define at least two components of resident-centered collaboration between therapy and nursing in wound care.
- Identify the roles of at least three members of the multidisciplinary team in collaboration when addressing wounds in the LTC setting.
- Identify at least three common errors and key elements in documentation to prevent denials.
- Define at least two principles of effective documentation for nursing and therapy to support delivered wound care services.
- Describe at least two aspects of essential wound documentation required for reimbursement.

Overview

Case Study

- Ms. Smith admitted to skilled nursing facility 11/25/20.
- Ms. Smith is a 74 year old female admitted following fall and diabetic ulcer of right foot.
- Medical history: obesity, polyneuropathy, HTN, syncope and collapse, Type 2 diabetes mellitus.
- Findings: Open wound right foot, muscle weakness, balance deficits, difficulty walking.
- Prior functional level: Lived in a private residence alone, Independent for all aspects of ADL's, transfers and ambulation including within the community without an assistive device. Ms. Smith is a master gardener and cares for foster dogs on the weekends.

Case Study



- Describe the wound as you would in an evaluation.
- Write 1 goal for Ms. Smith.

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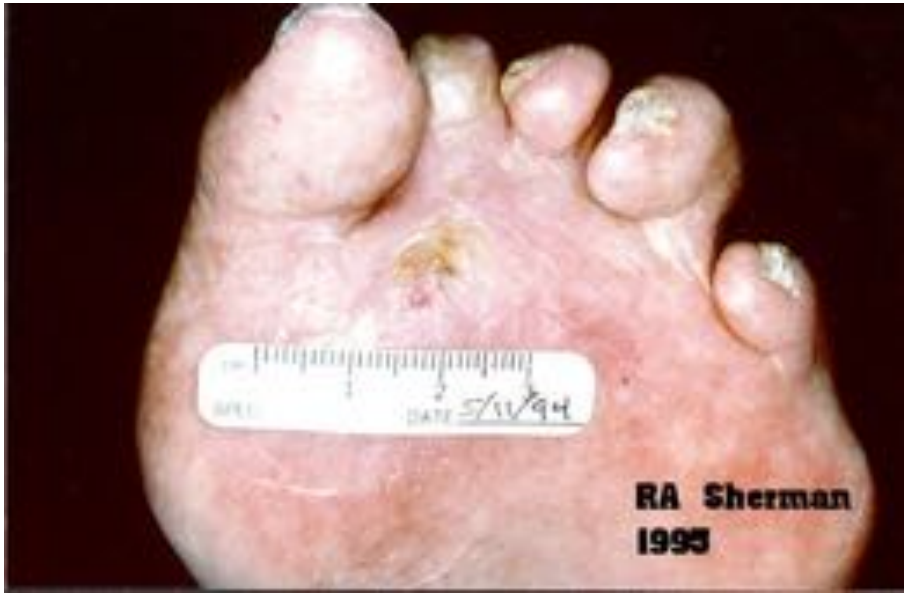
MEASURE

- Measure: length, width, depth, and area
- Exudate: quantity and quality
- Appearance: wound bed, including tissue type and amount
- Suffering: pain type and level
- Undermining: presence or absence
- Reevaluate: monitoring of all parameters regularly
- Edge: condition of edge and surrounding skin

Case Study

- Focus of intervention: Standard of Care was met and patient was being treated with debridement, offloading with contact casting
- Patient also being seen for strengthening of BLE's, transfer training using rolling walker, balance activities, gait training, and safety instruction
- Functional activities to simulate activities to be performed upon returning home (gardening and walking dog)

Progression



- Describe the wound as you would in a therapy progress note.

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Starting from the Beginning

- A formal wound assessment is a necessary part of wound management
- Accurate documentation of wound assessment facilitates communication
- Accurate documentation of wound characteristics can provide a baseline for changes
- Accurate documentation can assist in planning care during the wound management process

Why is Correct Documentation Essential?

- Wounds constantly change
- Multidisciplinary team documentation ensures continuity of care
- Necessary for legal purposes
- Provides a description of client care

Surgical Wound Benchmark Tool and Best Practice Guidelines

(Birchall & Taylor, 2013)

- Audit of 80 client records in a trauma unit
- Sixty-seven wounds were identified, 40 of which had a surgical etiology
- In surgical wound group:
  - One had a wound assessment documented
  - 16 had dressing type documented

Creating a Wound Assessment Record (Bachand & McNicholas, 1999)

- Survey of general wound documentation by hospital staff
- Documentation of wound assessment was inconsistent, incomplete and scattered throughout the medical records
- Documentation was difficult to decipher wound assessments and monitor the documented progress of wounds

A Proposed Assessment Framework for Developing Best Practice Recommendations for Wound Assessment (Keast et al, 2004)

- Reviewed wound measurement approaches in response to a lack of uniformity in assessment terminology
- Found inconsistent use of terminology
- Used acronym MEASURE for key wound parameters in wound care documentation

MEASURE

- Measure: length, width, depth, and area
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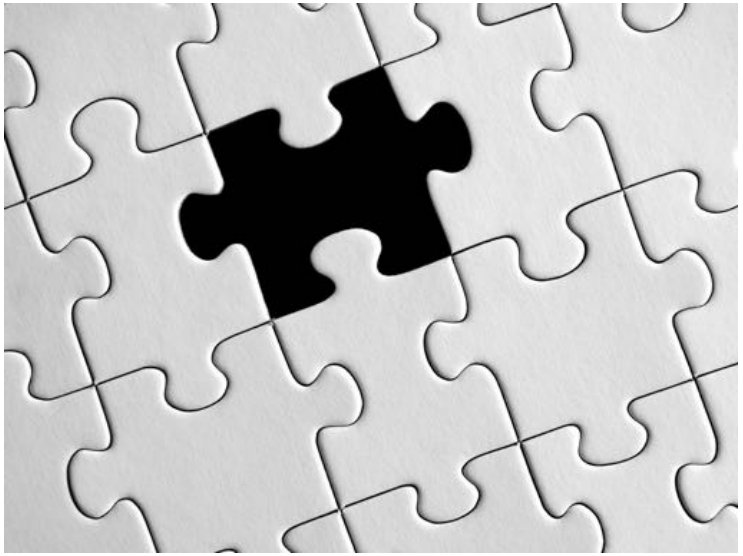
An Audit of the Adequacy of Acute Wound Care Documentation of Surgical Inpatients (Gartlan et al, 2010)

- Audit of 49 records of acute wound care documentation of inpatients
- ¾ of clients had no documentation of wound margins and over 1/2 had no documentation of wound dimensions exudate and wound bed
- 122 dressing changes were documented by nurses and 103 by doctors, only 75 were reviewed by both medical and nursing staff
- In more than 1/2 the cases, there was no documentation about wound bed, margins, exudate and state of surrounding skin
- Wound dimensions and skin sensation were recorded in less than 5%

Side note

- Gap in research looking at the quality of wound care documentation in LTC settings



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Scope of the Problem

- FY 2019 improper payment 7.25 percent
- CMS has an increased focus on reducing improper payments
- CMS is using a variety of approaches to reduce improper payment include

Image: Pictures of Money on flickr

Breaking News

- As of April 2020, CMS has suspended most Medicare Fee-For-Service (FFS) medical review during the PHE.
- No additional documentation requests will be issued for the duration of the PHE.
- CMS may conduct medical reviews during or after the PHE if it is indicated.

Why is it Important to You?

- Volume of medical records requests
  - Technical denials
  - Response time
- Lengthy and costly appeals process
  - How many requests are in appeals?
  - Denials cost the community both time and money

Why is it Important to You?

- Identifying compliance issues
  - What are your denial reasons?
- Financial implications to the community
  - How much are the denials/appeals costing the community in time and resources?
  - How are denials/appeals impacting cash flow?
  - How are denials/appeals impacting the facilities bottom line?

