4-28-25 Weekly Clinical Update

In one of this week's association updates, an article was shared to related to the increased importance of documentation in multiple areas. Complete, accurate and comprehensive documentation has been a challenge since resident records started. In fact, clear back in 2007, a study was done related to barriers to effective documentation which pointed out 4 common barriers (https://health.maryland.gov/mbon/Documents/documentation_challenges.pdf):

- Redundant documentation: double documentation leads to excess time & documentation inconsistencies and errors
- Excessive time spent documenting taking staff away from direct resident care
- More than 1/3 of the nurses reported routinely staying beyond their scheduled work hours to complete documentation and almost 2/3 of these were paid for the "stay over period,"
- Routinely documenting for reasons other than recording and communication of pertinent clinical information. (e.g. regulatory requirements and third party payors.)

That being said, the requirements for good documentation is the only way a facility and the individual nurse can protect the organization and the staff themselves from regulatory and legal repercussions.

This week, the focus will be on appropriate documentation of behaviors. This is an emphasis in QSO-25-14-NH REVISED https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos/policy-memos-states-and-cms-locations/revised-revised-long-term-care-ltc-surveyor-guidance-significant-revisions-enhance-quality-and-0

Key components of behavior documentation include:

- Behavior description
    - Clearly describe the behavior observed, avoiding vague terms. For example, avoid using generalized terms like "agitated", or "anxious" and instead, specifically describe what the resident was doing at the time of the observation/assessment such as "resident was observed constantly pacing in room and in hallway and into other resident room and raising voice when approached"
- Context and triggers
    - (WARNING: this is a Root Cause Analysis): Note the time, the location, who was in the area, identified or potential triggers to the identified behavior(s) such as: PAIN, over stimulation from dining room/common area/excessive

lighting, loud noises, over-stimulation from TV, under-stimulation from lack of meaningful activities, loneliness, cold, hot, hunger, thirst, fear, etc.

- Interventions and Outcomes which should be included in the resident's care plan
    - Record the specific actions/interventions implemented by staff and the resident's response such as: music therapy, reminiscence, assistance in making contact with family member(s), taking resident outside, offer comfort foods, 1:1 compassionate touch with hand massage, pet therapy, etc.
- Frequency and Duration
    - Document how often the behavior occurs and how long the behavior lasts
- Impact on Care
    - Document details on how the behavior affects the resident's quality of care and quality of life and the resident's interactions with others

Best practices for documentation include but is not limited to:

- Use Electronic Medical Record tools and forms to ensure consistency but remember…NO BLANKS
    - Teach licensed nurses and all direct care partners in documentation expectations based on sound principles of documentation
- Multidisciplinary input
    - Collaborate with the entire IDT including the resident, resident family members and the Direct Care Partners to gather information
- ALWAYS use Person-Centered Approaches
    - Focus on the resident's preferences, history and comfort to guide all interventions
- Regular Updates
    - Continuously update records including the documentation and the resident's care plan to reflect any/all changes in behavior or effectiveness of interventions
- Training and Education
    - It is the responsibility of the facility leadership to ensure that all staff are trained in recognizing and documenting dementia-related behaviors, then hold staff accountable in implementing the education provided

Effective documentation of dementia-related behaviors is a basic cornerstone of quality care in any facility. By adhering to best practices and regulatory guidelines, staff can enhance residents' well-being, ensure compliance, and support the resident's quality of life and quality of care.