Documentation in the ASC

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Disclosure

• Crissy Benze is a consultant for Progressive Surgical Solutions, LLC, an ASC consulting firm.

Learning Objectives

• Describe the purpose of accurate documentation
• Identify five (5) documentation requirements in an ASC medical record
• Identify legal issues associated with nursing documentation
Purpose of Documentation

- Tells the patient’s story
- Provides an illustrated timeline
- Shows how patient care decisions are made
- Shows communication among caregivers
- Creates a legal document
- Provides documentation for reimbursement
- Provides retrospective review of patient care for QAPI activities and peer review

Sources of Standards

- Nurse Practice Acts
- State licensing and federal regulations
- Accreditation Standards
- Insurance companies
- Institutional Policies
- Standards of practice (ANA, AORN)
### Basic Documentation Rules

- Document each phase of care
- Document nursing process:
  - Assessment
  - Outcomes
  - Care Planning
  - Nursing Interventions
  - Evaluation

### Basic Documentation Rules cont.

- Write objectively and legibly
- Use correct grammar and spelling
- Document in blue or black ink
- Be specific, concise
- Use appropriate forms (i.e. MAR for medication administration)
- Date and time each entry
- Write on every line
- Draw a line through unused spaces
- Use approved abbreviations and symbols

### Basic Documentation Rules cont.

- Follow facilities policy for error and late entries
- Do not use white out
- Document care given and response to care
- Document only the care you provide
- Document at the same time care is given
- Do not document prior to activity
Basic Documentation Rules cont.

- Be aware of critical times
- Abnormal vital signs or critical values
- Patient hand offs
- Taking verbal orders
- Noting physician orders
- Verifying medication orders
- Transfers and codes

Basic Documentation Rules cont.

- Include initials/signature along with credentials
- Document medication administration including dose, route, site, person administering Rx and signature
- Record allergies and adverse reactions
- Document any complications

Basic Documentation Rules cont.

- Follow facility policy for telephone and verbal orders
- Document read backs and verifications
- Document an incident in the record and on an incident report (do not document that an incident report was completed)
- Be sure documented events occur
  - Use of safe surgical checklist
  - DVT or fall risk assessment
Basic Documentation Rules cont.

- When documenting by exception be sure to understand how WNL (within normal limits) is defined for your facility.
- Avoid general statements.
  - “spoke to physician” vs “reported abnormal values to physician and no orders given.”

Basic Documentation Rules cont. Physician Orders

- Obtain physician orders for all treatment.
  - Date and time orders.
  - Note all physician orders with date, time, signature and credentials.
- Pre-printed orders.
  - Admit to facility.
  - BS pre and post op.
- Verbal Orders.

Basic Documentation Rules cont. Scribing

- Can nurses perform and write on H&P?
- Can nurses write on op report or op note?
- According to TJC, a scribe is an unlicensed person hired to enter information into the medical record; normally used in EDs.
Basic Documentation Rules cont.

Scribing

- If used:
  - Job description
  - Orientation and training, specific to job
  - Competency assessment and performance evaluations
  - Role of scribe must be identifiable and distinguishable from that of the physician
    - “Scribed by Dr. X by name of the scribe and title” with the date and time of the entry
    - Physician must authenticate the entry by signing, dating and timing before leaving the patient care area
  - Scribes cannot take verbal orders as only licensed personnel can take verbal orders

An Attorney’s Dream

- Notes that are sloppy, incomplete, inconsistent, illegible or have gaps
- Entries that show delay or failure to initiate orders
- Entries that are not timed or dated or out of sequence
- Entries that show substandard or inappropriate care

An Attorney’s Dream cont.

- Unexplained late entries
- Erased or obliterated entries
- Lack of patient education or discharge instructions
- Physician never reviews a record because it is apparent nurse performs documentation
Statute of Limitations

- State by state
- In general, retain all documents (incident reports, peer review) for 6-8 years unless state specific

ASC Regulatory Requirements and Recommendations

- Individual State Nurse Practice Acts
- ANA (American Nurses Association)
- Professional Associations (AORN)
- State licensing requirements
- CMS
- Accrediting Bodies

CMS Requirements

- 416.47: Medical Record Organization
  - The ASC must develop and maintain a system for the proper collection, storage and use of patient records
  - Retention of records
    - State
    - Facility Policy
CMS Requirements cont.

• CMS 416.47(b): Form and Content of MR
  • Patient identification
  • Medical history and physical examination (416.52)
  • Pre-op diagnostic studies
  • Findings and techniques of operating, including pathology results
  • Allergies and abnormal drug reactions

CMS Requirements cont.

