If it is not documented, it never happened. Document, Document, Document!” We all know that mantra. Yet many dietitians are finding themselves on the wrong side of the witness stand. Why do so many legal cases come down to poor documentation? Who among us hasn’t whipped through the last 30 minutes of our day in order to ensure a timely departure because facility hours are tight or because we have other plans after work? Pushing documentation aside is not a good practice. Documentation protects residents’ wellbeing and our livelihoods. Good documentation is the best protection in a malpractice proceeding. Improving documentation skills requires personal effort and practice, practice, practice.

The Medical Record
The medical record chronologically documents the nutritional care of the resident and is an important element contributing to high quality care. Documentation is required to record pertinent facts, findings, and observations about a resident’s history including past and present relevant conditions and diagnoses, diet history including past and present eating habits, food and fluid intake, nutrition related medications, lab values, physical and mental functioning, weight status, skin conditions, treatments, interventions and outcomes.

The key to documentation is to leave absolutely no doubt that your resident was continually assessed, monitored and treated by a competent dietitian. Documentation helps prove you provided the standard of care to your resident.

Follow Established Standards of Care
Standards of care are standards developed by national credible regulatory agencies or professional organizations such as Center for Medicare/Medicaid Services (CMS), Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations), Agency for Health Care Policy and Research (AHRQ), American Medical Directors Association (AMDA), American Dietetic Association (ADA), National Pressure Ulcer Advisory Panel (NPUAP), etc.

Your facility policies, procedures and protocols should be based on these acceptable standards of care.

We are all taught specific lingo; we think we know what it means. If you don't know the meaning of a term, don't use it. Standardized terms don't mean the same thing from one facility to another. Non-standardized abbreviations should not be used. Use only terms and abbreviations noted in your policy and procedure manual.

Liability
Typically, not notifying the doctor about a change in nutritional status of the resident can result in liability. You have the responsibility to your resident to intervene on their behalf, when they are incapable of doing so. Document the interventions you took until the physician responded to the request. If a physician receives information regarding a change in nutritional condition but does not give orders to rectify or follow up, document that.
Attorneys and Juries consider the medical record the most reliable source of information to determine what actually occurred. If you document properly, your chances of being named in a lawsuit may be lower, and in addition, if you are named in a lawsuit, your chances of defending yourself and/or your company are higher.

Under federal law, record falsification is viewed as submitting false claims. Record tampering undermines a dietitian's credibility in the event of litigation. It is important not to jeopardize the integrity of a resident's medical record. Upon legal examination of a medical record, the documentation will be closely and carefully scrutinized and the standard of care given will be expected to be reflected by the standard of documentation. An absence of documentation would ordinarily be interpreted as inferring that nothing was done in a particular circumstance. (“If it wasn’t documented, it wasn’t done.”)

Legal proceedings may occur after significant periods of time have elapsed since the care was provided, thus, Courts tend to give greater credibility to the accuracy of written, timely notes over verbal evidence that relies solely on memory. Health records may be admitted without the person who actually wrote the record, being present to give evidence. For this reason, we need to ensure that our documentation is accurate, comprehensive, and legible.

**Accurate and Comprehensive Documentation**
Accurate and comprehensive documentation honors the ethical concepts on which best practice is based and demonstrates the basis for professional and clinical decisions. Good documentation will also ensure that the ethical values of professional practice are understood and fulfilled. Such values include the need to protect confidentiality, to ensure informed consent, and respect the values and rights of individual residents. We have an ethical and a legal duty to maintain confidentiality so that personal information of residents does not become known by persons other than those who are directly involved in their care. Information contained in resident records should be held in confidence and viewed only by those who have a legitimate access to these records. Residents must be secure in the knowledge that the information that they share is treated with respect for their privacy and is kept secure and confidential.

**Confidentiality**
The application of electronic information technology for documentation should not be allowed to breach the important principle of confidentiality. Organizations are encouraged to have policies and procedures in place for staff that directly relate to the use and maintenance of, and access to any electronic information system. Examples of such mechanisms include personal identification codes, authentication, encryption, and segregation of different information classes. Legal advice should be obtained prior to the establishment of such a system.

Issues that should be considered with the use of electronic documentation include, but are not restricted to:

- Who will have access to the records
- How corrections will be made
- Who will make corrections in records
- Under what circumstances will corrections be made
- What mechanism/s prevent erasure of all or part of the record
- How entries will be identified
Appropriate access control mechanisms should be used with electronic records to both validate entries and prevent unauthorized access. When using an electronic information system, it is important to ensure a duplicate of all information stored is maintained and that the responsibility for this is clearly delegated to an appropriate person.

Summary
Careful attention to charting is never a waste of time. It helps you demonstrate the excellent nutrition care you have provided, saving yourself the need to defend it in court someday. REMEMBER: **IF IT IS NOT DOCUMENTED, IT NEVER HAPPENED**

Documentation Guidelines
1. Use black ink (colored ink may fade).
2. Do not skip any spaces or lines.
3. Direct quotes from residents should be included and identified.
4. State only facts. Opinions and impressions should be identified as such.
5. When entering data on a form with blocks or spaces for specific data, complete all spaces. Draw a line through all unused blank spaces.
6. Use standard, legally valid abbreviations.
7. Date all entries with month, day, year, and time.
8. Date all entries with full names and credentials.
9. Do not obliterate anything on a record. If a mistake is made, make a single line through the incorrect entry without rendering it illegible, sign and date the correction, then enter in the correct data.
10. When information is omitted from the record, it is considered acceptable to amend the record. “Late entries” are also acceptable, however should these be used infrequently. Take the time to document accurately in the first place.
11. Acceptable methods for recording “amendments”, “addendums” and “late entries” include: Create a new entry for the additional information. Do not annotate in the margins to add information. Keep all entries chronological and in record sequence. Title or head the entry or note as “Addendum”, “Amendment” or “Late Entry”. Use the actual date of the addendum, amendment or late entry. Reference the original entry or document by indicating the date of the service.
13. When noting a referral of a return visit on a specific day, use the full date (month/day/year), not the day of the week.
15. Document teaching methods. Include what was taught, when the teaching occurred what method was used, techniques used to ensure understanding of the material, and the resident’s response. **16. Do not backdate any medical record; it is illegal.**
17. Document lack of resident’s compliance.
18. Do not make uncomplimentary comments about the resident or a member of the resident’s family, or another member of the health care team. Remember, this is a legal document, which may become public if a liability case occurs.
19. Any discussions of problems or concerns with the resident, the resident’s family, or another member of the health care team should be recorded.
20. Do not criticize prior care or the incompleteness of the record keeping other health care professionals in the medical record.
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