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# Legal Aspects of Documentation, HIPAA And Resident's Rights for the CNA

Objectives:

- Examine the legal requirements for a CNA
- List three reasons why it is important to document patient care
- Review three characteristics of proper documentation
- Define HIPAA
- Identify five examples of protected health information
- Recognize three tasks that a CNA may document on about the patient
- Demonstrate methods to document on a late entry note
- List at least four daily CNA responsibilities
- Discuss and list 6 patient's rights
- Review Informed Consent
- List methods to involve the patient in self-care and decision making

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**Course Outline:**

- Introduction
- Mandatory topics for CNA's
- The CNA's scope of practice
- Basics on Medical Records Documentation and Legal Issues
- HIPAA review
- Daily CNA Responsibilities
- Resident Rights

Certified Nursing Assistants (CNA's), assist individuals with healthcare needs (often called "patients", "clients", "service users") with activities of daily living (ADL's; bathing, feeding, shopping, cooking, etc.) and provide bedside care—including basic nursing procedures in hospitals, nursing homes, physicians offices, clinics, and in home care - all under the supervision of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) (Florida Nursing Boards). The most common tasks of the CNA are to assist with bathing and feeding. CNA Training takes a minimal amount of time and can be completed usually within 8 weeks. In the state of Florida, A CNA may work in a variety of health care settings including home health agencies. This can either be a career or a stepping-stone to another healthcare profession. Among the requirements of becoming a state-certified nurse assistant is the mastery of a set of basic skills. These skills are needed to care for patients in both long-term-care facilities and in home settings.

In Florida, the CNA registry is a part of the Department of Health. The board issues a certificate to practice as either a Level I or Level II CNA and maintains a registry of those with current certification. A CNA must work a minimum of 8 hours within two years to maintain a state certification. Depending on the place of employment, a background screening is required for nursing assistants. In addition, CNA's need to take both a written and clinical state exam. The scores are good for 2 years and then the CNA will need to obtain continued education. The recommended requirements are 1.0 contact hour of in-service per month or 12 credits per calendar year.

The Florida Nursing Boards states the following topics are mandatory for the CNA:

- HIV/AIDS
- Infection Control
- Domestic Violence
- Documentation & Legal Aspects for CNA's
- Resident Rights
- Communication with impaired clients
- CPR skills
- Medical Error Prevention/Safety

Specific agencies may have in-service requirements in addition to the above requirements. These courses are mandated by the State of Florida. Florida Law allows the CNA's license to be valid for 2 years. If this requirement is not met, certification cannot be renewed, the certification will lapse, and both the written and the performance exams will be required to be re-certified. State-approved training programs must be attended and a minimum of 75 hours must be met. This includes 16 hours of supervised clinical training (Florida Nursing Boards).

**The CNA's scope of practice (what one is legally responsible for):**

- Assistance with meals
- Topics in nutrition and hydration
- Methods of care for patients that are long-term or terminal
- Obtaining vital signs such as blood pressure, pulse, temperatures and respirations
- Recognition of dangers within a living environment that may put the patient at risk for falls, skin infections, or ulcers
- Notification of a supervising nurse when complications arise

The CNA is responsible for completing all tasks that have been assigned by an RN in a timely fashion while keeping the patients best interest in mind. The Nursing Assistant must give care, respect, up hold the code of ethics, and have integrity. Chapter 435 in the Florida Statues also includes a criminal background check for all Nursing Assistants. There are some criminal offenses that will prohibit a person from obtaining the CNA credentials.

The Federal Law for the Certified Nursing Assistant has been revised several times since 2001. These changes have proved to increase competency and an increase in compliance with the law. For recent updates on these changes, the following website www.myflorida.com is extremely helpful.

**Medical Records Documentation:**

In all aspects of documenting for caregivers, it is important to do it correctly and with accuracy. The CNA will be expected to know when to document, what to document, and how to document. In all cases, there will be an orientation period with staff that will guide the CNA on these expectations. After the orientation period, the CNA will be responsible to follow those instructions as directed. Medical facilities will have other caregivers, such as registered nurses and licensed practical nurses who will oversee the care of the patients as well.

It is the expectation from each individual to report off any significant information pertaining to the patient that will be considered useful in the care of the patient. Such documentation will then be accessible to the patient's doctor or other caregivers, so the best care can be provided. The patient's medical record is where all of the important information about the patient can be found. Therefore, it is also used as a reference for all the patient's health professionals to communicate to each other about the patient and what has been done for them. (This may also be referred to as the Plan of Care). Doctors will often leave "notes" on the patient's chart - documenting the care they are providing and what their intentions are for helping the patient's recovery. Other doctors on the patient's case can review this documentation, so they too can see what each doctor is doing to assist with the plan of care.

