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POLICY:

- Helms Home Care shall set legibility and legal standards for clinical documentation and monitor compliance with these standards as part of the agency's QAPI program.

- Agency registered nurses (RNs) are required to make and maintain records of their practice.

- Agency RNs are accountable for ensuring that documentation (whether using a paper-based or electronic system) is accurate and meets local and state Standards of Practice for Registered Nurses.

- Clinical documentation standards establish accountability, promote quality nursing care, facilitate communication between healthcare providers, and serve to convey and record the progress of nursing care and related patient outcomes.

- All clinical forms, whether Helms Home Care, pharmacy specific, copyrighted or otherwise, submitted for an Agency client are subject to this policy and any applicable state and federal regulations regarding clinical, medical, and/or nursing documentation.

- Clinical documentation, individually and commonly referred to by the Agency as a "Visit Note" is a legal document and shall be treated as such in conjunction with agency PHI policies, HIPAA standards and recognized practices & standards of the American Nurses Association (ANA).

STANDARDS & REQUIREMENTS:

1. Following a clinical visit, unless otherwise specified, the nurse performing services shall complete, sign, and submit clinical documentation to the Agency within 48 hours of visit completion.
    - The Agency shall review and submit signed clinical documentation to the patient's medical record within three (3) business days of visit completion.

2. Clinical documentation shall be a true and original note for the specified visit date and times listed.
    - Copying and / or re-using previous documentation is considered fraudulent.
    - RNs submitting clinical documentation that has been copying and / or re-used will be reprimanded, up to and including reporting to the State Board of Nursing, termination, and withholding / reversal of pay for the visit.

3. Each clinical note must minimally include:
    - Patient's legal First and Last Name
    - Patient's Date of Birth
    - RN Arrival and Departure time (to and from the patient's residence)
    - RN Signature and legibly printed name, with credentials
    - Patient vitals (Blood Pressure, Temperature, Respiratory Rate, Pulse)
        - RNs are expected to obtain true and accurate vitals
        - Additional vitals at required intervals (and accurate infusion rates as applicable) for RN administered infusions / injections.
    - Narrative notes, with appropriate level of notation.

4. Nursing care shall be documented in chronological order, including all aspects of the nursing process: assessment, planning, intervention, and evaluation.

5. Documentation shall include both objective and subjective data.

6. Documentation shall include pertinent and / or significant communication with family members / significant others, substitute decision-makers and other care providers.

7. Documentation shall include any advocacy that was undertaken on the client's behalf.

8. RN shall provide a full signature and professional designation with all documentation.

9. RN shall attempt to obtain a legal signature, as required, directly from the patient, when physically/mentally able, or from a responsible party when physically/mentally unable.

10. Hand-written paper documentation shall be legible and completed with blue or black ink.

11. Abbreviations and symbols should be used sparingly, by ensuring that each has a distinct interpretation or is approved by agency policy.

12. Documentation shall include all advice, care or services provided clearly and accurately.

13. Documentation shall include any nursing care provided via telecommunication technologies.

14. Documentation shall include informed patient / caregiver consent / acknowledgement / understanding for treatments or interventions performed.

Falsification of clinical documentation is considered fraud, and violators will be reprimanded up to and including reporting to the State Board of Nursing, termination, and withholding / reversal of pay for the visit(s).

ACCOUNTABILITY & LIABILITY:

1. Whenever possible, clinical documentation should be completed while in the patient's residence, during the delivery of care, or as soon as possible after, to ensure the most accurate account of the visit.

2. Agency staff will communicate with nurses regarding clinical documentation that has not been submitted in a timely manner, as necessary throughout each pay period and immediately prior to the payroll deadline each pay period.

3. Nurses that fail to submit clinical documentation by the Monday noon payroll deadline are subject to forfeiture of incentive, mileage, holiday, and other additional pay options as deemed appropriate.

    - Nurses will not forfeit additional pay options if there are reasonable circumstances, explanations or an agency agreement / understanding for accepting documentation late.

