Will your COVID-19 documentation protect your facility

A white paper by Michelle Skaggs,
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Facilities may want to consider establishing a binder, folder and/or tracking system in order to provide a continual historical timeline of events for this pandemic.

Document, document, document — a phrase that is familiar in the senior living industry and many other healthcare arenas. During the COVID-19 pandemic, documentation is critical in order to provide a historical timeline of the facility's response to the COVID-19 pandemic. Many facilities may be at risk for lawsuits and CMS Infection Control Focused Surveys in the future, and the documentation process for providing a historical timeline of each facility's individual response is key. This timeline may include preparation training, policy revisions, communication, decision-making, etc., and may be a critical element when defending lawsuits and completing the survey process tasks. These lawsuits may not only be applicable to resident care, but also the facility's response to suspected or potential employee exposure, testing, PPE compliance, training, etc. Guidance relating to COVID-19 is changing daily, and facilities should be documenting their timeline as each new guidance is implemented.

Facilities may want to consider establishing a binder, folder and/or tracking system in order to provide a continual historical timeline of events for this pandemic. Events to be documented may include the below items. Please note the below are general topics and may not be all-inclusive.

Emergency management/preparedness plan (e-plan)

- Documentation of review and activation of the emergency preparedness plan, signed and dated.
- Identification of an individual person(or persons) to monitor and maintain current and ongoing knowledge of COVID-19, and updates from the CDC, CMS, your state department of public health and other local health departments.
- Evidence that policies and procedures are developed and implemented to address the COVID-19 pandemic affecting residents, staff, visitors, community, etc., and that these policies are reviewed and incorporated into the planning for the facility. The document should be available for review and revisions.
- Evidence of training on the emergency preparedness plan to include content, duration of class, date of class and attendees.
- Click here for a CDC checklist for emergency preparedness tips.

Infection preventionist designation, and current infection prevention and control program

- Evidence the facility has designated an individual as the infection preventionist who is responsible for the facility's infection prevention and control program. Refer to State Operations Manual (SOM) F882.
- Evidence of completion of the CDC infection control self-assessment.
- Current infection prevention and control policies to prevent the development and possible transmission of COVID-19 and other communicable diseases. Refer to the CMS COVID-19 Focused Survey for Nursing Home guidance.
- Evidence that CDC guidelines were reviewed for collecting, special handling techniques and testing of clinical specimens from persons suspected for COVID-19, and rationale relating to business/operational decisions.
- Evidence that PPE resources were inventoried and reviewed, and documentation of rationale relating to business/operational decisions in regards to the use or reuse of PPE, including the availability of resources.

It is important to keep residents and families informed. Communication is key.

- Evidence that the facility has addressed staffing issues during the COVID-19 pandemic.
- Evidence of staff training relating to the COVID-19 revised policies to include content, duration of class, date of class and attendees.

Survey and certification letters relevant to COVID-19 and the documentation to support when and how the guidance was communicated, implemented and staff trained (if applicable)

- Evidence and dates of the steps taken to screen visitors, employees, residents, consultants, EMS and other essential personnel; copies of sample screening logs; evidence of completed logs; and maintenance and retention of these forms
- Sample facility postings relative to COVID-19 and date of postings
- Evidence that information was communicated to staff, residents, families/visitors and other essential personnel regarding visitation limitations, communal dining limitations, group activities limitations, etc., and identification of how and when the information was communicated
- Evidence of implementation practices outlined in QSO letters relating to admissions, transfers, reporting (person under investigation), cohorting of residents, testing, etc., and the rationale relating to business/operational decisions
- Samples of correspondence to families relating to any COVID-19 topics such as screening, visitation, testing and results including dates correspondences were forwarded
- Evidence of steps the facility implemented in order to keep the family engaged with the resident, i.e., increased phone availability for residents, videophone call options, increased staff communication to families and any other additional steps taken by the facility
- Evidence of the mechanisms the facility is using to inform the residents and resident representatives of COVID-19 infections and mitigating actions taken by the facility to prevent or reduce risk of transmission (i.e., email, newsletter, website, voice message)
- Evidence the facility is providing cumulative updates to residents and resident representatives as per CMS guidelines
- Evidence the facility is reporting to CDC as per CMS guidelines with the required data elements in the NHSN COVID-19 Module

Employee inservice and training

- Dates and topics of staff training relating to infection control, revised policies, universal precautions, PPE, screening or any other topic relative to transmission and prevention of COVID-19.
- Evidence that the staff was trained on HIPAA regulations, confidentiality of PHI and social media. Documentation that staff was advised not to discuss any resident health information and to refer questions to the facility-designated spokesperson.
- Evidence that staff was advised to communicate if they are working in multiple facilities.

