Psychosocial Documentation: Guidelines and Case Examples to Improve Social Work Risk Management

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Paige is skilled at inspiring staff to critically evaluate their own organizations and then gives them the resources and guidance to make desired changes.
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Objectives
- Define risk management and areas of risk in long-term care facilities
- Recognize risky words and phrases and objective alternatives
- Review examples of documentation including complaints
- Incorporate defensive documentation components with two case examples

Documentation can be either a facility’s “saving grace” or its “worst nightmare.” Plaintiffs’ attorneys love vague entries in medical records. They can become whatever an attorney needs them to become.


What IS Risk Management?
- Risk management is a continuous action
  - NOT one task
  - NOT one department
  - NOT one moment in time
- EVERY staff member must practice risk management all day, everyday
What are the **Exposures** in your facility?

*In other words, what are the areas of risk?*

- Falls
- Wounds
- Wrong patient/procedure/side/site
- Medication Errors
- Improper discharge
- Changes of condition (untreated or undiagnosed)
- Weight loss
- Death

**Areas of Risk?**

**NO!!!**

- Those are **EVENTS**
- As clinicians, **WE KNOW** those events are likely going to occur
- More importantly
  - Do the residents, patients and families know and understand these events?


So, What are the **Exposures** (Areas of Risk)?

- Staff unprepared for consequences of guilt induced anger
- Staff unprepared to defuse escalating situations
- Family or residents concerns going unreported
- Voiced concerns not addressed (from a customer service perspective)
- Lack of documented support from the physician for nursing care plans and resident's diagnoses and prognosis
- Facility failure to negotiate risks and minimize this in the record and care plans


**Why Do We Document?**

- Provide a vehicle for healthcare workers to share information
- Demonstrate compliance with standards of care
  - JCAHO, the Centers for Medicare and Medicaid, federal and state reimbursement guidelines, and facility policy and procedures
- Demonstrate that patient care meets safe, effective and legal requirements
- Reimbursement, eligibility and other financial requirements
Outside Readers

○ The medical record is not just a facility document
○ Outside readers include:
  ◦ Insurance companies
  ◦ Surveyors
  ◦ Ombudsmen
  ◦ Consultants
  ◦ Medicare intermediaries
  ◦ Authorized family members
  ◦ Attorneys

Common Areas of Litigation

○ Failure to diagnose
○ Mediation errors
○ Wrong patient/procedure/site
○ Dehydration
○ Falls
○ Improper discharge
○ Changes of condition (untreated or undiagnosed)

Not Documented, Did Not Happen?

○ “If it’s not documented, it wasn’t done.”
○ Very familiar saying – we probably use it!
  
  Is it true?

True?

○ Absolutely not!
○ There are hundreds of interactions between staff and residents (families) that are not captured in the medical record

Our Challenge

○ Select interactions that support care provided to the resident, record information about those interactions and outcomes
○ Avoid pitfalls that can lead to adverse outcomes in the courtroom

Paint the Picture

○ The reader should be able to SEE the behavior and/or HEAR the resident verbalizing

Greenwald, Steven C., Social Work Policies, Procedures and Guidelines for Long-Term Care, Social Work Consultation Group Publishing, 2002
Painting a Picture Example

Example:

- "Resident was agitated."

OR

- "Resident was pacing rapidly around the room and rubbing her hands on her blouse. Twice she kicked the end table and cursed, 'God-damnit, why is that thing in my way!' When approached by staff she yelled, 'I don't want to talk right now!''

Risky Words & Phrases

Words to Avoid

- Mistake
- Accidentally
- Incident
- Grievance
- Abuse/abusive
- Somehow
- Unintentionally
- Miscalculated
- Confusing
- Apparently
- May be
- Could be
- Assume

Use This Instead…

- Do Not Use
  - Anxious

- Use instead
  - Eager
  - Unless truly anxious and then just describe what is seen and heard
  - Just leave this out
  - Describe
  - Describe
  - Declines medication, etc
  - Pt. verbalized understanding

“Appears”

- This word can be confusing as staff may describe the same situation differently
- What “appears” upset to you may appear angry or frustrated to me
- Provide qualifiers after the term using “as evidenced by”
- Examples:
  - “Patient appeared elated as evidenced by laughter and a smiling face.”
  - Or, “Patient was laughing and smiling.”
  - “Patient appeared discouraged as evidenced by a downturn look and turning his body toward the wall and putting his head down.”
  - Or, “Patient did not make eye contact and turned his body toward the wall.”
  - “Patient appeared furious as evidenced by yelling and banging his fist on the arm of his wheelchair.”
  - Or, “Patient was yelling and banging his fist on the wheelchair.”

