ANNUAL REFRESHER R05

Documentation & Standards Update

Annual Refresher Training

WHAT YOU'LL REVIEW

Learning Objectives

01 Identify the most common documentation errors found in home care audits

02 Apply updated documentation standards to your current practice

03 Describe the audit trail and what it means for your records

04 Recognize how documentation affects care coordination and patient safety

05 Complete documentation that would withstand regulatory review

THE PROBLEM

Documentation Drift

As you gain experience, your care quality typically improves — but documentation quality often **doesn't keep pace**.

Time pressure, routine, and familiarity lead to shortcuts. This refresher specifically addresses documentation drift.

> *If you didn't document it, it didn't happen — legally speaking.*

AUDIT FINDINGS

Top Documentation Errors

01 **"All care provided per care plan"** — Not acceptable. Documents nothing specific.

02 **Inconsistent times** — Clock-in doesn't match schedule or EVV system

03 **Missing refusals** — Patient declined a task and it was simply omitted

04 **Vague descriptions** — "Patient was fine" tells a surveyor nothing

05 **Backdated notes** — Submitted days later without amendment notation

06 **Opinionated entries** — "Patient was being difficult" vs. objective facts

EVERYTHING IS VISIBLE

The Audit Trail

Electronic records create an automatic audit trail that shows:

- When you logged in
- When you started and saved the note
- Any edits or amendments made after initial submission
- Whether your clock-in time matches the system's record

Late submissions, inconsistent times, and unauthorized edits are visible to supervisors, auditors, and state surveyors.

THE STANDARD FORMAT

SOAP Format Review

S — SUBJECTIVE

What the patient reports in their own words. Example: "Patient states, 'I felt dizzy when I stood up this morning.'"

O — OBJECTIVE

What you observe and measure. Example: "Patient ambulated to kitchen with rolling walker, unsteady gait noted."

A — ASSESSMENT

Your summary of patient status. Example: "New onset dizziness with unsteady gait — increased fall risk."

P — PLAN

Actions taken and next steps. Example: "Supervisor notified at 9:45 AM. Patient instructed to remain seated."

KEY TIMELINES

Care Plan & Assessment Timelines

- **Initial care plan:** Within 30 days of start of care
- **Care plan review:** Every 60 days, or sooner if condition changes
- **Comprehensive assessment:** Within 48 hours of referral (5 calendar days with documented exception)
- **Record retention:** Minimum 6 years from last date of service

Your observations drive care plan updates. If you notice a change, **report it** — your documentation is the input.

THE PROCESS

Care Plan Changes & Documentation

01 You observe a change → **document it** in the visit note

02 You notify the supervisor → **document the notification**

03 Supervisor updates the care plan → **you document** that you received and reviewed the update

04 All future notes **reflect the updated** care plan

Never informally adjust how you provide care without a corresponding care plan update.

WHAT WOULD YOU DO?

Scenario

SITUATION

An ODH surveyor pulls three months of visit notes and finds one caregiver's notes for every visit over **six weeks** read: *"Personal care completed. Breakfast prepared. Patient in good spirits. No changes noted."*

A) Efficient documentation — confirms everything was done

B) Acceptable as long as the care plan is current

C) Deficient — no individualized information, suggests templated documentation

D) Good documentation that covers required elements

CORRECT ANSWER: C

Every Visit Is Different

The surveyor sees: no specific descriptions, no objective assessment, no variation. This signals templated copying, not genuine documentation.

- The notes are cited as **deficient**
- The agency must provide a **plan of correction**
- The caregiver receives additional training and monitoring
- Identical notes raise questions about **actual quality of care**

> *Every patient has a different day. Your documentation should reflect that.*

SUMMARY

Key Takeaways

- **"All care provided per care plan"** is never acceptable as a visit note
- The **audit trail** shows exactly when notes were created, edited, and saved
- Use **SOAP format** consistently for organized, complete notes
- Amendments must be **clearly identified** with date and time
- Never informally change care without a **care plan update**
- Document **accurately the first time** — every visit is different

ANNUAL REFRESHER R05 COMPLETE

Documentation & Standards Update

Scroll down to complete the Knowledge Check.
5 questions — you need 80% to pass.