DEPARTMENT: All Glenner Departments	**POLICY AND PROCEDURE DESCRIPTION:** Electronic Health Record Documentation
PAGE: 1 of 4	**REPLACES POLICY DATED:** N/A
DATE: 12/20/2024	**RETIRED:** N/A
APPROVED: 12/20/2024	**REFERENCE NUMBER:** N/A
EFF. DATE: 12/23/2024	**LAST REVISED/REVIEWED DATE:** N/A

SCOPE: All George G. Glenner Alzheimer's Family Centers, Inc.® (GGG/AFC)

PURPOSE: To ensure each Adult Day Program (ADP) and Adult Day Health Care Center (ADHC) has an established Policy and Procedure for accurate, complete, and timely documentation of participant care in compliance with legal, regulatory and organizational standards.

POLICY: All documentation in the established Electronic Health Record (EHR) system (i.e., XCITE!™) will comply with the following criteria:

1. **Accuracy**: All entries in the EHR must be accurate, clear, and concise; reflect all relevant information including the participant's condition, treatment/care provided, names (and title) of all individuals associated with the documentable event, a resolution (if applicable), and any required follow-up.
2. **Timeliness**: Documentation is to be completed in a timely manner; ideally at the time of service/engagement ("real-time") or as soon as possible thereafter. Depending on the type of documentation (see **PROCEDURE** section below), documentation is to be completed no later than twenty-four (24) hours after the time of service/engagement.
3. **Completeness**: All entries are to contain relevant and objective information regarding participant care and include any assessments, interventions, treatments, outcomes, and communication. Depending on the organizational role of the individual creating the documentation, the use of standardized medical terminology and abbreviations is recommended.
   [***Relevant*** *= important or significant to a person or situation.* ***Objective*** *= based on facts and evidence]*
4. **Confidentiality (HIPPA Compliance):** Participant information must be kept confidential and only shared with authorized personnel as defined under HIPPA and stated in Addendum IV of the GGG/AFC Admission/Participation Agreement.
5. **Corrections:** Errors in documentation must be corrected promptly using the proper method as outlined in the **PROCEDURE** section below.

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PROCEDURE:

A. <u>Progress Notes</u>

- Document all relevant and objective information in a timely manner/real-time.
- Certain situations/circumstances may not allow for the ability to document in real-time. An example might be with an emergency that occurred, or a situation that transpired, at the end of the workday. In this instance, documentation is to be completed within twenty-four (24) hours of the occurrence, being sure to note **"Late entry from [*insert date]*"** in the ***TOPIC*** field.
- All late entries are to be noted in the ***TOPIC*** field as a late entry with the date of occurrence noted (see bullet point above). <u>Altering of the ***Date*** field is not permitted.</u>
- The description in the ***TOPIC*** field should be accurate, clear, and concise to assist all authorized staff with understanding the information contained within the Progress Note. <u>For example</u>, if an incident/situation occurs at the center, indicate the type – behavioral (aggression, anxiety, exit-seeking, etc.), fall, 911 call, etc. This information is also utilized for risk management purposes.
- The ***Status*** field of each Progress Note should read as ***Complete***, as soon as the documentation is considered final.
- Utilize the ***AMEND*** function to correct any Progress Note. All amendments are to be completed as soon as the need for a correction or an addition is identified; include the date and time of the amendment, the reason for the amendment and the name and title of the individual writing the amendment.

B. <u>Personal Care</u> - For the purpose of all George G. Glenner Alzheimer's Family Centers, Inc.®, Personal Care (PC) is to be provided to the participants at a **minimum** of **every 2 - 3 hours**, and **high priority participants** (any participant in a wheelchair, any participant with known urinary incontinence or any participant not

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identified as *Independent*) are to be provided Personal Care **upon arrival at the center** therefore starting the PC requirement of every 2 – 3 hours.

- All Personal Care is to be documented at the time provided.
- All fields are to be completed and accurate.
- The ***Comments*** field is to be utilized as follows:
  - Indicate the applicable PC code(s) – Example: UI,C,IP
    - **UI** = Urinary Incontinence
    - **FI** = Fecal Incontinence
    - **D** = Diarrhea (only if confirmed by the nurse on duty)
    - **C** = Changed (include **IP** for Incontinence Product and **CL** for clothing)
    - **R** = Refused PC
  - Include other relevant information as needed.
- ***Independent Participants*** (see details in the bullet points below) are required to be logged for documentation purposes only. ***Independent Participants*** are identified as ***Independent*** on the Personal Care log when entering and exiting of the restroom is witnessed by staff, yet actual use of the toilet may be unwitnessed by staff. When logging an ***Independent Participant***, the ***Urine*** and ***BM*** fields will not populate; whereas, the ***Comments*** field is still available for use if needed.
- ***Independent Participants***, for PC purposes, are defined as follows ***[Note: all the parameters must be assessed and met for a participant to be identified as Independent]:***
  - Without any hands-on assistance, the participant is able to get to and from the toilet safely, use it appropriately and adequately clean oneself.
  - The participant does not experience any form of incontinence.
  - The participant is able to understand and respond to instructions in a sensical manner.
  - The participant does not have a documented movement disorder, visual deficit and/or gait instability.
  - The participant does not utilize a wheelchair and/or a gait belt/transfer belt.

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- Coding a participant as ***Independent*** in the Member Health Profile (MHP) section in the EHR:
  - Click on the ***ADLS/IADLS/INTERESTS*** tab.
  - Under the ***Toileting*** field, select ***Independent w/reminding/cueing.***
  - Under the ***Toileting Needs*** field, select ***Independent/Reminders.***
  - Enter ***"Stand-by assistance for safety and hand-hygiene reminders"*** in the ***Toileting needs Comments*** field.

REFERENCES:

- https://m365.cloud.microsoft/chat?auth=2&internalredirect=CCM
- https://www.ncbi.nlm.nih.gov/books/NBK470404/
- https://nhdementiatraining.org/2023/01/11/dementia-effects-on-activities-of-daily-living-adls/
- https://www.atrainceu.com/content/8-dementia%E2%80%99s-effect-activities-daily-living-0