“Will follow up” or “Will monitor”

- Social workers also use “Will monitor and assist as needed” or “Will continue to implement the plan of care”
- When used, these statements **must demonstrate** the “next steps” of care/treatment/plan
- Unfortunately, that component is usually missing
- Be careful!
  - HOW and WHEN do you plan to follow up?
  - What is your personal system to keep track of things you have agreed to do either verbally or in the care plan?
Think Bullets

- Be succinct
- Get to the point quickly
- "Just the facts Ma’am"
- Try to compose information into bullet format
- Not necessary to use complete sentences!
- It is necessary to use correct grammar and spelling in order to avoid unnecessary problems

DARE Criteria

- Follow DARE criteria as a mental format to review as you write a narrative note
  - D: Data, Details
  - A: Assessment, Action
  - R: Response, report
  - E: Evaluation, education

Data, Details

- What information is needed to establish a baseline?
  - Vitals, labs, percentage food consumed, pain scale, investigative information, etc.
  - PHQ-9 scores, cognitive status, status of discharge plan and services, etc.

- What did the patient say?

- What do caregivers report?

- What did the family or other team members share?
Response, Report

- How did the resident respond to the action(s) taken?
  - The overall goal is a sense of well-being, not a cure-all
- Who else needs to have the data, assessment, actions and responses?
  - Nursing management, administrator, physician, care plan team, family
  - "Report pertinent information once you have it."

Beicher, Tra, RNC, ARM, HRM, CWS, Defensive Documentation for Long-Term Care: Strategies for creating a more lawsuit-proof resident record, HCPro, Inc, 2003

Evaluation, Education

- Review everything you have done during the care process
- Does the documentation contain all necessary information to support good judgment?
- Do you need to educate anyone, i.e. techs, aides, housekeeping, family, etc?

Beicher, Tra, RNC, ARM, HRM, CWS, Defensive Documentation for Long-Term Care: Strategies for creating a more lawsuit-proof resident record, HCPro, Inc, 2003

Documentation Examples

Example 1

- 5/29/12 Waiting on trapeze for her bed.

Improvement

- 5/29/12 0900 Patient seen by PT and recommendation made for a bed trapeze to assist with independence for transfers. Patient is able to transfer at this time but it is difficult for her to pull herself up. The trapeze will make it easier for her. The fall risk assessment on 5/28/12 does not indicate she is a fall risk nor has she fallen since her admission to the facility. Patient in agreement with the trapeze. Ordered by central supply and will be here in 1-2 days.
Example 2

○ 4/2/12 English is extremely limited as patient speaks Arabic.

○ 4/19/12 Speaks Arabic and understands a few English terms. Needs a translator.

Evaluation

○ Missing times of entries

○ How does staff facilitate communication?

○ If a translator is not available, how does staff communicate with resident to meet her needs?

○ Does the care plan reflect the language barrier and necessary interventions?

Improvement

○ 4/12/12 0945 Resident’s primary language is Arabic although she understands a few English words including water, hurt and eat. During weekdays, there is a nurse assistant who can translate for her. In the evenings, family usually visits but is always available by phone to assist. The daughter is working with the rehab dept to develop a communication board. When an interpreter is not available, staff uses the language service by calling 555-555-5555. Care plan updated.

Example 3

○ Care conference notes: "Has upper and lower dentures, he takes them out and doesn’t like anyone touching his mouth."

Evaluation

○ Why doesn’t he like his mouth touched?
  - Pain? Confusion? Fear? What else?

○ What is his intake?

○ How does staff ensure he does not develop oral problems?

○ Does he have a denture cup in his room?

○ Is he capable of cleaning the dentures? Does he clean them?

Improvement

○ Patient wears upper and lower dentures but does not like staff to provide oral care. He has a denture cup in his bathroom and staff has observed him putting the dentures there at night. He says he took care of his dentures at home and he’ll do the same here. Denies mouth pain and intake is consistently above 90%. Daughter aware of situation and stated she is not surprised with his reluctance to let staff help with dentures. She agreed to notify staff if she detects a concern with oral care.
Documenting Complaints & Risk Management

Importance of Validation & Apology
- Definition of apology – “a written or spoken statement expressing remorse for something” Encarta Dictionary 2009
  - “An apology does not mean the acceptance of blame.”
- Offering an apology is very important and also helps to validate the concern
- The investigation of the problem may reveal other factors that come into play but for the moment, “the concern should be validated.”
- By validating a complaint, the person feels like they are being heard which is critical toward de-escalating behavior
- Example:
  - “I see how this would concern you.”
  - “I am sorry the glasses are missing.”
  - “I am sorry your mom’s clothing is soiled.”


Document Reality
- When documenting a complaint, include the patient or family member’s perception of the problem
- And then, document the reality

Complaint Example
- 8/1/12 1730 This writer observed patient yelling at charge nurse “You’re an idiot! I haven’t gotten my pain medicine all day!” Nurse administered pain med per orders at 0800 and 1600 today. A breakthrough dose was administered at 1200. Spoke with patient who complained of pain in her lower back...

