HEADS UP...

TOPIC: Documentation and Record of Care
***SETTING:* Home Care (OME) Programs**

Why is this important?

A complete and comprehensive record of care is essential in the patient's care treatment and services. Ensuring proper documentation of a patient records is a key component of safe patient care. Disparate information between the patient and clinical documentation may lead to inappropriate care.

Scope of the Problem:

Time period: **January 1, 2019 – December 31, 2019**
Number of full surveys performed: **2,015**
Number of surveys (in the high-risk SAFER categories) related to documentation and record of care (**RC.02.01.01 EP 2**): **42 (2%)**

Observations identified within a specific topic area may reveal systemic areas for improvement across the organization. These improvement opportunities might be reflected in other chapters, standards or EPs.
See also RC.01.01.01 EP 2, RC.01.01.01 EP 3, RC.01.01.01 EP 5 (depending on deemed status).

Sample survey observations [from surveyor notes] (and contributing factors)

- Review of clinical records revealed that medication reconciliation was not being performed or documented accurately. Agency's medication list did not correspond with the medications the patient was taking (e.g., Medication list did not contain PRN medications that the patient was taking at home including Volteran gel, Tylenol and Hydrocortisone cream).
- Frequency of medication in the medication profile did not match what the patient reported taking or what was observed (e.g., Ibuprofen was listed on the medication profile to be taken every 8 hours, but patient was taking PRN).
- Clinical documentation was not updated to reflect current treatment (e.g., patient record indicated warfarin was discontinued six weeks ago; however, the nurse failed to write the physician order to discontinue warfarin).

Potential contributing factors:

- Documentation process for monitoring patient care, treatment, or services is unclear.
- Lack of consistency regarding clinical documentation (e.g., use of standardized terminology, abbreviations, acronyms or symbols in the patient record).
- Verbal orders not documented in record of care.
- No process for verbal readback.
- Oral and written communication needs may not have been confirmed (e.g., preferred language for discussing health care).

How to identify potential problems in your organization

Review policies, procedures and protocols

☐ Does organization have defined process/procedure to ensure that patient records contain information that accurately reflects the patient's care, treatment, or services?

- Is there an auditing process to regularly review patient records? (e.g., is there a process to review medical records during any supervisory visits in the home?)

☐ Does staff receive ongoing training to maintain or increase competency to properly record patient profiles?

☐ Has the organization clearly identified who will be responsible for medical records (e.g., RN, PT, OT, ST or other members of the team)?

Interview staff (e.g., clinicians and support staff)

☐ Does staff understand how to document the monitoring of a medication/treatment regime in patient records?

☐ Does staff assess and document the comprehension of patients receiving any care, treatment or services?

☐ Is there appropriate oversight of clinical documentation by leaders?

Assess your environment

☐ Do electronic and/or paper medical records and forms allow for the documentation of all relevant information?

☐ During home visit, compare the medication profiles in the record of care to the medications in home.

Evaluate implementation

☐ Review a sample of patient records to ensure that documentation was complete and that all required items are present

- Review charts at various points of care (e.g., initial, reassessment, discharge)
- Review records for medication prescriptions that change frequently (e.g., insulins, anticoagulants, etc.)
- Possible observation of a medication reconciliation process on a home visit.

☐ Assess patient/caregiver comprehension by asking questions and through observation.

What are some resources that can assist in mitigating risks in these areas?

- Patient Safety and Quality. An Evidence-Based Handbook for Nurses (2008). Chapter 38: Medication Reconciliation https://www.ncbi.nlm.nih.gov/books/NBK2648/
- Home Health Quality Improvement. Nurse Medication Management Checklist (2010). https://cvquality.acc.org/docs/default-source/initiatives/hospital-to-home/mind-your-meds/success-metric-6/6e7e-hhqi-nurse-med-management-checklist.pdf