



CAREGIVING

Where Quality Care Begins

Thorough examinations at admission foster patient health and help stave off survey deficiencies

Even the most quality-conscious providers can get sweaty palms when it comes to the survey process. Increasing scrutiny of nursing facilities—by the public and the media as well as by surveyors—has heightened anxieties over survey deficiencies and stepped up the pressure on providers to cover all bases.

Despite chronic staffing shortages and payments that are often lower than necessary to get the job done, there are several preventative steps that providers can take proactively—at the time of a patient's admission—to help ensure the patient's well-being and mitigate or avoid survey deficiencies in the process.

The admissions process should be viewed as a line of demarcation between a patient's prior medical history and the care to be provided. To find that line, however, a provider must first identify all existing medical issues and those that are likely to arise from the patient's condition.

Admissions Checklist

Providers can determine the line of demarcation in a patient's medical history by systemically adhering to the following checklist at or near the time of admission:

■ *Full-body inspection.* There is no substitute for a full-body inspection upon the admission of a new patient. Caregivers must take the time to carefully and systematically describe such things as pressure ulcers, sores and wounds, scars, sutures, discoloration, cracked or missing teeth, disfigurement, signs of dehydration and lethargy, and any other notable issues.

JONATHON E. COHN, SHIRLEY J. PAINE, AND SHARON KEARNEY

The size, scope, and severity of these conditions should be noted and, more important, fully documented at the time of admission. In cases where the full extent of a patient's condition is not accurately reflected in the admission records, a family member, surveyor, or judge reviewing the record later can and will presume that the condition developed or worsened during the patient's stay.

■ *Weight assessment.* Issues involving weight assessment can provide important clues about the patient's condition, but such issues may also form the basis for many survey deficiencies. A few precautionary steps can help providers to properly assess the patient, while alleviating potential black marks by surveyors. First, the provider should accurately weigh the patient and document the conditions under which the weight was measured, including such details as time of day, type of scale used, and what clothing the patient was wearing at the time of the weigh-in.

If the provider is unable to accurately gauge the patient's weight—if, for example, the patient refuses to be weighed—the reasons should be documented.

■ *Discharge information.* If the patient has been discharged from another facility, an acute-care hospital, for example, the provider should seek to obtain a copy of the patient's weight and nutritional information from the discharge record and chart it. Any other relevant information from the discharge record should also be noted at the time of admission to a nursing facility.

■ *Skin examination.* The importance of assessing and charting skin tears or pres-

sure sores, especially upon admission, cannot be overemphasized. If not caught early, these can quickly fester into more serious problems for the patient. In addition, pressure ulcers are always subject to great scrutiny and are commonly involved when a facility has a serious compliance problem.

It is important to differentiate pressure ulcers from other lesions or blisters. If the provider spots a skin lesion that may or may not be an early-stage pressure ulcer, it is best to explain the issue in the medical record and err on the side of inclusion. It is always better for the patient to document and care-plan a blister as a pressure ulcer than vice versa.

■ *Nutrition and hydration.* On admission, a provider should pay close attention to signs of dehydration such as lethargy, parched lips, skin tightness, or sunken eyes. All such signs should be carefully documented. If signs of poor nutrition or dehydration are detected, the provider should consult a dietician no later than what standard facility policies and procedures dictate or three days after admission, whichever is earlier.

Providers should chart the results of the dietician's examination and recommendations and communicate the findings to the attending physician. The provider might also suggest lab work, such as blood count and urine analysis and creatinine tests, to establish the patient's nutritional baseline upon admission. If the physician's order deviates from the dietician's recommendations, the provider should obtain a note from the physician listing the reasons for the order. This helps minimize any later confusion over whether the physician knew of the dietician's recommendations when the order was issued. If the order is not implemented, such as when the patient refuses to cooperate, the provider should



document the facility's attempt to comply with the order, specifying the reasons why it was not carried out. The provider should also consult any laboratory reports for the patient, including those generated at a discharging acute hospital, if any, and document them.

Document Carefully

■ *Complete the minimum data set (MDS).* Providers should be sure to accurately complete the patient's MDS within two weeks of admission or if there is any significant change in condition, whichever comes first. The process of completing the

9 a.m. Even if the 2 p.m. dose is eventually administered to the patient at 2 p.m., the entry made at 9 a.m. would probably be considered false because it was false at the time it was made.

Advanced charting is grounds for a deficiency and constitutes bad nursing practice. A record of having done something that was not done is potential grounds for confusion and may lead to improper administration of medication. Also, it may expose the staff and facility to civil and criminal liability.

■ *Care planning.* The key to good care is to document and implement an appro-

making a timely record of implementation is essential. If no timely record of implementation exists, most surveyors will not take the provider's word. Instead, they may presume that the treatments contained in the care plan were not performed. In the event that there is good reason for not implementing a care plan, the provider must record the basis for nonimplementation and revise the care plan.

Providers should keep the care plan as simple as possible. For example, providers should not include a regulatory mandate, such as placing the call light within the reach of a patient, in the care plan. Although this direction should be entered in the nurses' notes, it is not considered a treatment and would be inappropriate in the care plan. The consequences of including extraneous measures in the care plan may be significant because then, if staff fail to implement them, two deficiencies could be issued rather than one: violating a regulation and failing to implement the care plan.

■ *Communicating with the physician.*

Providers should always maintain open lines of communication with a patient's attending physician. Although nursing staff do not formally diagnose patients, they are medically trained, provide direct care, and are generally more familiar with a patient's condition than the physician. Consequently, physicians rely heavily on nurses' observations in making medical decisions, and they generally welcome recommendations.

If a provider believes that a physician's order overlooks a significant factor in a patient's condition, the provider must inform the physician and record the physician's response. If the physician can't be reached on the first try, the provider should make multiple attempts and document each. ■

.....
Jonathon E. Cohn and Shirley J. Paine are partners in health law at the firm of Foley & Lardner, Los Angeles. Sharon Kearney, R.N., a former nursing home administrator and director of nursing, consults nationally on skilled nursing facility compliance issues.

If, at some point after a care plan is generated, the staff realize that a different treatment plan is in order, the care plan must be revised in writing.

MDS—assessment, care plan, care plan implementation, reassessment—may occur at multiple levels, since the immediate medical condition sometimes triggers other related resident assessment protocols (RAPs).

For instance, cognitive deficiencies will trigger the RAP area involving falls. Providers must make sure that every RAP area triggered by the patient's condition is noted in the MDS and care-planned, the care plans are implemented, a record of implementation is generated, and the patient is reassessed.

■ *Charting.* The first rule is that providers must chart everything. The second is to chart accurately. The third is to chart truthfully, and this means, among other things, that the practice of advanced charting is never appropriate. "Advanced charting" generally refers to the practice of documenting the implementation of a treatment plan in advance of when it was actually implemented. For example, if a patient is scheduled to take a 2 p.m. dose of medication, it should not be recorded at

appropriate care plan for the patient. A care plan that represents a standard of care that is beneath the community standard can obviously lead to allegations of improper assessment. However, a care plan that overshoots the relevant community standard is equally problematic, because it raises the standard to which the facility is held and requires an unnecessary commitment of resources.

In an effort to provide good quality of care, staff may document an unrealistic care plan that reflects a more intensive standard of care than is necessary. When this is the case, unless the higher of the two standards is implemented, the facility may be cited for failure to implement its care plan in addition to failure to assess.

If, at some point after a care plan is generated, the staff realize that a different treatment plan is in order, the care plan must be revised in writing.

Caregivers should implement the current care plan and make a record of implementation. Unless there is good reason for not doing so, following the care plan and