Different Types of Audits

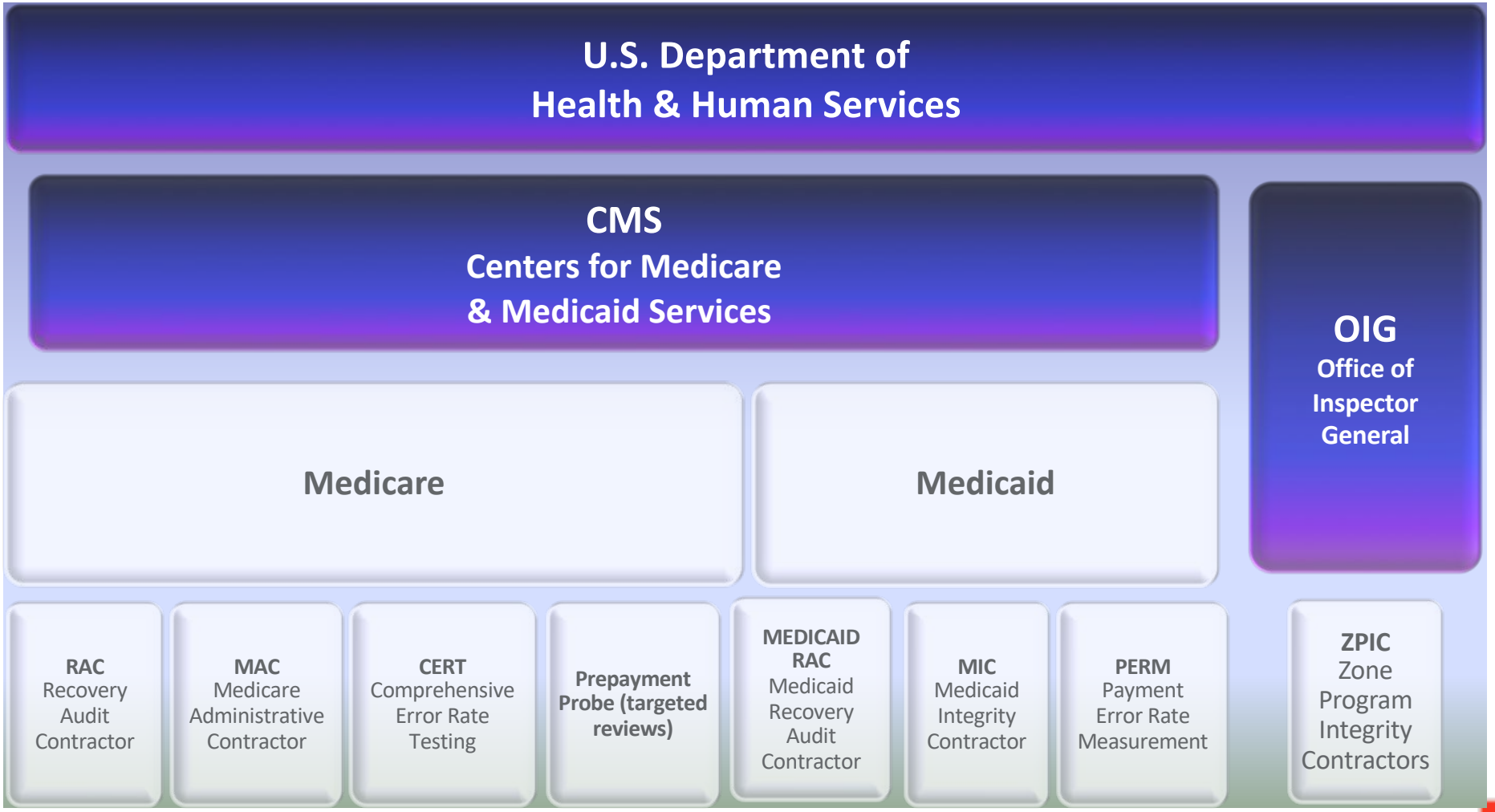
Type	Function
RAC	• Medicare Recovery Audit Contractors • Improper Payments • Goal is to recover money for Medicare
MAC	• Fiscal Intermediary/ Medicare Administrative Contractor (FI/MAC) • Administer payments • Do probe audits to correct and educate
CERT	• Comprehensive Error Rate Testing (CERT) • Measures Improper Rate for payments made by the MAC
Probe Audits	• MACs will do testing on claims to see if providers are implementing billing guidelines correctly
ZPIC	• Zone Program Integrity Contractors (ZPICs) • Also known as UPIC (Unified Program Integrity Contractors) Investigate Fraudulent activity

Different Types of Audits

Type	Function
Medicaid RAC	• Medicaid Recovery Audit Contractors (RAC) • Identify Improper Payments
MIC	• Medicaid Integrity Contractor (MIC) • Identify fraudulent patterns; appropriate utilization of Medicaid
PERM	• Payment Error Measurement Testing (PERM) • Establish Improper payment rate made by state Medicaid • Once every 3 years per state
QIO	• Quality Improvement Organizations (QIO) • Investigate Quality of Care, DRG's and Medical Necessity complaints
Commercial Audits	• Identify Improper payments • Establish quality data

State and Federal Auditors

U.S. Department of Justice



Types of Review

- Probe review
  - Provider-specific
  - Widespread probe
- Pre-pay review
- Post-pay review
- Targeted medical review (TMR)

Components of Client Centered Collaboration Between Therapy and Nursing

Client Centered Wound Care

- Plan of care developed without consideration of whole person
- Clients feel disengaged in decision making regarding wound care
- Client should be at the center of treatment

Client Centered Wound Care

- Often clinicians treat the wound rather than the client
- Clients with wounds may have comorbidities that interfere with healing
- Narrow focus fails to take into account that treatment affects other aspects life

Client Centered Wound Care

- Treatment is centered around closing the wound
- Clinicians approach treatment from their own narrow focus
  - May impede their ability to treat the broader health issues

Client Centered Wound Care

- Guidelines often limit what technology/treatment can be used
- No strong evidence-based approach to evaluating these treatment approaches

Future of Client Centered Care

(The Angiogenesis Foundation, 2017)

- Clients with wounds would have an multidisciplinary team of professionals caring for them
- The physical, emotional, social, and cultural needs of the client would be central creating a plan of care
- Each client would receive the right care, at the right time, by the right professional

Future of Client Centered Care

(The Angiogenesis Foundation, 2017)

- Clients and caregivers would be listened to and respected by clinicians
- Clients would not be blamed when their wound does not heal
- The interests of clients, caregivers, clinicians, payers, and society would be integrated
- Treatment for people with wounds would be proactive rather than reactive

Roles of the Multidisciplinary Team in Addressing Wounds

World Health Organization

- *"Professionals who actively bring the skills of different individuals together, with the aim of clearly addressing the health care needs of patients and the community, will strengthen the health systems and lead to enhanced clinical and health related outcomes."*

The Multidisciplinary Team

- A client centered approach ensures that the team is focused on the needs of the client/caregiver
- The involvement of individual team members depends on the needs of the client/caregivers
- As the client becomes more independent, the focus of service would reflect this

The Multidisciplinary Approach

- Assessment
- Care planning
- Intervention
- On-going management

Image by Gerd Altmann from Pixabay

The Multidisciplinary Team

- The client
- Family
- Physician
- Administrator
- DON/ADON
- RNs
- LPNs
- Rehab staff
- Activities
- Social services
- Dietary
- Housekeeping
- Maintenance
- Divisional & corporate teams

TEAM GOAL: Timely, cost-effective healing of wound and return to meaningful activities

Role of the Multidisciplinary Team

- Identify appropriate candidates for skilled wound interventions
- Ensure clients are provided the opportunity to attain their highest level of independence
- Provide best practice guidelines for documentation
- Ensure continuum of care with emphasis on physician/staff/caregiver training

The Three Cs: Collaboration, Coordination and Communication

- Documentation of “the three C’s” may demonstrate coordinated multidisciplinary care
- Wound care consultants should communicate in a consistent manner
- Adequate follow up should be ensured prior to the client being discharged from therapy

Multidisciplinary Team and Documentation

- Should be legible, thorough, professional, and factual
- Consistent documentation is a reflection of quality, multidisciplinary care
- Documentation of underlying concerns requires a well- structured documentation system
- P&P should be updated and documentation should reflect these new practices

Communication Between Nursing and Therapy

- Essential part of identifying appropriate candidates for therapy and supporting interventions
- Make it a habit
  - Always be looking for clients who have skilled needs
- Document what you see
  - Look for a pattern of change

Supportive Nursing Documentation

- Prior to therapy evaluation
  - Supports prior level of function
  - Supports need for evaluation
- During therapy
  - Changes in function must be documented to show progress and carryover

Supportive Nursing Documentation

Bed Mobility/Transfers

- How much assistance to sit up in bed?
- How much assistance for transfers?
- Is assistance more or less than usual?
- Is there loss of balance?
- Are there safety concerns?
- Any assistive devices used?

