Documenting Interventions/Resident Response to Care

Documentation in the medical record is essential. It provides a chronological record of the residents' experiences while in your care, including the services provided to meet their needs and achieve their highest practicable well-being as required by the Centers for Medicare & Medicaid Services. This information is used to create and manage treatment and care plans. It is also a legal record that may be used in risk management and in defense for litigation, making it crucial to meet criteria for professional documentation standards. Just as important, it is a mechanism for communicating information about past and current medical and functional resident status between caregivers and across disciplines and care settings.

Explore the Issue: Documenting Interventions – Questions to Ask

- How are staff trained on expectations for documentation? How do we assess competency with expected documentation practices?
- What guidance or support is provided to ensure quality documentation?
- What process is in place to ensure the resident's response to care is assessed then documented?
- How do we build in a fail-safe for ensuring what is documented is completed? For example, something will be done in two hours; is it?

Conduct a Performance Improvement Project (PIP): Suggested Steps

Step 1: Determine the key areas for improvement: (Refer to questions listed above under "Explore the Issue")

- Review at least two charts for residents recently identified with a change in condition.
- Look for gaps in nursing assessment notes. What important information is missing that would be helpful to other staff who are caring for the resident?
- Does the documentation show an accurate depiction of the resident's condition and nurse interventions?
- Do you notice any patterns in missing information?

Step 2: Create a goal that focuses on the key area you have identified as needing improvement. *Consider both knowledge and process gaps.*

For example:

- If process is an issue, consider what kind of tools are needed to guide the nurse with documentation to ensure all necessary information is included and there is a follow-up process when documentation is missing. Also, consider any workflow challenges that may impact documentation.
- If education is an issue, consider what type of documentation training needs to be provided to new and current nursing staff. How do you ensure documentation standards are met and competency is regularly assessed?

Step 3: Consider the barriers or factors contributing to breakdowns whenever the documentation process is not followed correctly. Quality resident care suffers when these breakdowns occur. Identify all reasons why this is happening by using the Root Cause for the problem (applying the "5 Whys" technique).

- Does the issue(s) stem from the facility process, staff training /education or both?

Step 4: Why is it important to address your facility's specific documentation issues?

Ensuring quality documentation can facilitate improved clinical outcomes and coordination of care through better and more timely communication of a resident's status and response to interventions when a change in condition occurs. As documentation can impact multiple areas, it is important to have a process to identify and correct any issues.

Step 5: Brainstorm to develop your Plan-Do-Study-Act (PDSA) cycle

- What exactly are we going to do? List action steps.
  - Some suggestions include:
    - Setting up guides that can be used during documentation will help the nurse ensure they capture all necessary data (e.g., checklist, EMR setup for change in condition reporting, etc.)
    - Peer-to-peer assessment to review the nurse's notes. This can be done by a nurse manager, another nurse peer or a medical records staff member who knows what to look for in documentation to ensure the maximum reimbursement.
- Set a timeline for the PDSA process.
- Evaluate each part of the process. ***NOTE:*** Change takes time, so ideally test for six months to make sure the process is ingrained.
- Were the results the desired outcomes? Is the outcome consistent with the expectations set?
- How will we know that change is an improvement?

Step 6: Implement and evaluate your **Plan-Do-Study-Act (PDSA) cycle**

- What changes to the process are we going to make based on our findings?
- How are we going to sustain all processes and continue to build a culture of safety (i.e., turnover in leadership or caregiver staff)?
- How will we communicate to all staff, residents, families and affiliations our quality-of-care improvements? (e.g., checklist)

Examine Your Practices: Peer Insights to Consider

- **Documentation serves many purposes and is critical to resident care and team functioning.** Staff don't always remember documentation is part of a legal document and can be used in court. The record needs to describe what care/services were provided and why, the resident's response to the care/service and the effectiveness of the intervention. Documentation can serve as an effective communication tool between care team members and may **impact payment for care**.
- **Training is necessary to ensure competencies with documenting according to professional standards and center expectations.** Remember, documentation should be clear, concise, timely and objective, and free of dangerous abbreviations or subjective statements from staff. The only subjective comments should be from the resident or family and bracketed by quotation marks. Think about documenting according to the steps in the nursing process (assessment, nursing diagnosis, planning, implementation and evaluation). Consider providing samples of effective and ineffective documentation. Lists of elements to include in certain types of documentation or flip cards with examples may also be useful.
- **Leadership is responsible for ensuring the quality and timeliness of documentation.** Establish a system or process for monitoring documentation by everyone using the medical record. This includes physicians, other practitioners and consulting pharmacists.
- **Using multiple strategies for conducting trainings and auditing documentation to strengthen the quality of documentation and the ability to establish consistent standards.** Some centers have monthly licensed nurse (LN) meetings with a designated slot for LN documentation training or provide individual training through audits of where opportunities of improvement exist. Consider involving other individuals, such as medical records specialists, MDS coordinators, staff development directors and state health department personnel, in training staff. Nurse managers conduct audits as part of the event reporting process or run audit reports from their medical record systems.

- **Consider how you involve residents in assessing and documenting response following a change in condition.** For example, one center mentioned observing a resident's response to care during stand up and stand down within a 72-hour window following any change in condition. This allows adequate time to determine if a resident appears to be returning to baseline; if not, this prompts the team to review and update the resident's advance directives to reflect any changes in their care plan and wishes.

