

*Documentation:  
A Key Part of the Visit*

Subscriber Webinar  
July 2016

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*Plan for the day*

- Healthcare Documentation
- How We Got to Where We Are Today
- Time to Make a Change?
- Workable Solutions

Disclaimer: The presenter believes that, with rare exceptions, documentation should be completed as part of the visit encounter and that failure to do leads to falling short on our promises to patients and families.

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*Documentation in Healthcare: Purpose and Practice*

The clinical record chronicles care being provided by health care professionals and includes

- Assessments and evaluations
- Medications, treatments and responses to both
- Communications between healthcare professionals
- Planned upcoming visits and interventions
- Current POC and progress toward meeting goals
- Medical history
- And more...

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*Documentation in Healthcare: Purpose and Practice*

Also used to demonstrate compliance with institutional, professional or governmental regulation and to support payment; may be used in a court of law

Expected to be completed as closely as possible to time of the actual delivery of care or marked as a "late entry"

Part of a healthcare professional's responsibility to follow standard documentation practices; failure to follow policy or standard practice can lead to adverse action on license

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*Documentation in Hospice: Purpose and Practice*

Purposes remain the same as on previous slide

More important than ever before as related to compliance and payment

Departures from previous slide's practice points

- Often not completed during the actual delivery of care – may not even be completed by the end of the work day – or longer
- Rarely identified as "Late Entry" even if done days later

What on earth happened?

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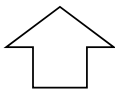
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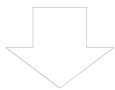
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*The Relationship*



Time elapsed since the encounter



Quality of the documentation

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*The Hospice Population*

- Life expectancy of six months or less, ~36% die in 7 days or less
- Families often very stressed and on information overload
- Things can change quickly
- Symptom management frequently requires new medications or changes to current ones
- Calls to on-call or back to the office are frequent

Is this a population that needs an up-to-the-minute clinical record?

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*The Reality*

At this moment, the electronic medical record is here with all its warts and, at times, unrecognized promises

Wasting time lamenting over it is fruitless

Let's improve our techniques and get on with it

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*How Did We Get Here?*

Although frequently identified as an EMR issue, that is a partial truth. The device is just a handy thing to blame it on.

"I always start my documentation in the home; I believe that it shows the patient and the family that I am taking their care seriously."

Joyce Morley, RN  
Interview comment around 1996 or 1997

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*From the Patient and Family Perspective*

Does it make a difference?  
What is the value of consistency?  
What is the patient and family experience ?  
Are we delivering what we promise in hospice care?

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*This Applies to Just Nurses, Right? Wrong...*

As social workers, we are the discipline that others should be able to rely on to find constructive methods for working through change as it occurs. Initiating and addressing change in positive ways should be part of our DNA!

Gary Gardia, MEd, MSW, LCSW

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*Feedback and Considerations*

"You won't believe this – the nurse was just here and she had a little computer that had all the information about me in it!"  
Call to daughter from 89-year-old father upon start of home health care

"Where is my smart nurse – the one with the computer?"  
Comment from elderly hospice patient to hospice RN making visit for vacationing RN

"My sister had two nurses – one documented on her laptop during the visit and the other didn't. The one who did seemed more organized – we just felt safer with her."  
Hospice employee sharing caregiving responsibilities with another sister

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*Feedback and Considerations*

"The nurse came to do the admission and she hardly looked at us – all she did was ask us questions and put information in the computer. She never even asked to hear my uncle's story and it's such an interesting one."

Hospice RN observing admission visit for her uncle

"I wasn't sure about how this would fit in with my role as a chaplain but I decided to try it to build relationship with a new patient – an elderly man who loved the desert. I loaded some pictures on the laptop. It worked."

Hospice Chaplain

I told them that "they said that we had to use the computer unless you don't want us to"

Hospice RN's account of what she said to patient and family

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*So...*

Where are you now?

Where do you want to be?

What would it take to get there?

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*Current Policy and Performance on Documentation*

What is considered timely documentation?

- Is it monitored?
- Is it enforced?

What is the current % of compliance with policy?

- Agency
- Team
- Individual

Do individual clinicians know where they are now?

- Relative to others
- Relative to policy

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*Conclusion Reached*

The device is as much of a barrier or a tool as the user believes it to be

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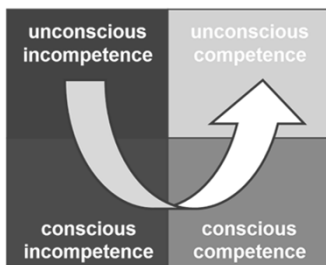
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*The 4 Stage Conscious Competence Learning Model*



<http://tacticstime.com/chess-tactics/the-four-stages-of-learning-chess-tactics/>

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*Beliefs to be Considered and Skills to Be Mastered*

Our role as healthcare professionals  
Our individual feelings: if it makes me uncomfortable, why?

Practical Skills

- Keyboarding
- Moving around in a Windows environment
- Setting expectations
- Introducing the device into the visit
- Capturing and entering information during the visit

Discipline Specific Skills

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*If Hoping Won't Get You There, What Will?*

- Identify what you want and set the date by which you want to be there
- Communicate expectations clearly
- Ask staff to identify
  - Hardware challenges
  - Areas in which they need self-development
  - Their own feelings about requirement
- Make learning opportunities available
- Identify and correct any mixed-message practices
- Establish monitors and make data available to managers
- Stay the course & expect success

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