Supportive Nursing Documentation

Functional Mobility

- How much assistance to walk to the bathroom?
- If you left the client's side, would he fall?
- Any assistive devices needed?
- How far can the client walk?
- Is this distance more or less than usual?
- Is assistance more or less than usual?
- Are there safety concerns?

Documentation Example

- "Amb ad lib"
  - INADEQUATE: Not specific, does not support PT intervention or functional status

- "Walks in corridors independently with RW, able to go to/from activities and dining room with verbal cues for safety maneuvering around obstacles"
  - ADEQUATE: More specific info re: AD, ability to amb & level of assist

Supportive Nursing Documentation

Positioning

- Less comfortable than before?
- Leaning?
- Sliding?
- Falls?
- Safety concerns?

Example of Collaboration

- Medicare Meetings
  - Purpose
    - Communicate
    - Coordinate
    - Capture

Director of Nursing's Role

- Take information from meeting and verify that nursing documentation supports reason for referral
- Check that clients treated by therapy have supportive nursing documentation

Social Worker's Role

- Bring multiple copies of required Medicare denials fill out at the meeting as necessary
- Be able to identify upcoming dates of client care planning conferences
- Provide BIMS scores for clients receiving therapy

Therapy's Role

- Identify current therapy caseload and their tentative discharge dates
- Identify upcoming scheduled/unscheduled assessments set in collaboration with nursing
- Speak in general terms about wound status, basic mobility, ADL function, and nutrition status of the client, if applicable
- Provide nursing documentation checklist for clients on caseload with:
  - BIMS score less than 6
  - ADL Index score less than 5
  - Clients seen to maintain function or prevent decline in function

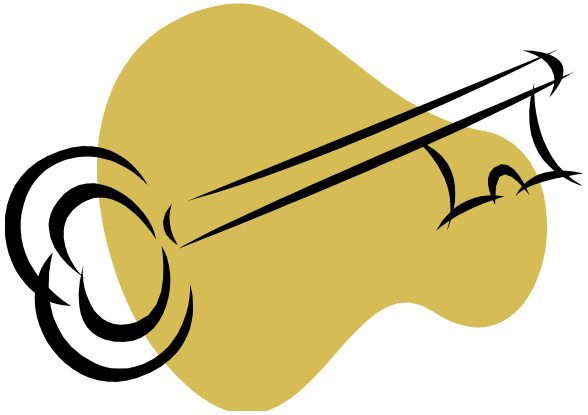
Common Errors in Wound Documentation to Prevent Denials

“Can I see a receipt?”

Would you pay a mechanic $1000 for car repairs if he didn’t have an itemized receipt to support his charges?

The Top 5

- Reason for Referral
- PLOF
- Goals
- Plan of Care
- Skilled Interventions



Reason for Referral

- Why does the client require intervention AT THIS TIME?
- Discipline-specific
- RFR can include information on wound status, etiology, and treatment plan
- Include factors affecting healing
- Must obtain data from referral source in the record

Reason for Referral

- "Therapy orders s/p venous ulcer on R anterior calf"
  - INADEQUATE: What discipline? What problem are you going to treat?
- "S/p venous ulcer on R anterior calf client requires ↑ (A) w/ community ambulation and asc/desc stairs"
  - ADEQUATE: Clarifies functional deficit to be addressed by Therapy

Prior Level of Function

- Document how client was functioning just prior to the onset/exacerbation of the wound
  - Understand the history of the wound site
- Discipline-specific
- Detailed

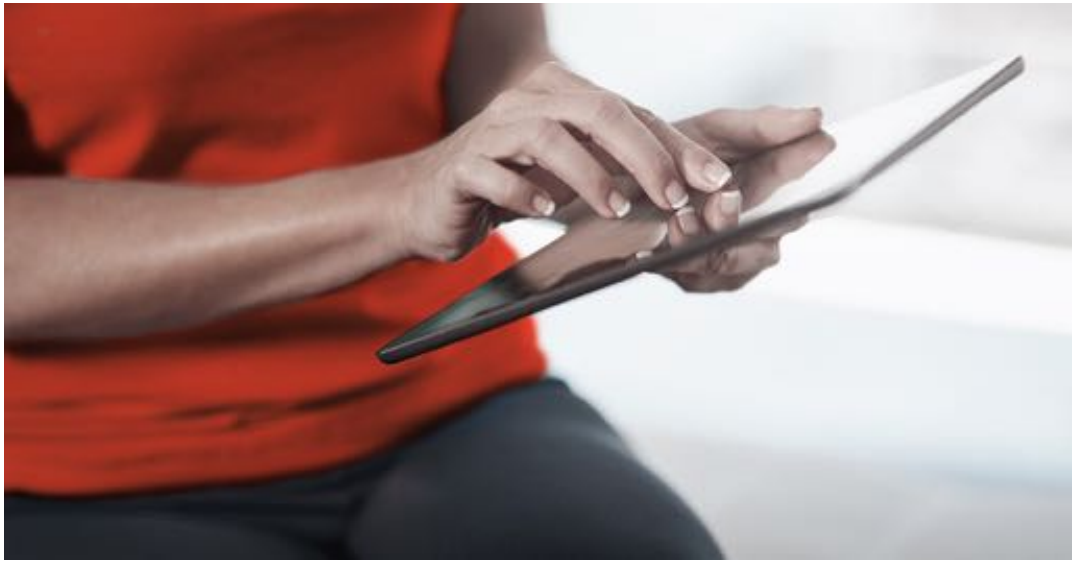
PLOF

- "Lives with wife, 2-story home"
  - INADEQUATE: No info re: client's functional status or abilities

- "(I) community ambulation w/ quad cane and up/down 12 stairs w/ rail to 2nd floor bedroom"
  - ADEQUATE: Specific info re: AD, ability to do stairs & level of assist

PLOF

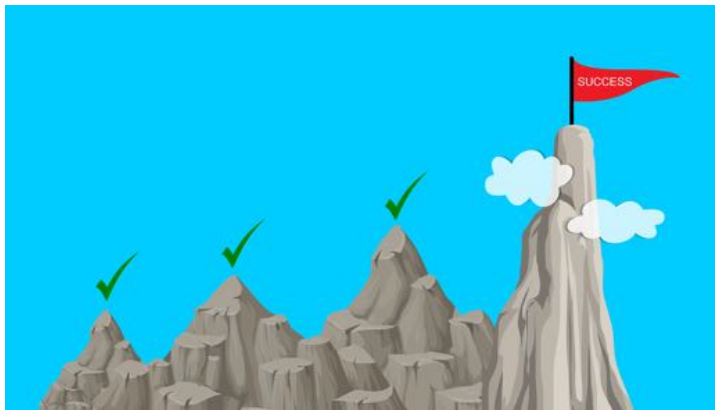
- LTG(s) should directly relate to PLOF
- A detailed, specific PLOF lends itself to identifying functional LTGs



Goals

- Long-term goal: Functional level to achieve by the end of therapy (PLOF)

- Short-term goal: Step to reach the long-term goal
  - Objective
  - Specific
  - Measurable
  - Functional
  - Timeframe



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Goals

- "Decrease edema in periwound R anterior calf"
  - INADEQUATE: No timeframe, not specific. What function?
- "Decrease edema in periwound R anterior calf as evidenced by decrease in periwound (from 4 cm at 12 o'clock to 2 cm at 12 o'clock) to allow client to amb 100 feet without pain"
  - ADEQUATE: Specific w/ respect to measurement & functional task/impact

Skilled Interventions

- Justify CPT codes on the claim
- Describe unique, complex services only you can provide
- What did **YOU** do during the treatment?

U.S. Navy photo by Mass Communication Specialist 3rd Class Matthew Jackson / Public domain

Skilled Interventions

- In order to be medically necessary, services must:
  - "Be of a level of complexity and the services can only be safely and effectively performed by a qualified therapist, or under a qualified therapist's supervision"
    - Complexity of the intervention itself
    - Complexity of the client

CMS Pub 100-02, Chap 15, Section 220

Documentation Requirements

- There are very specific ICD-10 codes that will trigger a modality being covered
- Modality treatments are being due to medical and treatment diagnosis
- Should we decrease this intervention due to fear of denial?
  - No – Therapists should be efficient and work as a team

Let's Practice- G0281: Estim for Wounds

DOCUMENTED STATEMENT

- "Estim for wound healing x 60 minutes."

