DOCUMENTATION : Writing down what you do!

And what you don't do, when it <u>is</u> on the care plan!

With today's economy and legal system, **documenting precisely what you do for your client** is more important than ever. It is important for:

- **consistent care** (especially when there is more than 1 caregiver in the home),
- helps us know if the **plan of care is being followed**
- helps the Medicaid Nurse Reviewer with the annual assessment and determining **how many hours your client needs for the next year,**
- **legally protects** yourself and our agency.

Take the time to **read carefully through the Negotiated Service Agreement ("NSA"** or the **Plan of Care** for client. It must be in the client's binder under "Care Plan." (If it is not there, please inform the office immediately.) This lists the tasks authorized by Health and Welfare, or by the client is who is paying privately.

It is so very important that you document your work <u>each day</u> according to the SPECIFIC DETAILS OF THE PLAN!!! Anyone who visits the home:

- Schedulers
- or the Nurse (at annual, quarterly or drop-in visits)
- or the RMU Nurse Reviewer
- or the client's family members

needs to be able to tell at a glance **whether the care fulfills what is on the NSA or care plan.** RMU reviewers use your progress notes just as we do - to evaluate whether the client is being taken care of as needed and has been authorized, and whether the plan still meets the needs of the client – whether they need more help or less.

When the Health and Welfare nurse reviewer makes her/his annual assessment visit for adult clients, s/he uses an assessment tool called the UAI, which has questions about what the client needs help with and how much help they need for each task. **If there are some tasks you are doing but not checking off on the progress notes, the nurse will think the client doesn't need the help anymore.** That will mean taking that task off the client's care plan (NSA) for the next year. Then the client wouldn't receive the care s/he needs, and hours of help may be reduced for the whole year.

On the other hand, if there are tasks that are **not** on the care plan, and the client's health changes so much that s/he needs more help, talk to someone in the office about that. (The change needs to be major like a heart attack or stroke, or a big change in family help available.) **If a scheduler in the office tells you to give extra help to your client** for things like bathing, toileting, and meal preparation, **be sure to check them off on your progress notes, too**. That provides documentation of the change in needs when we request more hours for a client. Also, when the nurse reviewer from Health and Welfare does the annual assessment, and the client says "Now I need help with my bath" (for example), the nurse can look in the progress notes, and see that you have indeed been

helping with the bath. The client will be more likely to receive a little increase in hours for the next year, then.

If the client's health improves, the opposite is true. Talk to someone in the office, and document that the client no longer needs help with a certain task. Perhaps the PCS hours need to be reduced to accurately reflect the client's needs.

Recording your work accurately on the progress notes is a really important part of being a caregiver. Incorrect documentation is grounds for probation or termination. And **daily** means just that – don't wait to document in a few days (how can you remember every detail accurately?!) and don't document a few shifts ahead. The client must sign the progress notes daily, too, for accuracy purposes and to avoid Medicaid fraud. Medicaid can drop in to audit progress notes in the client's home without notifying Above and Beyond. (Or in an extreme case, if you and/or the client fill out the progress notes a day or two early and then one of you happens to die so the progress notes can't be accurate, and the progress notes happen to be required in court for some reason, you and/or the client would be indicted for Medicaid fraud.)

And of course, **don't check off work that you don't do.** This is also Medicaid fraud, and you could lose your job and any future job with the state of Idaho. The client (since s/he signs the progress notes, saying that they are correct) could lose all Medicaid benefits. Both the client and you may be legally forced to **pay monetary fines.** It's serious business.

It is also important that **if a task is authorized and is on the care plan, and the client doesn't want you to do it that day , or you aren't able to for some reason,** mark **R for Refused**, with a circle around it, on the Progress Notes. **Explain why** the task wasn't done in the comments column. For example, the client may refuse a bath because s/he doesn't feel well that day, or you aren't able to vacuum the floor because the vacuum cleaner is being repaired. Or the client may feel too independent to want help with a bath, so you can write "client declines help with bath." Daily documentation protects you from being rightfully questioned about the work you are doing/not doing for the client.

If there is a pattern of R's for refused care for a week, or if the client frequently declines help with care that is on the care plan, call your supervisor ASAP 468-9504.

Thank you for taking the time to review your documentation for accuracy! Let's all be compliant with H&W rules for care and documentation.

Just a reminder about Above and Beyond's requirement: Progress notes not submitted by the Monday before a Friday payday can result in you being written up or even terminated if it is an ongoing problem. This is because we can only pay for services that we have been able to bill Medicaid for. In other words, A & B can't hand out pay checks if the money isn't coming in! Your help in turning in progress notes on time is critical to being paid for your work. Thank you for working with us! -Revised Jan 2010 Judy Unrau RN

QUIZ FOR "DOCUMENTATION" continuing ed.

Documentation means ____

Write down 2 of the 4 reasons writing things down (documenting) accurately is so important:

1. ____.

2. ____.

True False (circle one): Unless a client pays privately, Medicaid decides how many hours of PCS a client qualifies for, and how much the co-pay is, if the client has one.

True False (circle one): It is Medicaid fraud if you check that you are doing tasks for the client but you don't really do them. The state can require those who commit fraud to pay back any money they earned while working dishonestly.

It helps the Medicaid nurses when they go to client's homes for the annual a __ __ __ __ __ __ __ __ __ t s and can read the progress notes to see exactly what kind of help the client needs.

A client has the right to refuse help with something that is on the NSA or the Care Plan. The caregiver just needs to write the letter ______ and e __ __ __ __ __ __ __ w __ __ the task wasn't done.

Progress notes must be filled out and signed (circle a, b, or c for the correct answer):

a. each shift for that shift
b. Two days later
c. At the end of each week

True False Medicaid can audit a caregiver's progress notes in the client's home without Above and Beyond knowing about it.

True False Incorrect documentation is grounds for probation or termination.

For Above and Beyond, progress notes must be submitted by the ______________ before a ______________ payday. Later than that can lead to losing your job.

Name ________________________________ Date ____________________