Documentation that Defends: Protecting Your Community Before a Claim Arises

Why Documentation Matters

- Regulatory Compliance
- Contemporaneous with Care
- Primary Source of Evidence
- Jury Expectation
- Limits the Plaintiff's Story

Regulatory Compliance

- Community Residential Care Facilities (CRCFs) 60-84

- "The record shall contain sufficient documented information to identify the resident and the agency and/or person responsible for each resident; support the diagnosis, secure the appropriate care/services (as needed); justify the care/services provided to include the course-of-action taken and results; the symptoms or other indications of sickness or injury; changes in physical/mental condition; the response/reaction to care, medication, and diet provided; and promote continuity of care among providers, consistent with acceptable standards of practice" (emphasis added)

- Failure to comply with regulations is not proof of violation of standard of care but plaintiff's counsel will use it to show lack of care

Regulatory Compliance

- Notes of Observation
  - Every month
  - Significant changes in a resident's medical condition and/or the occurrence of a serious incident, notes of observation shall be documented at least daily until the condition is stabilized and/or the incident is resolved
    - Injury
    - Hospitalization
  - Should be legible and contemporaneous

Regulatory Compliance

- Individual Care Plans
  - Within seven (7) days of admission
  - Reviewed and/or revised as changes in resident needs occur, but not less than semi-annually
  - Attended by and signed by resident, administrator (or designee), and/or the responsible party
  - Should be appropriately updated

Regulatory Compliance

- Incidents
  - Maintain a record of each accident and/or incident
  - Report every serious accident and/or incident that results in
    - (1) resident's death
    - (2) significant loss of function
    - (3) damage to a body structure, not related to the natural course of a resident's illness or underlying condition or normal course of treatment
  - “Serious accident and/or incident” – hospitalization, suspected abuse, laceration/hematoma, fracture, etc.
  - 24 hour and 5-day report to Department of Public Health
  - Must inform family within 24 hours

Contemporaneous with Care

- Demonstrates the care, observations, and interventions provided at the time they occurred
- Reliable and accurate source of evidence
  - Would you agree that your recollection of the incident was more accurate at the time it occurred?
  - Is it fair to say that the incident report is the most reliable source of what happened at the time of the incident?
- Reduces the risk of misunderstandings or conflicting accounts of what happened

Primary Source of Evidence

- Limited supporting evidence once lawsuit is filed
  - Staff turnover
  - Status of resident
- Passage of time reduces likelihood of reliable and accurate recollection of events

Staff Credibility

- Shows that staff were actively monitoring residents and responding to their needs
- Consistency in documentation supports a defense that staff are credible witnesses
- Documentation shows whether incident was foreseeable and if facility followed appropriate precautions

Jury Expectation

- Jurors cannot see the care that was provided, but they can see the documentation
- Helps jurors understand what happened, when it happened, and who was involved
- Jurors may view missing or incomplete documentation as evidence that care was not provided
- Place significant weight on records created before litigation began because they are perceived as less influenced by hindsight or self-interest

Limits the Plaintiff's Story

- Poor documentation can create doubt and invite speculation even when the actual care provided was appropriate
- Plaintiff's counsel will fill in the gaps of documentation with their own story
- Every note, assessment, and entry helps complete the factual picture and reduces opportunities for mischaracterization
- Inconsistency in documentation will also allow an opportunity for plaintiff's counsel to create their own narrative

Documentation Pitfalls that Create Liability

- No organization
- Late entries
- Copy-and-paste charting
- Missing follow-up after an identified risk
- Lack of consistency
- Failure to follow policies and procedures

Hypotheticals

- Good care deserves good documentation

- Make sure the documentation tells the story you want the opposing side to know