



Assure Compliance by Accurate Record Review


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At the conclusion of the seminar, participants will be able to:

- Describe the methods to review a clinical record in an accurate and efficient manner
- Identify the reasons for reviewing the multi-disciplinary team documentation
- Assure that documentation correlates between disciplines
- Describe the regulations and requirements for charting

What a patient's clinical record should tell you




PAINT THE PICTURE

. . . Don't paint a Picasso



TELL THE STORY

. . . Don't Have a Mystery Novel



Reviewing a Clinical Record

- When you review a clinical record, this is the recommended order:
 - Comprehensive OASIS Assessment
 - Medications
 - Orders
 - Skilled Need
 - Homebound Status
 - Multi-disciplinary evaluations

Comprehensive OASIS Assessment

- Start with the comprehensive OASIS assessment
 - Review for consistency - see if you can tell the story of the patient
 - Many times after reading an OASIS assessment:
 - There is not a good picture of what is happening with the patient overall.
 - It is not clear why homecare is in there – either no primary reasons and/or no skilled need. Often there is truly a skilled need and the patient really needs homecare, however, the assessment does not show this.
 - This will lead to ADR denials!
 - It will not hold up in legal cases
 - A surveyor will not be able to identify what is going on with the patient which makes it very difficult to review a chart

OASIS Assessment - Continued

- There should always be a narrative paragraph with the OASIS assessment. When the clinicians do this narrative, it paints the picture of the patient, then the rest of the OASIS assessment ties it all together
- The narrative is the first part of the assessment that I read. Based on that, then I can go through the head to toe OASIS questions and have a good feeling for what the patient is going through and if the OASIS answers jive with narrative and head to toe.

Narrative Paragraph:

Example #1

SN SOC complete. Patient has been newly dx with colon CA. Pt is having a colonoscopy on 10/22/10 to assess for tumors. Pt is on anti coags for CAD and last dose of Coumadin was 10/18/10. Pt to start Lovenox 60 mg daily today until 10/21. Pt also has a HX of IBD, CAD, HTN, pacer, anxiety, depression and osteoarthritis. Pt alert but anxious upon arrival. VSS, WT as stated 122, 8/10 pain in bilat knees. Pt states she needs them replaced. Pt taking Darvocet for pain. LCTA, BS active. Pt to start bowel prep for colonoscopy tomorrow. Trace non pitting edema to ankles. 60 mg of Lovenox prepped and administered to right side of ABD without complication as ordered by SN as per order. Pt tolerated well. All needles disposed of as per OSHA. Pt was instructed on giving own injections but needs reinforcements. Pt very anxious about injections and no willing caregiver. Pt lives at home with husband whom provides assistance PRN. Pt refuses PT/OT referrals. All meds reviewed with Pt. Standard precautions maintained. Remains homebound due to decreased endurance. If leaving home must be assisted by husband. Pt does not drive.

Narrative Paragraph:

Example #2

Admitted to HHC following discharge from hospital for treatment of right foot osteomyelitis. Had a right talus biopsy. Incision on right foot has good skin approximation with sutures still intact. No drainage or S/S of infection at incision site. Clean DSD applied. I/S caregiver on wound care. Patient is not to weight bear on right foot. Using crutches to ambulate. Has a right arm 5 French dual lumen PICC line. Dressing is coming off of PICC. Dressing changed by SN using sterile technique. No S/S of infection at PICC site. IV Ancef 2GMS in 20ml SW Q8 hours. IV push ordered through PICC. I/S caregiver (mother) on prep and admin of Ancef and using SASH method. Mother did very well using good aseptic technique. Written I/S also left with mother. Mother states she can do the IV by herself. I/S to call HHC with any questions or problems. Mother verbalized understanding. Patient is mentally challenged and needs support from his family.