Resiliency

> ***"I did then what I knew how to do. Now that I know better, I do better."***
> *Maya Angelou*

Providers and the long-term care system were largely caught off guard by the coronavirus. Despite efforts to prepare, it was impossible to fully predict its impact, how long it would last and what systemic vulnerabilities it would reveal across care settings. Eighteen months into the pandemic, we have an opportunity to assess and adapt our response. As active crisis periods wane, opportunities for debriefs or after-action reviews allow organizations to take stock of their processes, determine areas for improvement and remain responsive.

Explore the Issue: Documenting and Adapting Your Crisis Response - Questions to Ask

- How are we recording needs, actions and lessons learned during this crisis?
- What have we done to capture our effort and how is this shared with staff?
- How has this impacted/informed our response going forward?
- How do we bring the resident's voice into our crisis response?

Link the Concepts: Quality, Safety and Wellness

- "Doing better" with organizational resiliency involves ongoing planning and monitoring of your organization's readiness and response throughout the course of a crisis. The American Medical Association has developed a **Caring for Healthcare Workers Resource Guide**, outlining steps organizations can take before, during and after a crisis to build resilience, support their team and learn from the experience.
- Debriefs are an important mechanism that individuals and teams use post-incident to learn and improve performance. **Research** indicates that well-conducted debriefs can improve team effectiveness and are used by high-performing organizations to enhance their team's ability to maintain smooth operations.
- While there are numerous formal and informal formats for conducting a debrief or after-action review, keep in mind the following: It is not only vital to examine processes that impact quality of care, but also to establish a culture that invites critical feedback free from hierarchy and supportive of psychological safety. Because **quality and safety** suffer when staff are in distress, an evaluation of organizational and individual wellness is a crucial element to any debriefing.
- Peers shared the following insights:
  - Use formal and informal opportunities to solicit feedback. One center conducted a QAPI review after an COVID-19 outbreak to learn what worked and what did not, and surveyed staff for input. This helped them improve and update their action plan. Others suggested huddles, town halls or lunches to reach direct care staff. Journaling was identified as a helpful mechanism for capturing effort and lessons learned.
  - Mechanisms to maintain connectedness for residents can also be helpful for meeting staff needs. Electronic tablets that help residents communicate with family and staff can also be used for staff-to-staff video chats to reduce isolation, as can providing walkie-talkies for unit staff. A behavioral health group brought in for resident support needs in one center has now developed staff trainings on core development and grief. This group brings in food and makes the staff feel appreciated, with a goal to conduct these trainings monthly.

- The debriefing process should examine both clinical, resident/staff-specific crisis issues and emergency preparedness issues. One center employs a "damage-control team" that follows the FEMA format. Team members have assigned roles and tasks, implement drills and complete after-action reports and plans, taking staff and resident feedback into account with lessons learned.

Assess the Approach: Actions for Leadership

- Take an opportunity during calmer moments to reexamine your crisis plan and make necessary adjustments. Remember to include staff wellness as part of this discussion.
- Proactively uncover opportunities for improvement, hidden safety threats and need for additional support through routinely employing debriefing processes. Use structured tools such as the **Promoting Excellence and Reflective Learning in Simulation (PEARLS) Healthcare Debriefing Tool**. Resources include a pocket card for personal use, posters for printing and display and electronic versions for download to personal devices.
- In addition to examining mistakes and areas for improvement, debriefing should explore where positive performance was identified. The Safety II debriefing tool in this **Institute for Healthcare Improvement (IHI)** article offers a framework to safely set the stage, analyze actions taken and synthesize participant feedback. Make debriefing the norm to increase staff comfort, productive conversations and team performance.

Put to the Test: Next Steps

1. Bring the *Questions to Ask* back to your QAPI or leadership team.
2. Conduct one small test of change to strengthen documentation practices or implement a process to assess the quality of documentation. Use the *Performance Improvement Project* steps as a guide.
3. Review your crisis/emergency preparedness plan. Consider adding or revising a component that addresses staff well-being throughout a crisis.
4. Share resources/this summary of practice ideas.
5. Join the next session, **QI Review of Transfers; Drivers of Admissions/Readmissions**, on Aug. 13, 2021 | 11 a.m. PT/noon MT.

Resources

1. **Webinars – The Green House Project** PDPM: Weaving it into a Person-Centered World
2. **Nursing Documentation - Nursing on Point**
3. **American Nurses Association's Principles for Nursing Documentation – Guidance for Registered Nurses**
4. **American Association of Post-Acute Care Nursing's Documentation Toolkit for the Nurse Leader**
5. **Quality Skilled Nursing Notes in SNFs Require Management** (article)
6. Centers for Medicare & Medicaid Services **State Operations Manual**
7. **Linking Quality, Safety, and Wellness Through Health Care Debriefing (ihi.org)** (article)
8. **The PEARLS Healthcare Debriefing Tool; PEARLS for Systems Integration Debriefing Tool - Debrief2Learn**
9. **Ideas for Team De-Brief .pdf - Google Drive**
10. **Do Team and Individual Debriefs Enhance Performance? A Meta-Analysis - Scott I. Tannenbaum, Christopher P. Cerasoli, 2013 (sagepub.com)**
11. **QAPI at a Glance** PIP Guidance Resource: Refer to Appendix A: QAPI Tools – *Goal Setting Worksheet*

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