• Entries related to anesthesia administration
  • 416.42 (a): pre and post anesthesia assessment
  • 416.52(a): H&P
  • Properly executed informed patient consent
  • Discharge diagnosis

CMS Requirements cont.

• 416.48: Pharmaceutical Services
  • An MD or qualified practitioner must sign an order for every drug and biological administered to the patient
  • Adverse drug reactions must be documented
  • Blood product administration must be documented
  • Verbal orders must be followed by a written order signed by the prescribing physician
  • Use of read back and verify
CMS Requirements cont.

• 416.50: Patient Rights
  • Advance Notification of Patient Rights. ASC policy on
    Advance Directives and ASC Ownership
  • Provide in advance of procedure
  • Confidentiality of Clinical Records (HIPAA)

CMS Requirements cont.

• 416.52: Patient Admission, Assessment and Discharge
  • Comprehensive H&P ≤ or = 30 days (medical history and
    physical exam)
  • Pre-surgical assessment “immediately” before surgery
  • Written discharge instructions
  • How to contact the physician providing follow-up care
  • Indicate prescriptions given to patient
  • Copy of discharge instructions in the patient record

CMS Requirements cont.

• 416.52 ( c ): “Ensure each patient has a discharge order,
  signed by the physician who performed the surgery or
  procedure…”
  • Per ASCA: “The guidelines now state that “it is permissible for
    the operating physician to write a discharge order indicating
    ‘the patient may be discharged when stable.’” even if that is
    past the 15-30 minute window.”
Safe Surgical Checklist

- Safe Surgery Checklist Resources:
  - eSupport

Safe Surgical Checklist cont.

- The requirement stems from CMS CIC 416.42 Interpretive Guidelines:
  - Generally accepted procedures to avoid such surgical errors require:
    - A pre-procedure verification process to make sure all relevant documents (including the patient’s signed informed consent) and related information are available, correctly identified, match the patient, and are consistent with the procedure the patient and the ASC’s clinical staff expect to be performed.
    - Marking of the intended procedure site by the physician who will perform the procedure or another member of the surgical team so that it is unambiguously clear.
    - A “time out” before starting the procedure to confirm that the correct patient, site, and procedure have been identified, and that all required documents and equipment are available and ready for use.

- CMS is non prescriptive in it’s requirement. It does not mandate what items must be included on a checklist, where the checklist is located, if it is part of the MR, etc.

Accrediting Body

- Ensure standards are reflected in policies
- Ensure standards are reflected in medical records
- AAAHC Example:
  - Summary of history if multiple admissions or large chart
- TJC Example:
  - Range of waived testing results documented
ASC Clinical Chart – Pre Op

- Demographic information for identification
- Privacy Notice (every 6 years unless updated)
- Advance notification of Patient Rights, Advance Directive policy, Ownership
- Pre-op Phone call performed by RN
- Pre-admission assessment/history completed by patient

ASC Clinical Chart – Pre Op

- Physician orders for treatment
- Date and time admitted
- Vital signs, weight
- Pre-op medications, if applicable
- IV site documentation and rate, if applicable
- Comprehensive H&P/Update note for H&P

ASC Clinical Chart – Pre Op cont.

- DVT and Fall risk assessment, as applicable
- Disposition of jewelry, dentures, hearing aids
- NPO status
- Allergies noted in prominent location
- Surgical Site marking by physician
- Facility consent signed and witnessed; including consent for anesthesia
- Nursing assessment as defined by ASC policy
ASC Clinical Chart – Pre Op cont.
Facility Consent
- Informed Consent
- Need FACILITY consent
- Description of and indications for proposed surgery given at MD office
- Statement of understanding of material risks, benefits, alternatives
- Surgical Practitioner/Anesthesia provider
- Other practitioners involved in procedure “performing important tasks”

ASC Clinical Chart – Pre Op cont.
Pre op Nursing Assessment
- Nothing specific in regulations
- Must have nursing at each phase of care
- Head to toe assessment?
- Pre-op Phone call for patient history?
- On site patient history and medication list?