Narrative Paragraph:

Example #3

Admitted to HHC following discharge from Rehab following ORIF surgery for right humerus fracture. Surgery performed at hospital on 9/24/10. Patient fell at home in her bathroom when she got up during the night to go to the bathroom. Cannot remember why she fell. Did not trip over anything. Patient now has her right arm in a sling with a padded pillow attached that cushions the arm against her lower chest. Patient complaining of pain in right arm with movement. Pain is rated 7. Taking Vicodin with relief Q6 hrs. Has a 6cm incision at the right shoulder area. Incision is completed healed. Right arm is of normal color. Warm and dry with no edema. Good radial pulse. Able to move fingers freely. Focus of visit is for admission assessment and development of plan of care. Skill reasonable and necessary due to unstable medical condition due to fracture of right arm, pain and inability to perform ADL's. Has history of spinal stenosis, disc surgery, ulcerative colitis, A Fib, asthma, and Graves disease. All systems assessed, VS stable, no SOB, lungs clear bilaterally, no BLE edema, has a bloodshot area on the whites of her left eye. Pt states this is part of Graves disease. C/O having no BM for 4 days. Patient has a chronic constipation problem. Patient ambulating without any assistive device. Tried a cane when at Rehab but tripped with it. Therapist said she is better without it because of fracture in right arm. Needs assistance with ADL's. Has private caregivers but requesting HHA when caregivers not available. Order for CBC and BMP weekly x 2 with report to MD. PT and OT referrals. Homebound status: If the patient leaves home, the absence from home are infrequent or for periods of relatively short duration or are attributed to the need to receive health care. Standard precautions maintained.

Medications

- After reading the assessment, review the medications.
 - Identify what is new, changed, discontinued, etc.
 - Identify if the high risk drugs concur with the OASIS answer (i.e. are there high risk drugs or not)
 - The medications also help to identify what diagnoses and sequencing will be
 - Medications have to have documentation from the COP's that all was taught – *RN reviewed on SOC and changed within 60 days to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy*

Orders


- When reviewing the orders, you will want to identify if the OASIS assessment coincides with the orders.
 - For example: A diabetic patient that has the foot care checked in the M item, it is important that there are orders for that
- The frequency and duration of visits are important so that the frequency and duration fits the patient situation
 - For example: A patient with CHF Exacerbated was just discharged from the hospital, a visit schedule of 1w9 is not adequate however a 3w9 is not often feasible

Skilled Need

- It is very important to be thinking "is there a skilled need in the documentation?"
- If there is no change in the past 14 days on the M item, then why is the patient being admitted
- It is difficult to justify that this patient is good for a homecare admission if no changes
- Clinicians, especially nurses, say that the patient "just needs to be watched so they do not get worse" – unfortunately this is so true, however will not qualify the patient for homecare.
- Look for the skill
 - Do they have medication changes?
 - Do they have signs or symptoms of one of their diagnoses?
 - What qualifies as the skilled need?
 - Do they have new physician orders?

Homebound

- Is there documentation to justify?
- Needs to be specific
- Lots of ADR denials due to the homebound status in the past 2 years



Multi-Disciplinary Evaluations

- It is important to review the therapy evaluations
- Look at their primary reasons for homecare
- Look at the frequency and duration
 - Does it jive with what the nurse has documented?
- Helps identify diagnoses and sequencing

On Going Chart Reviews


- Be sure that the all the clinicians sound like they are talking about the same patient
- Pick a week in a chart and read the notes of ALL the disciplines
 - You will be surprised at how often you will see areas in which the documentation does not match
PAIN / NO PAIN – WOUND MEASUREMENTS THAT ARE DIFFERENT – ETC.

On Going Chart Reviews (Cont'd)

- **BE SURE**
 - The same things are not taught over and over by the same or different clinicians
 - All the orders and goals on the 485 are addressed in the visit notes
 - The physician(s) is notified when there are ANY changes or adverse signs/symptoms for patient
 - Big area of weakness in documentation and practice
 - There is coordination of care and communication between all disciplines
 - Problems are being followed up on and resolved
 - There continues to be a skilled need

Recerts

Before you recertify a patient, be sure that you are not keeping the patient on “just in case”



Conclusion

- If you follow these recommendations for chart reviews and start doing them, you will find that you will become better at documentation!