4. Nurses that fail to submit clinical documentation within 30 days of the visit date forfeit all pay agreements and additional pay options (mileage, incentive pay, holiday pay, etc.). The nurse is paid hourly for the visit, at the state's current minimum wage rate.

5. Nurses that fail to submit clinical documentation within 90 days of the visit date will be terminated from employment with the Agency and reported to the state Board of Nursing for failure to document / supply nursing record.

6. Corrections to a clinical note shall be made by making a single solid line through the error (ensuring that the original information remains visible/retrievable) and noting the nurse's initials and date in which the correction was made.

7. Late Additions to a clinical note will be made by noting / starting with the date in which the addition is added, followed by the additional information, and ended with the nurse's signature.

8. The narrative note should be legibly spaced but avoid empty lines / spacing that would allow another person to insert information. If there is blank space at the end of an entry, the RN should draw a diagonal line through the blank space to indicate no further entries.

9. Nurses shall document any unanticipated, unexpected, or abnormal event for a client, in accordance with agency policy, recording the facts of the incident and any subsequent related care provided.

10. Nurses shall document when information related to a visit or care provided has been lost or cannot be recalled.

INFORMATION SECURITY

1. Agency nurses and staff shall protect the confidentiality of client health information, by securely maintaining folders / binders / paperwork as well as passwords / information / technology utilized to access client health records.

2. Agency nurses and staff shall understand and adhere to policies, standards and legislation related to confidentiality, privacy, and security of client health information.

3. Agency nurses and staff shall refrain from accessing healthcare records (including their own) for purposes inconsistent with their professional obligations.

4. Agency nurses shall maintain the confidentiality of other clients by using initials or indiscriminate reference terms such as “Patient 2” when referring to another client on a clinical document (for example, when providing reason for a late visit arrival due to a previous patient visit or when referring to travel to or from another patient/visit).

5. Agency nurses and staff shall obtain informed consent from the client or substitute decision-maker to use and disclose information to others outside the circle of care, in accordance with relevant legislation.

6. Agency nurses and staff shall use a secure method to transmit client health information (for example, a secure fax, encrypted email, or secure SMS system).

7. Agency nurses shall retain hard copies of or electronic access to clinical documentation and relevant health records for a period of three (3) months after the provided care date.

8. Agency nurses and staff shall ensure the secure and confidential destruction of printed client health documents after retention period elapses.

FRAUDULENT DOCUMENTATION

Helms Home Care maintains a zero-tolerance policy for nurses knowingly and purposely submitting fraudulent documentation.

Examples of Clinical Documentation Fraud:

- Photocopying a previous visit note, changing certain information (i.e. the visit date and vitals) and submitting for an alternate visit date;
- Using whiteout to modify a clinical document;
- Copying clinical information (e.g., vitals, infusion rates) from a previous visit note;
- Documenting vitals without physically obtaining them;

- Documenting narrative statements that are untrue or unverified / assumed;
- Documenting infusion rates that are assumed (from a previous infusion or from the orders / rate sheet) and therefore inaccurate (Infusion rates should be obtained / verified directly from the pump.);
- Noting items or checking boxes that require patient confirmation without getting patient confirmation. (E.g.: noting pre-medications or checking 'Pain' as "Denies Pain" without asking the patient if they are having any pain.)
- Documenting arrival / departure times that are inaccurate (rounding up or down to nearest 15-minute increment is acceptable);
- Documenting mileage and / or drive time that is inaccurate (over-estimated).

- Falsification of clinical documentation is considered fraud, and violators will be reprimanded up to and including reporting to the State Board of Nursing, termination, and withholding of pay for the visit(s).

- Patient clinical reports, providers' documentation, administrators' records, and other documents related to patients and organizations providing and supporting patient care are important evidence in legal matters. Documentation that is incomplete, inaccurate, untimely, illegible, or inaccessible, or that is false / misleading can lead to several undesirable outcomes, including:
    - Impeding legal fact finding
    - Jeopardizing the legal rights, claims, and defenses of both patients and health care providers
    - Putting health care organizations and providers (yourself) at risk of liability up to and including fines, forfeiture of license, and jail time.