SKILLED STATEMENT

- "Skin inspection revealed intact skin, no redness noted in periwound area. Client positioned in right side lying. Electric stimulation electrodes applied to medial and lateral borders of wound that is present on left greater trochanter. Gauze with saline moistened gauze applied to wound bed and held in place with a dry gauze and tape. Settings of negative polarity. 80 pulsed per second, 150 volts utilizing high volt galvanic stim. Treatment time 60 min."

"Skin inspection after treatment: Skin intact, no redness noted."

Let's Practice- 97530: Therapeutic Activity

DOCUMENTED STATEMENT

- "Client treated bed side for bed mobility activities. Client dependent for all activities."

SKILLED STATEMENT

- "Client seen bedside for training in right and left rolling to improve functional mobility and complete a positioning schedule for pressure reduction. Client requires minimal assistance for reaching with UE for bedrail to assist and max assist of 1 to complete rolling task. Client requires 100% cues and assistance to complete task. When sidelying client positioned with bolster behind back to maintain sidelying with a pillow between knees and ankles to avoid pressure. CNA's included in training and required 50% verbal cues and demonstration to complete proper positioning in bed for pressure reduction. "

Documentation Requirements

- Documented services MUST require expertise, knowledge, clinical judgment decision making, skills and abilities of a therapist

Documentation Requirements

- Documentation starts with choosing the appropriate medical diagnosis
- ICD-10 gives us the opportunity to be specific in our diagnosis code choices
  - ICD-10 has also opened the door for increased denials
  - The billing office is part of our multidisciplinary team

Documentation Requirements

- CMS has established Medicare Administrative Contractors (MAC's) for all states
- Be familiar with your state's MAC and the edits they put in place for coverage

Documentation Requirements

- There may be changes and new codes added
- Coding revisions were also made to National Coverage Determinations (NCD's)
- New NCD ICD-10 spreadsheet can be found at:
  - www.cms.gov/Medicare/Coverage/DeterminationProcess/downloads/CR10318.zip

Documentation Requirements

- CMS Medicare Coverage Database includes:
  - National Coverage Determinations and Proposed NCD's
  - Local Coverage Determinations and Proposed LCD's
  - Local Coding Articles
  - National Coverage Analyses (NCA's)
  - Archived Policies
  - Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) proceedings
  - Public comment tool
  - www.cms.gov/medicare-coverage-database/

Documentation Requirements

- There are also hierarchical condition categories
- Include underlying diagnosis that may affect the client's ability to heal
- Clearly show medical condition of client at the MOMENT

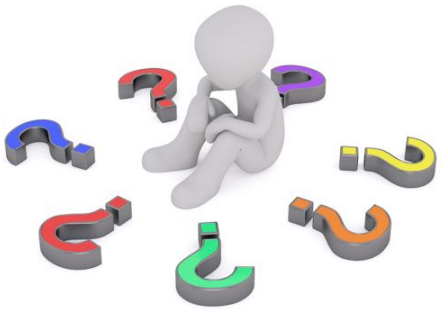
Documentation Requirements

- CMS interpretation of “Standard of Care” is uniform across states
- Standard of Care must have been in place for 30 days before a modality can be introduced to the plan of care
- Standard of Care Includes:
  - Optimized nutritional status
  - Debridement by any means to remove devitalized tissue
  - Maintenance of a clean, moist wound bed
  - Treatment of any infection that might be present

Documentation Requirements

- Are you confused yet??

- We are clinicians and can't possible manage all of this, that is why we need to partner with our billing experts in our community



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Principles of Effective Wound Documentation for Nursing and Therapy

Effective Communication

- Documentation must support the need for therapy intervention in care
- Nursing documentation must support the reason therapy is needed for client care
  - Includes documentation of standard of care, consistent tracking of wound status that is uniform and clear documentation of lack of progress with standard of care now requiring modality intervention

Supportive Nursing Documentation

- Reflects coordinated efforts between nursing and interdisciplinary team
- Nursing documentation supports therapy services and may make impact claim payment

Supportive Nursing Documentation

- Good nursing documentation
- Minimizes loss risk for a facility
- Avoids subjective terms
- Essential for anyone
  - Skilled by Medicare
  - Treated in therapy
  - Referred to therapy for a decline in function
  - Receiving Part B therapy service

Communication Between Nursing and Therapy

- Essential part of identifying appropriate candidates for therapy and supporting interventions
- Make it a habit
- Always be looking for clients who have skilled needs
- Document what you see
- Look for a pattern of change

Supportive Nursing Documentation

- Prior to therapy evaluation
  - Supports prior level of function
  - Supports need for evaluation
- During therapy
  - Changes in function must be documented to show progress and carryover

Phrases to Avoid

- Custodial care
- Maintaining
- Poor/fair rehab potential
- Inability to follow directions
- Refused to participate in treatment
- Chronic condition
- Not motivated
- Extreme depression
- Little change
- Status quo
- Plateau
- Ambulating “ad lib”

Supportive Nursing Documentation

- Assistance required
- Safety awareness
- Adaptive equipment
- Cognitive issues
- Functional activity tolerance
- Compensatory strategies
- Communication
- Dysphagia
- Positioning
- Pain

Effective Communication

- Nursing and therapy should have a consistent method of communication regarding clients with wounds
- Your community will need to determine what will work best
  - Separate wound meeting?
  - Part of Medicare meeting?
  - Part of morning meeting?
  - Wound rounds?

Effective Communication

- What can interfere with effective communication?
  - Lack of respect for other disciplines
  - Role not being understood by other disciplines
  - Control of work patterns, schedule and routine

Effective Communication

- Frequent stereotypes of Nurses:
  - Nurses just sit at nurses station
  - Nurses dump on the CNAs
  - Nurses just pass medications and document
  - Nurses don't know how to transfer and prefer not to when therapy is available

Effective Communication

- Frequent stereotypes of therapy
  - PT is perceived as the leader after the physician
  - PT can be “overrated or overbearing”
  - OT and nursing do the same thing with ADLs
  - Clients work harder for therapy
  - Scheduling is much more organized and routine

Effective Communication

- How can we work together on the same team for the best outcome for the clients?
  - Positive Attitude
    - How often have you heard someone make a negative comment about another discipline or nursing?
    - Have you ever made such a negative comment?

Effective Communication

- Don’t jump to conclusions
  - Have you acted without having all the facts?
  - Have you ever misunderstood or misread the situation?
  - Have you ever acted on some stereotypes instead of upon accurate information?

Effective Communication

- Understand and accept personal, cultural, and professional differences
  - Have you ever thought that you know more than nursing does?
  - Have you ever felt that nursing doesn't carry their fair share?
  - Have you ever gotten angry or upset because someone has a different work ethic than you? Or because they couldn't address your concern at the exact moment you wanted?

Effective Communication

- Set Boundaries
  - Does your social life creep into your work life?
  - Does that affect the relationships you have with colleagues

Image by Gerd Altmann from Pixabay

Effective Communication

- Be respectful
  - Do you listen to everyone's input at the team meeting?
  - Do you value the work that nursing does on a day-to-day basis?
  - Do you involve others on the multidisciplinary team in decision making?
  - Do you respect the functions that others have on the multidisciplinary team?

Effective Communication

- Does your team have synergy?
  - Do you recognize that we are all here for the same reasons ?
  - Does your documentation support the other disciplines?
  - Are you defensive during communication?
  - Have you oriented nursing to what role your discipline plays on the multidisciplinary wound care team? Have you openly listened when nursing defined their role?

Effective Communication

- Place the client at the center
- Understand and respect each other's contribution
- Use positive words vs. negative speech about other disciplines
- Coordinate treatments
- Collaborate with nursing regarding client schedules

Effective Communication

- Know your own responsibilities
- Be open to go beyond job description to do what is best for the client
- Promote open communication and mutual respect

Image by Gerd Altmann from Pixabay

Federal Regulations

- The clinical records must contain:
  - Sufficient information to identify the client;
    - A record of the client's assessments;
    - The plan of care and services provided;
    - The results of any pre-admission screening conducted by the State; and
    - Progress notes
    - Supportive clinical documentation

Principles of Determining Skilled

- The service must inherently complex
- Nature of the services requires the skill of licensed personnel
- Skilled service provided directly or under supervision of a licensed nurse or therapist
- Diagnosis and prognosis DO NOT determine what is skilled care

Practical Matter

- Considering economy and efficiency, skilled services can only be provided in a SNF
  - Contributing reasons for a skilled SNF stay:
    - Intensity of therapy provided
    - Medical complexity
    - Less than 24hour/day care would impose safety risks and/or adverse impact on client's medical condition

Skilled Care is a Process

- Assessment
- Diagnosis
- Planning
- Implementation
- Evaluation
- Documentation – If it is not documented its not done!

