Medical Documentation

Guideline: Information reflecting the medical plan of care as well as other pertinent information should be documented in the individual's record in an accurate, timely, and legible manner.

DEFINITIONS:

Individual's record: A permanent legal document that provides comprehensive information about the individual's health care status.

Primary care providers: Physicians, nurse practitioners, and physician assistants who provide primary care services and are authorized to prescribe medications and treatments for people on their assigned caseloads.

Medical progress notes: The section of the individual's record where primary care providers document their findings and provide rationale for treatment plans.

RATIONALE:[1]

1. Documentation in the individual's record facilitates communication among professionals from different disciplines and on different shifts. It provides information so that health care providers can deliver care in a coordinated manner.
2. Information in the individual's record is a source of data for quality assurance and peer review programs.
3. Reimbursement from third-party payers (i.e., Medicaid, Medicare) is based in part on the quality and timeliness of medical care reflected in the individual's record.
4. The individual's record serves as a legal document that may be entered into courtroom proceedings as a record of care the person received.

EXPECTED OUTCOMES:

Assessment

Documentation should reflect that medical assessment occurs on a timely and regular basis.

1. An admission history and physical should be completed in accordance with the regulatory standards for the facility. Intermediate Care Facilities for Individuals with Intellectual Disabilities **(ICFs/IID)**:[2] The admission physical examination must be completed by a physician[3] within 1 month prior to admission but no later than 48 hours after the person is admitted and include:
   a. Medical history completed within one month prior to or within 48 hours after admission.
   b. Physical findings; diagnosis.
   c. Orders written by a physician for medication, treatment, care and diet, which must be reviewed and reordered at least once every 3 months by a primary care provider.
2. A comprehensive annual assessment of the person's medical status should be completed and documented. Documentation should include:
   a. results of the physical examination including routine screening laboratory examinations as determined necessary by the primary care provider,[4]
   b. evaluation of vision and hearing,[5]
   c. immunizations, [6]

Assessment cont'd

d. pertinent changes in health status that occurred in the last year,
e. significant illnesses and/or diagnostic tests occurring in the last year, and
f. status of all major medical problems.

3. Results of physical examinations (or other medical appointments) should be documented or dictated the day the examination is performed. If documentation is not completed the same day, the medical progress note should reflect the day the examination was completed as well as the date it was recorded.[7]
4. Dates and signatures should be included on all progress notes the day they are recorded.

Diagnosis

All diagnoses should be properly documented in the individual's record. In Regional Centers, the Major Problem List should be complete and up to date.

Planning

Documentation should reflect that a medical plan of care is developed based on medical assessment and diagnosis.

1. There will be a medical plan of care for people needing 24 hour nursing care. The primary care provider should participate in the development of the plan.[8] The primary care provider's signature will indicate agreement with the plan that has been developed.
2. Self-administration of medication programs should be implemented only upon the recommendation of the interdisciplinary team and if a medical order exists.[9, 10]
3. The primary care provider should consider recommendations from the appropriate professional staff when prescribing modified and special diets.

Implementation

Documentation should reflect that the plan developed to meet health needs/problems is being implemented.

1. A progress note should be written that gives the rationale for laboratory work and x-rays ordered.
2. The primary care provider should review the results of laboratory work, x-rays, and consultations. The primary care provider should date and initial the reports to verify that review has been completed.
3. A progress note should be written regarding medical treatment rendered and the person's response to the treatment.
4. If recommendations made by consultants are not implemented, there should be documentation in the medical progress notes outlining the rationale of why recommendations were not followed.

Evaluation

Documentation should reflect that outcomes of medical interventions are carefully evaluated.

1. Documentation in the medical progress notes should reflect review of the person's overall health status and all prescribed medications at least quarterly.[11]
2. Regular and timely entries must be made in the medical progress notes reflecting ongoing medical review and interventions for acute health problems. Documentation should include the status of significant medical problems until problems are resolved.
3. Documentation in the medical progress notes should reflect review of pertinent x-ray and laboratory results.

Evaluation cont'd

4. Rationale for all changes in medications should be documented in the medical progress notes.
5. The medical progress notes should include information about adverse drug reactions, what treatment was rendered, and person's response to treatment.
6. In ICFs/IID, the review of the quarterly pharmacy report [12] and reports from other health related disciplines should be verified by the primary care provider dating and initialing the report at the time of review.
7. When irregularities in drug regimens are noted in the ICFs/IID quarterly pharmacy report[5], the primary care provider should make changes in the medication regime or provide rationale for continuing the treatment. Documentation of the action taken or rationale should be included in the medical progress notes.
8. If a person living in an ICF/IID is transferred to another facility, the transferring primary care provider or designee should write a summary note that includes the significant health history and current health status.
9. At the time of discharge, a summary of medical history and a post-discharge medical plan should accompany the person to the new residence. A copy should also be sent to the new health care provider, if that provider has been identified.

References

1. Scott, R. W. (2013). Legal, Ethical, and Practical Aspects of Patient Care Documentation: A Guide for Rehabilitation Professionals (4th ed.). Burlington, MA: Jones and Bartlett Publishers.

2. SC DHEC Regulation 61-13. Standards for Licensing Intermediate Care Facilities for Individuals With Intellectual Disabilities. Section 900 - Admission and Retention: C. (page 20). Available: http://www.scdhec.gov/Agency/docs/health-regs/61-13.pdf

3. State Operations Manual: Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities – §483.460 (483.460 (b)(1) - Tag 329. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

4. State Operations Manual: Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities – §483.460 (a)(3) (iii) - Tag W325. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

5. State Operations Manual: Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities – §483.460 (a)(3)(i) – Tag W323. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

6. State Operations Manual: Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities – §483.460 (a)(3)(ii) – Tag W324. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

7. Scott, R.W. (2013). Legal, Ethical, and Practical Aspects of Patient Care Documentation: A Guide for Rehabilitation Professionals (4th ed.). Burlington MA: Jones and Bartlett Publishers.

8. State Operations Manual: Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities – §483.460 (a)(2) – Tag W320. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

9. SC DHEC Regulation 61-13. Standards for Licensing Intermediate Care Facilities for Individuals With Intellectual Disabilities. Section 1203 – Administering Medication: E. (page 25) Available: http://www.scdhec.gov/Agency/docs/health-regs/61-13.pdf

10. State Operations Manual: Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities – §483.460 (k)(4) – Tag W371. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf

11. SC DHEC Regulation 61-13. Standards for Licensing Intermediate Care Facilities for Individuals With Intellectual Disabilities . Section 1005 – Physician Services: B and C (page 22). Available: http://www.scdhec.gov/Agency/docs/health-regs/61-13.pdf

12. State Operations Manual: Appendix J - Guidance to Surveyors: Intermediate Care Facilities for Individuals with Intellectual Disabilities – §483.460 (k)(4) – Tags W362, 363, 364. Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_j_intermcare.pdf