ASC Clinical Chart – Intra op
- Operating Room #
- Physician orders for treatment (intra op medications to the sterile field)
- Surgeon(s)/anesthesia provider
- Clinical Staff present
- Reps, students present
- Skin prep performed
<table>
<thead>
<tr>
<th>ASC Clinical Chart – Intra op cont.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Patient into and out of room time</td>
</tr>
<tr>
<td>- Time out</td>
</tr>
<tr>
<td>- Procedure start and stop time</td>
</tr>
<tr>
<td>- Pre-op and post-op diagnosis</td>
</tr>
<tr>
<td>- Procedure performed</td>
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<tr>
<td>- Patient position and positioning aids utilized</td>
</tr>
<tr>
<td>- Safety strap/rail</td>
</tr>
<tr>
<td>- Medication administered</td>
</tr>
<tr>
<td>- Implants</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ASC Clinical Chart – Intra op cont.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Cautery ground pad placement</td>
</tr>
<tr>
<td>- Specimen or culture, if applicable</td>
</tr>
<tr>
<td>- Dressings, if applicable</td>
</tr>
<tr>
<td>- Wound class, if applicable</td>
</tr>
<tr>
<td>- Equipment identification numbers, if applicable</td>
</tr>
<tr>
<td>- Sponge and Needle Counts</td>
</tr>
<tr>
<td>- Use of safe surgical checklist</td>
</tr>
<tr>
<td>- Time of transfer and to whom report is given</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>ASC Clinical Chart - Medical</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Operative Record by Surgeon</td>
</tr>
<tr>
<td>- Immediate post op note by Surgeon if operative record is dictated</td>
</tr>
<tr>
<td>- Anesthesia form including pre and post evaluations</td>
</tr>
</tbody>
</table>
ASC Clinical Chart - PACU

- Time patient is received and from whom
- Physician orders for treatment
- Admission assessment
- VS per facility policies
- Pain assessment, treatment and response
- Aldrete or other recovery score

ASC Clinical Chart – PACU cont.

- Patient activity
- Wound/surgical site inspection
- Discharge teaching/discharge instructions
- Physician order for discharge
- Condition at discharge
- To whom and how the patient is discharged
- Documentation of all reports to physician, if applicable

QAPI and the Medical Record

- Describes how you evaluate your nursing care (416.46)
- Complications
- Adverse Patient Events
- Chart Audit Results
QAPI and the Medical Record

- PI Project/QA Studies
- ASC Quality Measures (Burn, Antibiotic Timing, Transfers, Falls, Wrong Site/Side/Patient/Provider/Implant)

Chart Audit Sample

Chart Audit Sample
Incident Reporting

- Contents
  - Name and demographics of patient involved
  - Time, date and location of incident
  - Patient condition before and after incident
  - Staff involved/witnesses
  - Name of person who caused incident
  - OBJECTIVE description of event, including “type” of event: fall, equipment, medication, security, etc.

Peer Review

- Random sample
  - Determine sample # of charts to review on a regular basis
  - Have peers review patient record using standardized form

Peer Review

- Non random review
  - All emergency transfers
  - All known complications
  - All reported infections
  - All discrepancies between preoperative and postoperative diagnoses (per pathology report)
  - All incident reports related to the practitioner
Observed Deficiencies in ASCs

- Treatment in pre-op prior to physician treatment orders
- Medication administration written on orders
- No intra-op medication orders
- Physician orders not noted
- Entries not timed
- Several people documenting on one form

Observed Deficiencies in ASCs

- Safe surgical checklist utilization checked but not actually implemented during tracer activity
- No specific discharge order
- No op note; only notation of dictation
- Physician consent rather than facility consent
- Incomplete documentation for certain procedures: yag lasers
- Temperature not included in VS
- Range of medication dose vs. specific dose
- Blank areas

Observed Deficiencies in ASCs

- Medications missing dose and frequency
- Allergies not matching within record
- Lack of documentation of communication between patient care areas
- Weights listed but no scale in facility
- Nurses scribing op reports
EMR Challenges

• Same “basic” rules as paper records
• Access and security
• Proof of authentication (who truly signs?)
• Time and date stamping
• Late entries
• When chart is “closed”

EMR Challenges cont.

• Plan B
• Lines thru unused areas
• Prominent viewing of allergies and advance directive
• Increased provider time on computer

Name That Issue!
Listed under “Current Medications”

- 800 mg Motrin, phenergan, loperasor, flexeril, gabapentin
- Meds taken this morning: blood pressure meds

Listed under physical exam

- Mental Status: Normal for age

Pre op Order

- Physician to mark surgical site in pre-op
Post op order

- May give Demerol 50-75 mg IM prn pain

References

- CMS cFc and interpretive guidelines, Rev 76
- CMS Memo, March 30, 2012, Revisions to Ambulatory Surgical Center (ASC) Patient Rights Regulation
- TJC Standards FAQ: Use of Unlicensed persons acting as scribes, May 18, 2011
- Scott Becker, JD, CPA, McGuire Woods Consulting
- Progressive Surgical Solutions

Questions??

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