Documenting Critical Thinking

- The clinician should describe the why it was necessary for their involvement in the client's care
  - Assessment of client conditions, causative factors, and/or risk factors and concerns for safe function
  - Analysis of potential outcomes or consequences
  - The plan for action
  - Evaluation of the client's response to the plan

Documentation Basics

- The clinical record must contain:
  - Descriptions of changes in condition
  - Details of unusual occurrences
  - Evidence of physician and responsible party notification
  - Evidence of care provided and the response to treatment
  - Per Chapter 2 of RAI Manual - Develop and implement a baseline care plan within 48 hours of admission

What to Document?

- Assessment information
  - A collection of objective data and details about client's current condition
- Action
  - What did the nurse or therapist do with the findings?
- Response
  - How did the client react?
  - What did you communicate to others about the client's condition?
- Evaluation
  - Was the action taken effective?
  - Does the plan need to be re-evaluated?
  - What else does the clinician "anticipate" they will have to:
    - Observe, assess, manage, evaluate

How to Document

- Always follow facility policy
- Document events in chronological order
- Document the facts
- Do not chart in prior to providing care/treatment
- Make sure documentation is in keeping with acceptable standards of practice
- Document only what you are qualified to do
- Date and time all entries using AM/PM
- Sign all of your entries with your credentials
- Use only acceptable abbreviations approved by your facility

How to Document - Continued

- Documentation should include correct anatomical terms
- Know your medical terminology; Superior, inferior, anterior, posterior, medial, lateral, proximal, distal
- ICD-10 is very specific; documentation must support accuracy and specificity in order to avoid questions about claims
- Keep your documentation concise, objective and professional

Principles of Determining Skilled Care

- The service must inherently complex
- Nature of the services requires the skill of licensed personnel
- Skilled service provided directly or under supervision of a licensed nurse or therapist
- Diagnosis and prognosis DO NOT determine what is skilled care

Reasonable and Necessary

- Skilled care may be necessary to either:
  - Improve a client's current condition, or;
  - Prevent/slow further deterioration of the client's condition
- Skilled documentation must:
  - Substantiate daily skilled care was delivered
  - Record treatments, therapy and client's response to same
  - Communicate between the disciplines and serve to facilitate continuity of care

Medical Necessity

- The client's medical record must document as appropriate:
  - The history and physical exam
  - The skilled services provided
  - The client's response to the skilled services
  - Plans for future care
  - Detailed rational explaining the continued need for skilled care
  - Complexity of the services to be performed
  - Any other pertinent characteristics of the client

Facts and Details

- State the facts
- Provide comparison over time
- Give exact measurements and provide your observations in support of your clinical opinion
- Indicate “As evidenced by”
- Document the continued risks and concerns
- Document what you are planning next and why
- Incorporate considerations for all things that contribute to goal achievement

Examples of Nursing Documentation

- Left lateral calf wound healing as evidenced by decrease in size and amount of drainage from last week. Wound measures 0.2 cm x 0.5 cm. No drainage observed on dressing or in wound bed at time of scheduled dressing change. Oral intake has been optimal with client consuming at least 75% at every meal in the last week.
- client's condition is improving since admission as evidenced by client is now able to ambulate entire distance from room to dining room for meals without requiring a rest break and without evidence or complaints of shortness of breath.

Direct Skilled Nursing Services

- Considered skilled when so inherently complex that they can be effectively performed only by, or under the supervision of, a registered nurse
- If the service can be effectively performed by an unskilled person, it is not considered to be a skilled nursing service

Management and Evaluation of the Care Plan

- Develop the initial baseline care plan
  - Within 24-48 hours of admission
- Implement plan of care
  - Physician's orders
  - Nursing measures
- Evaluate plan of care
  - Is it working?
  - Have there been changes in client condition?
  - How have you adjusted the plan of care and rationale behind changes?
- Changes implemented to plan of care
  - Have new problems, concerns or risk factors been identified?

Example:

- 84-year-old client with history of diabetes and angina pectoris is recovering from an open reduction of the neck of the femur post fall and the client needs:
  - Careful skin care
  - Appropriate oral medications
  - Diabetic diet
  - Therapy services to regain PLOF
  - Observations for signs of deterioration or complications resulting from age, multiple comorbidities, risk factors, and restricted mobility

Observation and Assessment of Client Condition

- This consists of skilled services when the likelihood of a change in the client's condition requires nursing to identify and evaluate the need for possible modification or treatment
- Nursing care plan should describe the client's condition, specific or potential problems and planned interventions on a frequent basis
- Indication of daily or more frequent monitoring is related to the instability or probable change in condition

Example of Skilled Observation and Assessment

- A client 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

Example of Skilled Observation and Assessment - Respiratory

- Documentation of respiratory assessment should include:
  - Dyspnea, cyanosis
  - Lung sounds
  - Productive cough, sputum production and characteristics if cough/sputum present
  - Respiration rate and depth
  - Presence of chest pain
  - Utilization of supplemental oxygen, mode, liters
  - Vital signs including oxygen saturation
  - Sternal retraction, distended neck veins
  - Results labs or chest x-rays

Painting the Picture of Care

- Example Nursing Doc:
  - 1/1/20 – 4:50PM – Temp 100.2, P-76 – irregular, R-32 with dyspnea observed, client on O2 at 2lpm via nasal cannula continuous; pulse ox 89%, BP-178/88, Lung sounds with scattered rhonchi bilaterally, dry non-productive cough, 2+ pitting edema present bilateral ankles and feet; Educated client on importance of keeping feet elevated when sitting in chair while assisting client to place feet on stool. Client states she feels nauseated and that her chest hurts when she takes a deep breath in; Dr. Fixall notified of assessment findings and he gave new orders to hold Digoxin, obtain STAT digoxin level, STAT CXR. Notify MD with results and any new changes in condition; MD to examine client in the AM; Family notified of clients current condition and changes in treatment plan.

Subsequent Documentation

- 1/1/20 5pm – Nurse spoke with CNA who indicated client required Max Assist x 1 with dressing , toileting and transfers today and client declined to eat lunch or dinner. Client appeared slightly short of breath during ADLs.
- 1/2/20 – 1:28AM – CXR results received showing moderate CHF present; Digoxin level is elevated at 3.2, Dr. Fixall notified of test results, new order to hold Digoxin until further notice; Administer Lasix 40mg IV now.
- 1/2/20 – 1:36am After establishing peripheral IV IV Lasix 40mg administered as ordered

Teaching and Training Activities and Documentation

- Those that require skilled nursing personnel
- Teaching a client how to manage their treatment regime
- Type of instruction or teaching activity provided
- Identify who was taught – client or caregiver
- Assess readiness to learn
- Response to instructions
- Identify any barriers to learning and describe work arounds
- Return demonstration/retention of materials taught
- Teaching aides utilized

Skilled Teaching and Training Documentation Example

- Wife was instructed in tube feeding formula and potential side effects by dietician. Nursing demonstrated how to check placement of gastric tube prior to administration of feeding and how to check for residual. Wife instructed in use of stethoscope today. Wife voices concerns about “I am not sure I am listening to the right thing.” Nursing will continue with additional demonstration and skill practice this evening using the teaching stethoscope so nurse can verify the wife’s observation. Will progress to the mechanics of administering the bolus feeding as wife demonstrates comfort with current information.

