Newsletter

October 27, 2020

№ 82

Licensed and Certified Facilities

Aloha,

CTA is distributing this information which is approved by the Office of Health Care Assurance. It is being distributed to all CCFFHs, ADCCs, and CMAs.

Aloha CCFFH Operators,

CTA has a NEW website. Our previous website was outdated and could no longer support additions of new newsletters or updated documents. Therefore, CTA now has a new website platform. The new website is still located at http://www.comties.com

It will take several weeks for CTA to update all the documents that have links within the documents themselves. We appreciate your patience. In the meantime, just go directly to the website to locate the item you need.

1. Documentation-Falsifying Records

Medical records are essential in establishing and tracking the medical care and treatment provided to your clients and may also be used in legal proceedings in the event of an error or incident.

CTA's NEW WEBSITE, FALSIFYING RECORDS, and DOCUMENTING ERRORS

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ABOUT COMMUNITY TIES OF AMERICA, INC.

Community Ties of America, Inc. provides licensure and certification on behalf of the State of Hawaii, Office of Health Care Assurance

Our website address to find forms, information and helpful tools including COVID-19 resources:

http://www.comties.com

http://www.comties.com/ccffh-forms

OHCA website for posted surveys

https://health.hawaii.gov/ohca/inspection-reports/

Maintaining accurate credential and training documentation of all caregivers is essential in demonstrating that you have hired qualified individuals for your CCFFH.

Falsifying any medical record, credential/ documents/certificates, etc., is a crime.

This includes, but is not limited to, altering, changing, or modifying any document for the purpose of deceiving another person or trying to cover up information. A single incident can potentially jeopardize your CCFFH certification or professional licensing/certification. Falsifying documents could also lead to civil lawsuits or criminal charges.

Examples of falsifying records include, but is not limited to:

- Making up and charting vital signs that were never taken
- Documenting that a medication was refused by the client when it was never offered
- Documenting that a medication was given when it wasn't given
- Documenting that the client cannot walk independently when they are able to get up into a chair by themselves
- Copying an in-service training record for a person who never took the training
- Creating or modifying professional certificates or licenses
- Changing the dates on a TB result to show it was complete when it was not

During a visit/inspection, if any of the examples listed above are discovered, you may be reported to Prometric or the Hawaii State Board of Nursing.

A deficiency or Corrective Action Report (CAR) will be generated and you will be required to submit a Corrective Action Plan (CAP) and/or sanctions may be imposed.

It is always best to create habits which lead to timely and accurate documentation.

- The Hawaii Administrative Rules (HAR) require that you perform **"daily" documentation**. Do not wait to "catch up" on all your documentation later in the week. Instead, document all the care you have provided to the client as soon as you have finished with the task. It is much too easy to get confused or forget the details of what type of care you provided the client and any issues that were identified at that time.
- Medication Administration standards require documentation directly after giving the medication to the client.
- When charting, only document the facts and your observations. Do not elaborate or state your opinions in the charting.
- If you miss documenting something or chart something in error, use the standard approved process for documenting late entries or making corrections.

2. **Late entries and documentation errors**

Providing care to an individual can be a challenging task. Sometimes it is difficult to remember to document care in a timely manner, or details get mixed up leading to errors in charting. We are human, and sometimes mistakes happen.

Because of the importance of making sure

that documentation is timely and accurate, standards exist that guide caregivers on how to handle it when charting was not entered timely or errors in charting were made.

Documenting late entries

If you forget to document something, you may enter it later, but you must clearly state the date and time the updated entry was made along with the date and time the task was originally completed. Entries should also begin with the statement "Late Entry":

- Late Entry- 8/26/2020 @ 8am. On 8/25/2020 at 7:30am, client #1 complained of lower back pain and was given a heating pad which helped eliminate the pain.

Correcting errors in documentation

If you make a mistake in your charting, it is important that you don't erase or cover up the incorrect entry. Never use white out, correction fluid, completely cover an incorrect entry or throw away the original and re-enter information on a new form/sheet. Instead, draw a single line through the incorrect documentation, write "error' next to it, initial and date the correction, then enter the correct information.

Example: 8/25/20 @ 8am-Blood Pressure ~~20/70~~. (error, TV, 8/25/20) 8/25/20 @ 8am – Blood Pressure 120/70

Using these two methods for correcting inaccurate documentation entries will ensure your care is being captured truthfully as it took place and will avoid the potential for falsifying records.

Individuals reading a client's record need to get an accurate and truthful picture of their condition and the care being provided. Make sure to do your part by capturing the facts as they took place.

Therefore.....

For the safety and wellbeing of all of your clients, make sure to do your part by capturing the facts as soon as they occur.