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| Documentation Document Margins = .5'' top/bottom/left/right; .3'' header/footerFont = 18pt Arial Bold All other font = 12pt ArialColumn 1 width = 3''Column 2 width = 2'' | **Last Revision:** | January 2021 |
| **Last Reviewed:** | January 2021 |
| **Applies to the following THA Group of Companies:**  | * Island Health Care
* Island Hospice
* RightHealth®
* THA Services
 |
| **Included in the following THA Manuals:** | [Policy & Procedure Manual][Section #] |

### PURPOSE

Complete, accurate clinical documentation is vital for a number of reasons. It is used to communicate a patient’s “medical story” to staff and provides evidence of positive outcomes, quality care, and improvement. It is also the basis for which the company is paid.

When documentation and processes/systems work, everyone benefits. All information is aligned, legible, complete, and congruent. Care is coordinated and communicated across disciplines in a timely manner, enabling staff to have the information needed to review notes, make care decisions, bill and more.

Documentation shows the quality of care given to patients. It protects our clinicians and the company from malpractice and minimizes the risk of takebacks and/or audits. Additionally, well organized documentation makes it easier for surveyors to review care practices and find the information they are looking for quickly and easily.

### POLICY

The Clinical Record is:

1. The only written source for communication among the home health team members and caregivers
2. The written source that supports reimbursement for services provided
3. The written evidence of clinical decision-making
4. The legal record of client care
5. The basis for evaluation of care provided by peers; auditors; licensing, accreditation, and government surveyor review
6. The evidence that demonstrates meeting the standard of care

Your documentation must include:

* Individualized care plans
* Assessments and the patient’s clinical status
* Problems
* Goals
* Interventions and the patient’s response
* Variances from expected outcomes (medications, procedures, protocols) and the action taken
* Communication with physicians and others
* Coordination of services provided
* Facilitation of communication with staff, caregivers or other providers
* All unusual patient occurrences or incidents

In consideration of the negative impacts of untimely documentation, violation of this policy is subject to corrective action up to and including separation. In addition, there will be a 20% reduction in compensation for untimely documentation. Our standard model of care requires documentation to take place at the point of care to ensure documentation is immediate. Follow up will be adhered to by auditing completion of documentation daily. Thus, requiring any visits that took place the day before showing completion of documentation by noon the following day. Furthermore, any documentation that is not completed timely will incur a reduction in pay. Failure to complete documentation at the point of care as required, will result in the same consequences upheld for the company by CMS by a reduction in payment of 20%.

### PROCEDURE

1. Documentation must be reported immediately and completed within 24 hours in the EHR. A majority of what is being recorded must be documented in the home during in-person visits while the patient is present. While virtual visits must be recorded at the time of the virtual visit while the patient is available virtually.
2. Computer problems that arise that prevent timely documentation must be immediately communicated to your leader and the IT Helpdesk Specialist.
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