Essential Elements of Wound Documentation

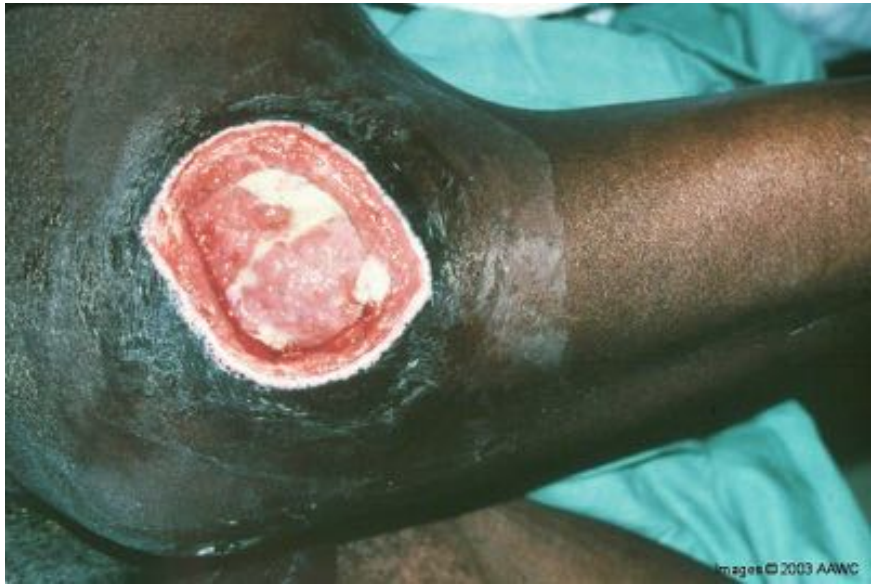
Wound Documentation

- Documentation should give a clear impression of the wound for anyone that is involved with care
- Therapy and nursing documentation should mirror each other

Essential Elements of Wound Documentation

- Location of wound – using anatomical description

Documentation Example: Location of Wound



- Wound located on right greater trochanter, best visualized in left side lying.

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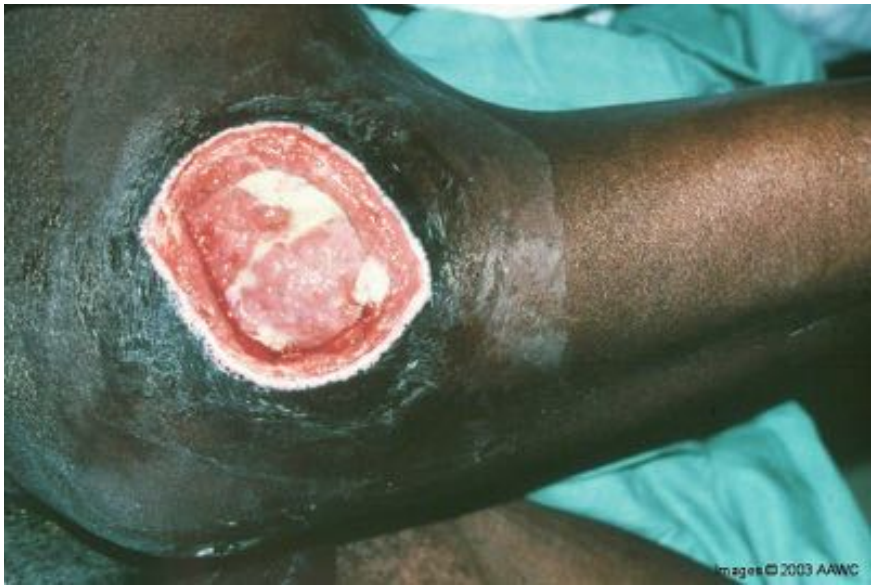
Essential Elements of Wound Documentation

- Wound etiology
  - Must stage pressure injury
    - It is acceptable to state unstageable if the wound bed is not visible
- Deep Tissue Injury should also be documented
- Do not downstage

Documentation Example: Wound Etiology



- Stage 3 pressure injury – recently underwent surgical debridement. No visible evidence of bone, muscle or tendon.

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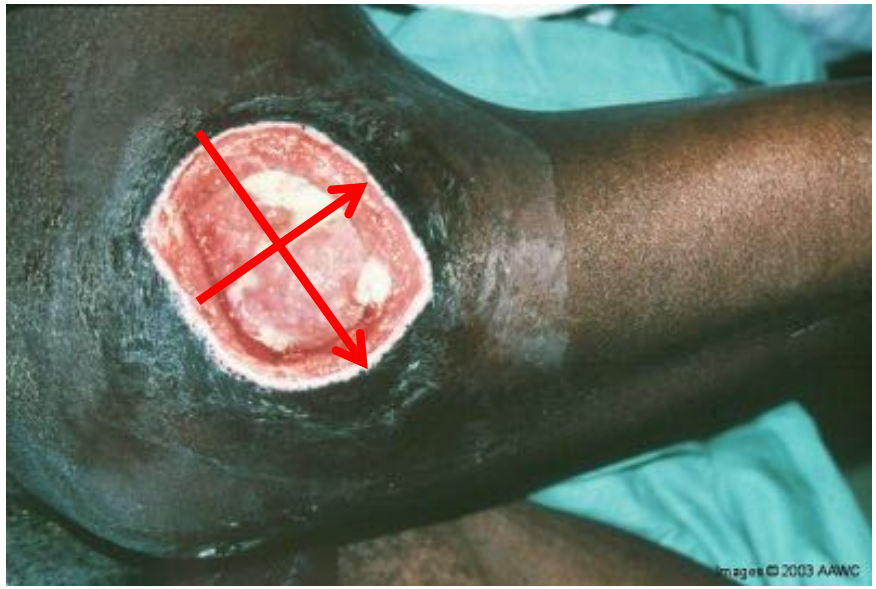
Essential Elements of Wound Documentation

- Measurements of length, width and depth are taken using the face of a clock for reference.
- The clock also needs to have an anatomical reference like the head.
- Measurements need to be consistent and reproducible.

Documentation Example: Measurements



- Longest point of wound is 4 cm measured from 12 to 6 o'clock, using the head as the reference for 12 o'clock. Widest point is 3 cm measured from 9 to 3 o'clock. Deepest point measured in center of wound at 2 cm.

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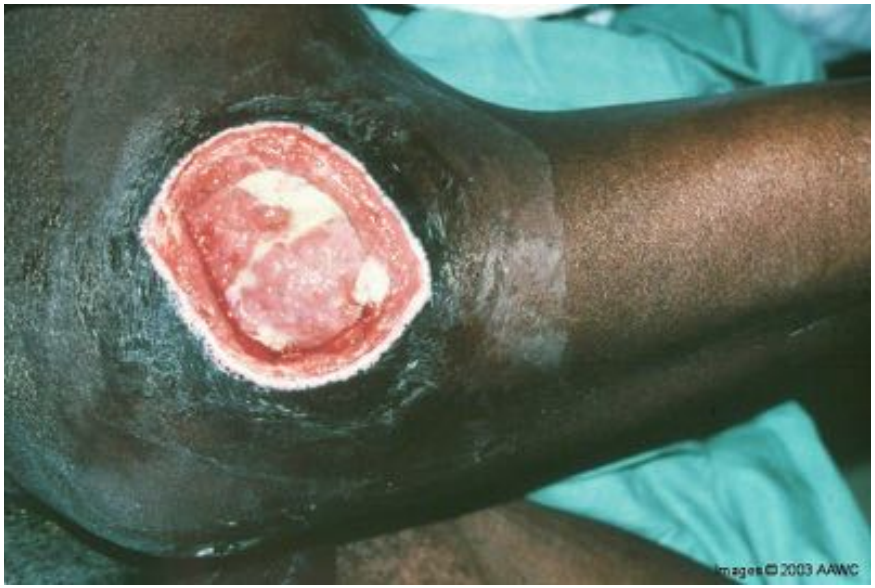
Essential Elements of Wound Documentation

- Composition
  - What does the wound look like using percentages?
  - Changing composition may be objective documentation of healing progression of the wound
  - Changing composition also helps to define when the wound is going through the various phases of wound healing

Documentation Example: Composition



- Wound is 70% red granulating tissue including wound walls and 30% fatty tissue following surgical debridement.