Complaint Example 2
- Son upset that dad does not have a private room, stated, “This place costs an arm and a leg. The least you can do is give him his own room!” Son doesn’t feel his dad should have to share a room. Resident payer source is Medicaid which does not cover the private room rate. Resident has not offered complaints regarding having a roommate. This writer explained his father’s payer source as well as talked with son regarding his feelings about dad’s placement in the LTC setting. He shared that he feels badly that he couldn’t care for dad at home any longer. SW offered support and encouraged son to call or stop by to visit anytime. He expressed appreciation.

Even if a patient or family member is not happy with the outcome, it does not mean the issue was not resolved
Part II – Case Examples

Case 1 – Mrs. Levy

- Mrs. Levy is an 84 y.o. female with a diagnosis of dementia and anxiety. She has resided on the secured dementia unit for ~6 months when her husband’s terminal illness no longer allowed him to be her primary caregiver. Significant short term memory impairment. Hearing is impaired and she wears hearing aids.
- Mrs. Levy has a long hx of anxiety which is exhibited by rubbing and picking at her scalp (she has bald spots) & repeatedly washing her hair. She wears hats to deter the behavior.
- Independent in ambulation but requires guidance, cueing, and supervision with ADL’s. Frequently wanders into peers rooms to use their toilet or wash her hair as she is not always able to locate the bathroom in her bedroom.
- Verbal responses with staff and family are appropriate, but does not initiate conversation and staff must anticipate all needs. To help with her adjustment to her living environment, the family keeps as many of Mrs. Levy’s prior routine as possible. This includes her daily lunch out with her husband and grandson in the cafe near his apartment on campus.

Customer Service Request/Concern #1

- **Issue:** Right hearing aide missing.
  Left and right hearing aides applied by personal caregiver in AM. On evening shift, only the left one was in her ear.

Concern #1 cont.

- **Investigation:** Multiple staff have searched rooms and are unable to locate hearing aid. Caregiver confirms resident went to brunch while wearing hearing aide. Security, housekeeping and laundry informed of missing hearing aide should it be located by another department outside of the health care center. Social worker informed grandson (caregiver for resident’s spouse who is very ill) of above.

Concern #1 cont.

- **Resolution/Notification:** Grandson will wait a few weeks to see if hearing aid turns up before filing for a new one under warranty. Discussed with grandson the option of a pocket talker due to resident level of dementia, constant rubbing of head and washing hair and resident inability to know if hearing aid is missing. Grandson wishes to replace hearing aid first.

Case 2 – Mr. Lewis

- Mr. Lewis is a 90 y.o. male with a diagnosis of dementia and psychosis. He previously lived with his wife in an independent apartment. He has lived in the nursing home for the past 3 months after wandering outside his home into the neighboring community during the middle of the night.
- Since admission, Mr. Lewis’ wandering has escalated to multiple elopement attempts complicated by aggressiveness toward staff with attempts at redirection. His medical and physical condition declined rapidly where he required increased assistance with ADL’s.
- Due to Mr. Lewis’ history of wandering, as his physical status declined, he became more restless when in his wheelchair or in bed. He often required more than one staff member for cares (one to assist with redirection, one to provide cares). Mr. Lewis had 2 medical hospitalizations and one in-patient psychiatric hospitalization during this time.
- Mr. Lewis’ wife visited briefly each day, and it was observed that Mr. Lewis’ behaviors decreased when he had someone (family or staff) with him at all times. Staff arranged 24/7 caregivers early in his stay for this reason. As Mr. Lewis’ condition declined and he no longer required extensive 1:1, the family chose to continue private caregiver services.
Customer Service Request/Concern #2

- **Issue:** Supervisor from the caregiver agency contacted social worker to relay that three caregivers from her staff were refusing to provide further services to resident. She relayed that the caregiver had put the call light on and staff was "non-responsive" for >1 hour leaving the caregiver to provide care without staff assist.

**Concern #2 cont.**

- **Investigation:** Social worker followed up with agency to request specifics of dates/times. Two of the three caregivers declined to provide details. Caregiver who worked 8a-8p shift on 5-9-13 stated that she put the light on three times and the wait was about 20 minutes, making the cumulative time >1 hour. Caregiver was unable to leave resident alone due to behaviors to physically look for staff assist and provided ADL care by self resulting in "hurting her back" and a subsequent request not to return to provide services to resident.

**Concern #2 cont.**

- **Resolution/Notification:** Pulled data reports for call lights for 5-9-13 thru 5-10-13 and 5-23-13. Report does not substantiate claim that light was not answered in >1 hour. Responses ranged from 56 seconds to 17 minutes. Followed up with agency supervisor to educate staff that if they feel call light is not being answered timely, to use phone in room to contact nursing station and stand in doorway to obtain staff attention.

**Summary**

- Documentation skills take practice
- Don't just "wing it!"
- Identify someone in your facility, corporation or an outside resource to consult before you chart it in the medical record

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Thank you for your time and attention. 
*Paige & Deb*