Media response

- In the event the facility maintains any social media information relating to the COVID-19 pandemic, the facility should maintain evidence (copy of actual postings) of what and when information was posted.

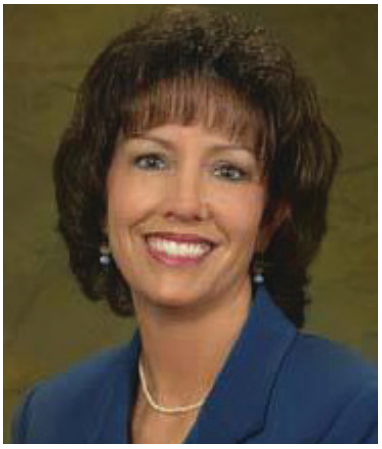
  - » The facility should focus on the virus and not the facility.
  - » The facility may want to focus on transparency (facts only) and urgency of relating information.
  - » Residents and family members should be advised of any facility-specific information prior to any social media postings.
- In the event the facility prepares a media response, the facility should maintain a copy of the response, who the specific individual the response was reported to and date of report.

The above information is important for maintaining a facility historical timeline of events in order to validate compliance with the CDC, CMS, ADPH and other regulatory bodies. In the event of future lawsuits, not only will the facility's timeline of its responses to the COVID-19 pandemic be critical, but the actual documentation in the resident's specific medical record will be pivotal as well. Below is an outline of information that may be included in the individual resident's medical record.

Note: According to SOM F842 Resident Records, the resident's current status should be reflected in the medical record at any given time (i.e., treatment plan/care plan, current medications, current VS, current screenings). In the event of a change in condition, the record **may** include:

- Documentation of what was observed, identified or reported (i.e., SOB, lack of eating, cough, confusion)
- Document of what medical interventions were completed to assess the resident (i.e., VS, lung sounds, O2 saturations, medical record review, medication changes)
- Document of what was observed from the assessment and document results in the nursing notes
- Documentation of communication to the MD/CRNP relating to the nursing assessment — some facilities may utilize the SBAR form
- Documentation of orders provided from the MD/CRNP, record orders and implement (i.e., labs, X-rays, medication changes, isolation)
- Documentation of when and what was reported to the resident representative and document the responsible party's response to the notification, if applicable
- Documentation of whether the care plan was updated
- Documentation of any follow-up assessments and, if indicated, documentation that the MD/CRNP was notified
- Documentation of any follow-up communication to the responsible party, if applicable
- Monitoring and documenting change in condition according to facility protocol
- If the resident's change in condition is not anticipated to return to baseline, documentation of resident representative communication and any resources offered to the resident representative

This is an evolving risk that Gallagher continues to monitor through the CDC and the WHO. For the latest information, please visit ajg.com/us/coronavirus-covid-19-pandemic or reach out to a member of your Gallagher team.



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About the author.

Michelle Skaggs, RHIA, CRM, RMC, CHSP, CDP is the Loss Control Program Manager for the Senior Living Risk Partners division of Gallagher Risk Management Services. In 1982, Michelle started her career in risk management, quality assurance and health information management in the long term care and acute care health settings. She provides risk management and loss control direction for a staff of experienced risk management/loss control consultants for senior living industry in various states. Michelle holds a bachelors of science degree in health information management from the University of Alabama in Birmingham. In 1998, she received the Certified Healthcare Safety Professional designation, Masters Level. In 2001, she received her certification as a Certified Quality and Risk Management Specialist and, in 2009, she received her designation as a Certified Risk Manager from the National Alliance for Insurance Education and Research. In 2017, she received her certification as a Certified Dementia Practitioner from the National Council of Certified Dementia Practitioners. Michelle is a member of the Alabama and American Health Information Management Associations and the Alabama Society for Healthcare Risk Management. Michelle has been employed with the Senior Living Risk Partners division of Arthur J. Gallagher Risk Management Services since 1993.

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