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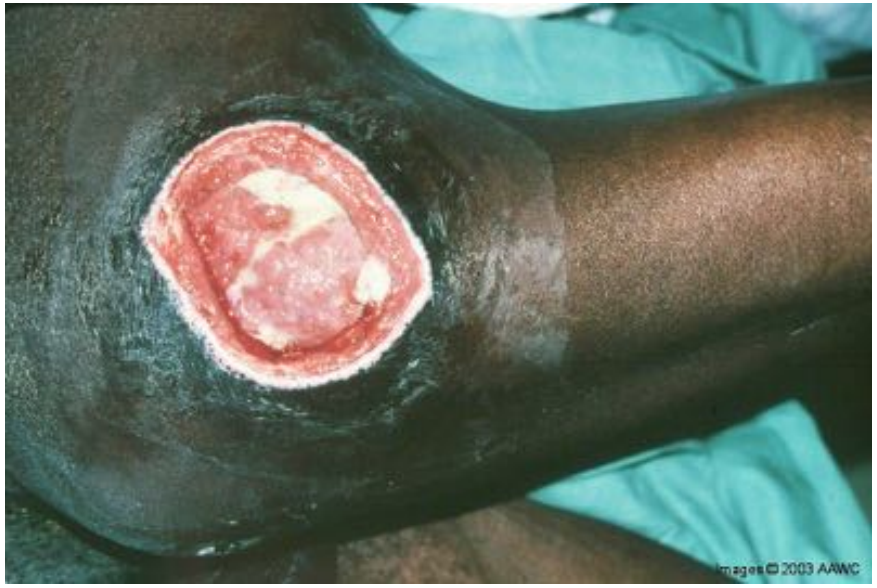
Essential Elements of Wound Documentation

- Drainage – minimal, moderate, maximal, scant
  - Be sure to remove dressing and irrigate before documenting on drainage
  - Some dressings interact with wound fluid which may give a false appearance of infection or pus
  - Be aware of systemic components of infection
  - Be aware of characteristics of dressings be used by nursing

Documentation Example: Drainage



- Dressing removed and wound irrigated with normal saline. Minimal amount of serosanguinous drainage noted.

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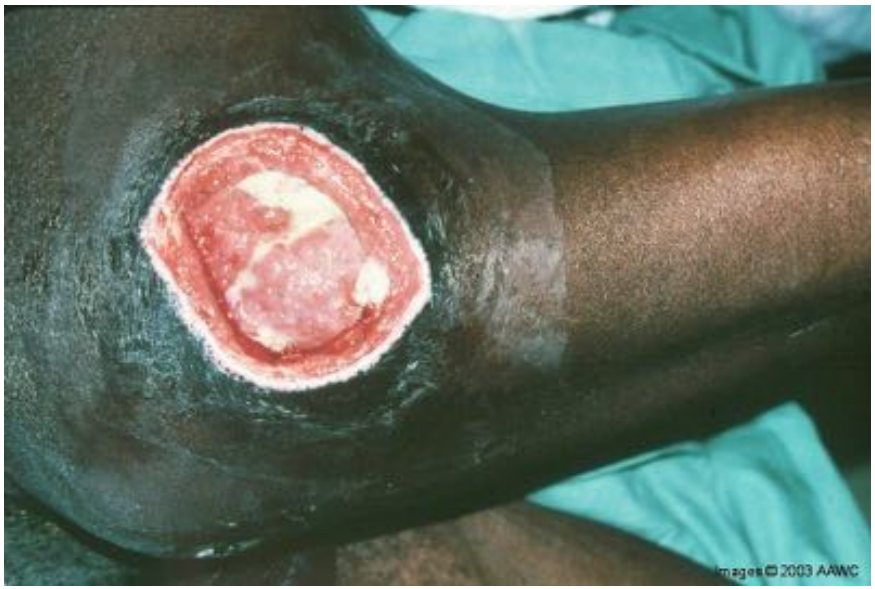
Essential Elements of Wound Documentation

- Periwound area – Is there erythema? Is it indurated? What does it look like?

Image: Burst from Pexels

Documentation Example: Periwound Area



- Periwound area unremarkable. Residual skin barrier cream present around wound.

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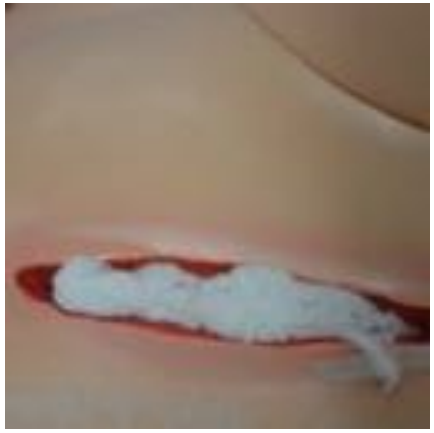
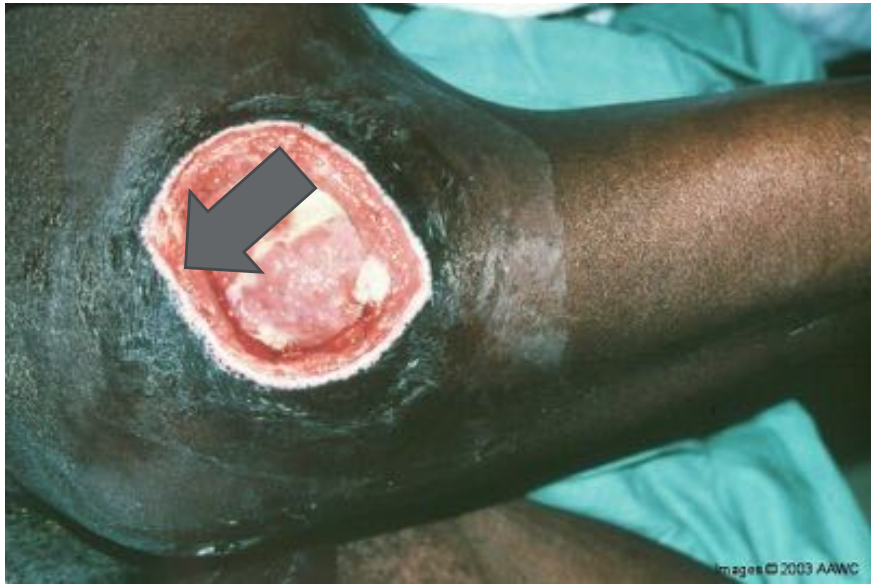
Essential Elements of Wound Documentation

- Tunneling or Undermining
  - If it is present, where Is it on the face of a clock?



Picture Source: Clip Art

Documentation Example: Tunneling or Undermining



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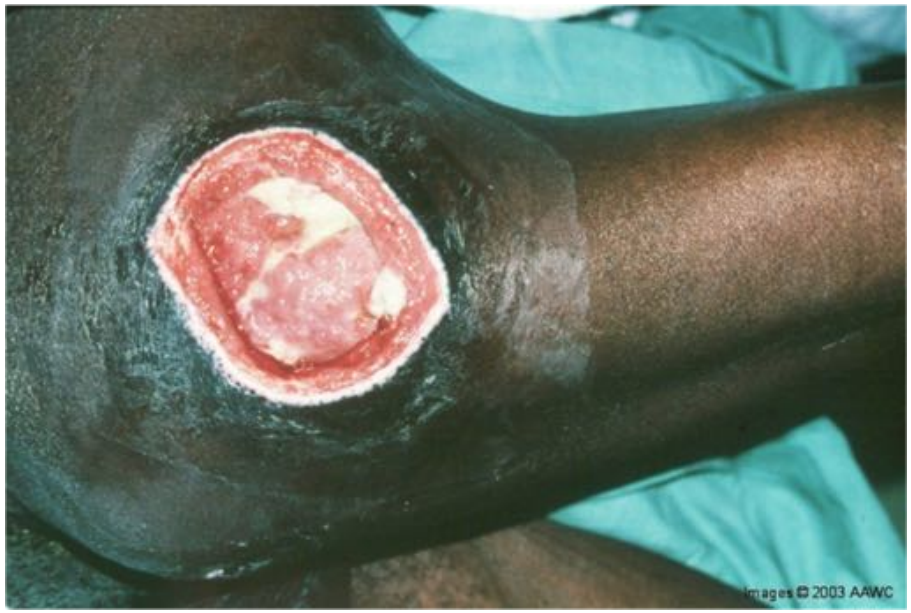
- This wound does not have undermining or tunneling but an example of documentation:
  - Undermining present at 9 o'clock, using the head as reference point for 12 o'clock, for 2 cm.

Essential Elements of Documentation

- Phase of healing
  - Clinicians need to be aware of what phase wound is in as the characteristics of the wound change
    - Inflammatory Phase
    - Proliferative Phase
    - Maturation Phase

Documentation Example: Phase of Healing



- Wound is in the proliferative phase of healing with primary function at this time to fill in depth to allow for contraction.

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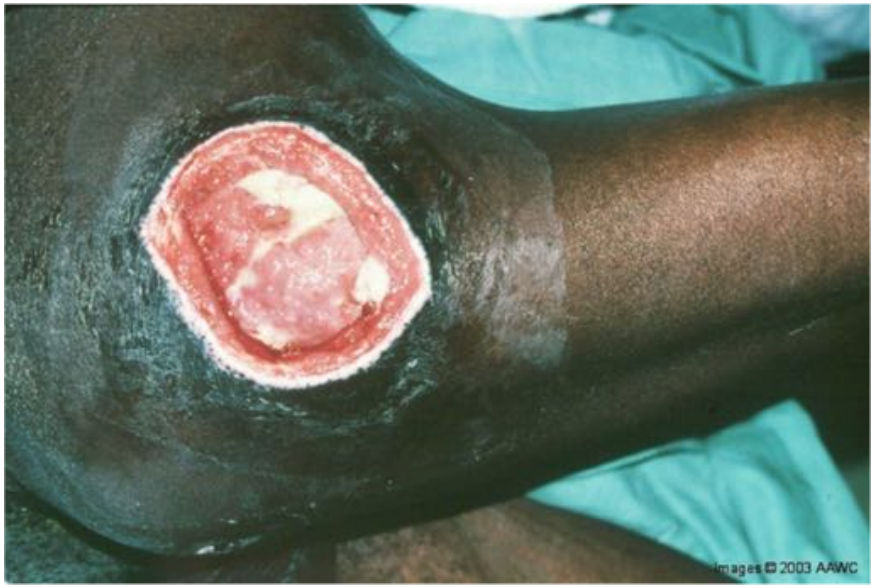
Essential Elements of Wound Documentation

- Odor
  - Present or Absent?
  - Description
  - Some odors are indicative of infection if other signs of clinical infection are present
  - Be aware of dressings being used
    - Occlusive dressing wound have an odor, without an infection

Documentation Example: Odor



- Dressing is removed, wound is irrigated with normal saline. No odor present.

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Essential Elements of Wound Documentation

- Goals should be measurable and functional
- Can not state the goal is for wound healing.
- So what does that mean?
  - Outcome is: Client can now sit in wheelchair with proper pressure relief cushion and good posture for 1 hour increments which will allow her to attend church services and bingo in community

Documentation Example: Goals for Clients with Wounds

- LTG – Upon wound closure, patient will be able to sit in a wheelchair with pressure relief cushion and good positioning for one hour intervals to allow her to attend a daily church service which was one of her goals.
- STG – Patient to tolerate left sidelying with pillows between knees and ankles and bolster behind back for 30 minute intervals to allow for pressure relief of right greater trochanter region.

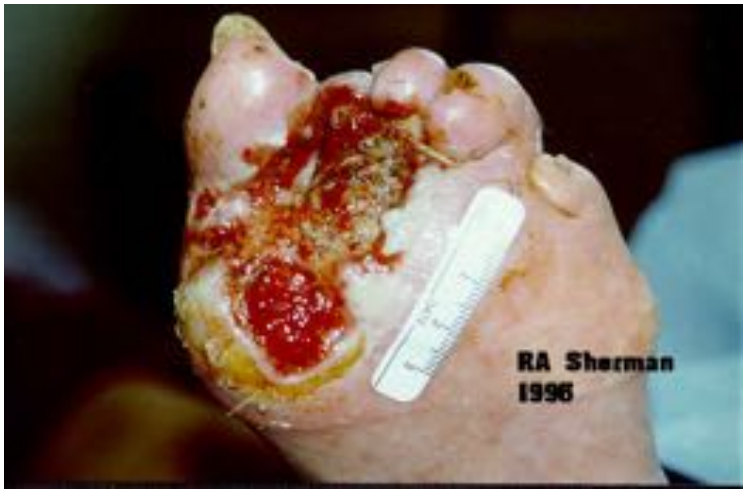
Essential Elements of Wound Documentation

- Documentation must support the skill being provided
- Detail should allow exact information on modality set up, including:
  - Positioning of client
  - Placement
  - Parameters
  - Time
  - Tolerance to treatment
- Skin inspection before and after treatment

Case Study

- Ms. Smith admitted to skilled nursing facility 1/25/20.
- Ms. Smith is a 74 year old female admitted following fall and diabetic ulcer of right foot.
- Medical history: obesity, polyneuropathy, HTN, syncope and collapse, Type 2 diabetes mellitus.
- Findings: Open wound right foot, muscle weakness, balance deficits, difficulty walking, pt. reports minimal pain in hip from fall (3/10 pain levels).
- Prior functional level: Lived in a private residence alone, Independent for all aspects of ADL's, transfers and ambulation including within the community without an assistive device. Ms. Smith is a master gardener and cares for foster dogs on the weekends.

Case Study



- Describe the wound as you would in a PT evaluation.
- Write 1 goal for Ms. Smith.

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Documentation Example

- Location: Plantar surface of right foot just distal to great toe and goes lateral to under third digit
- Etiology: Diabetic foot ulcer Grade 2 on Wagner Scale
- Measurements: Using the face of clock
  - Length – measured from 7 to 2 o'clock to be X cm.
  - Width measured from 9 to 3 o'clock to be X cm.
  - No measurable depth.

Documentation Example

- Appearance: 90% red granulating tissue and 10% tan necrotic tissue. Wound edges are irregular and from 12 to 8 o'clock there is callous formation.
- Surrounding skin is dry. There is evidence of foot deformity in forefoot as well as hammer toes which change the weight bearing surfaces.
- Drainage – can't tell from slide
- Odor – can't tell from slide
- Pain – can't tell from slide

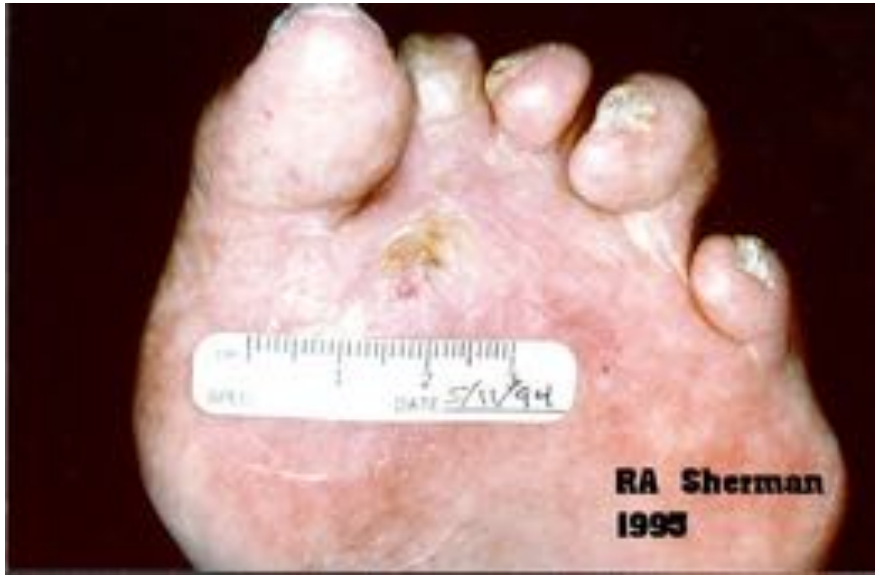
Documentation Example

- Goal: Patient to ambulate safely with a wheeled walker on level surfaces with supervision due to new unsteadiness and gait deviations created by total contact cast. Patient to verbalize 100% understanding for use of wheeled walker for safety.
- Wound to be 100% red granulating tissue and free of callous formation to allow for wound to progress in the healing process and enable patient to increase ability to participate in grooming activities.

Case Study

- Focus of intervention: Standard of Care was met and patient was being treated with debridement, offloading with contact casting
- Patient also being seen for strengthening of BLE's, transfer training using rolling walker, balance activities, gait training, and safety instruction.
- Functional activities to simulate activities to be performed upon returning home (gardening and walking dog)

Progression



- Describe the wound as you would in a progress note.

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Documentation Example

- Wound is in the maturation phase of healing
- Small area of fresh scar tissue just distal to 2nd digit.
- Would address all things that we did in initial measurements
- Describe plan for education

Documentation Example

- Patient to demonstrate good balance as evidence by Berg Balance score while wearing custom diabetic shoes to enable her to return gardening activities.

Photo by Emre Kuzu from Pexels

Recommendations

- Educate staff on skilled documentation
- Explain WHY and WHAT the ramifications can be
- Review documentation on a regular basis providing re-education as needed
- Have an effective new-hire training in place to teach staff at the start of employment

Thank You

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