The distinct purpose of documentation is to provide a clear, concise, and accurate record that allows everyone involved in the care of a patient to know what has happened, what is planned, and what needs to be done.

**Understanding Documentation:**

The assistant must be able to recognize the importance of documentation and how that information has consequences. Most everyone has heard the comment; "If it wasn't documented, it wasn't done." This needs to be recognized as "The Law". Medical records can be pulled and reviewed and used in court. Every individual who participates in the care of the patient and documents on the care of the patient is expected to provide the most accurate of information. All of the information about the patient; what was provided for him/her, what the intentions are, how the patient reacted to the care, what the patient's needs are, etc., must be documented.

**Accurate documentation is necessary:**

- To avoid Duplication:

Let's refer back to the quote "if it wasn't documented, it wasn't done", the understanding is: everyone participating in the care of the patient will follow up with some type of documentation.

No matter where the patient's care takes place - there is an "unwritten mindset" that - if the activity was not documented, than it must not have been done. If in fact, it *was done* - and *was not documented*-, it is likely someone else will follow up and duplicate the activity, unbeknownst to them that the activity was previously completed. This sets in motion the potential for all types of medical errors with possible harm to the patient and various legal complications could ensue.

- To prevent Exclusions:

One needs to keep in mind that they are reporting on a medical record and it is considered legal documentation. It is never acceptable to document on something that was not really done. This is considered an omission or exclusion. When one commits an omission, they are falsifying information. It may be entirely unintentional, but it in court- there are legal ramifications that can be enforced. The expectation is that the task will be done and then follow up documentation provided.

- To recognize Accountability:

That is, the act of taking responsibility for one's actions. If an activity has been provided to the patient and the CNA documents that they did this activity, liability is a result. One is legally responsible for providing accurate and appropriate care to the patient. Documentation is the very proof that the activity was done. In taking responsibility for those actions and then documenting those actions, one is legally bound and held accountable for those actions.

**Documentation on a medical record:**

Medical record documentation is simply charting an accurate report of the activities provided to the patient. It often comes with challenges since doing the activity and recording the activity are two different things and most often cannot be done at the same time. In order to provide correct documentation, one should consider the characteristics of charting that follow:

- Relevance of Time

Once the CNA is on the floor and doing the daily activities; including, -but not limited to: obtaining vital signs, assisting the patient with personal hygiene, helping the patient to the bathroom, assisting with meals, changing the linen, etc. - there are so many things to do- and that is just for one person. Add multiple patients to that regime and it is difficult to keep up the activities and documentation of those activities. It is expected that the CNA will perform and document their activities in a timely manner. By the time the CNA is done with the activities that got started at 7am, the documentation may not have been put in until 10am. It would be appropriate to document; "late entry, activity provided at 0700."

- Factual Information:

It is imperative that one realizes the importance of accurate information. As mentioned previously, the medical record is legally bound. If someone documents false information, it is considered fraud. When providing any kind of information, it should be reviewed quickly and checked for any mistakes.

- Correcting Errors on paper charting:

Once the information is submitted, it cannot be technically "undone". It cannot be erased, it cannot be scratched out, and it cannot be covered up with "white out". For paper charting, there is a very specific way to correct an error which includes putting a line through the incorrect information, follow that with the word "error", and then appropriate date and time and then initial it.

- Correcting Errors on computer charting:

With computer access, the wrong information can be reviewed and edited with new information, but the old information is linked and will be kept on file as well. When in the edit area, that is where there should be some type of explanation why the information has been edited. For example, a CNA was rushing and didn't check the information put into the computer before filing it, and the blood pressure was accidently put into the computer as 320/80. When in reality the blood pressure was 120/80 and it was just a "typo". This still needs to be edited in the file since that result would otherwise need immediate follow up - contact the nurse, contact the doctor, assess the patient, etc. The editing would simply indicate: "wrong results or update results". And new, accurate results should be put in.

- Impartiality: (having no direct bias)

Being objective allows the caregiver to be impartial and nonjudgmental. The documentation should be factual and not about someone's perception or expectations. You should document about your tasks and not include your emotional status. Documentation should be about what has been done - such as results, measurements, and activities. Avoid documentations on "feelings".

- Acceptable Terminology

Make sure you are aware of what are the acceptable expressions that can be used with the medical documentation. There are many forms of "jargon" that may be used in everyday conversations or even in "texting"; however, many of those forms of abbreviations are not accepted when documenting in a medical record. It is your responsibility to follow up with acceptable terms to be used.

- Individual responsibilities:

Everyone should be held accountable for his or her own actions throughout the shift. One should never document for another individual. It really falls into the category of charting with honesty and relevance. We are all expected to use integrity with our care as well as our documentation.

- Miscellaneous Notes:

It is very helpful to have a brief meeting or "huddle" before getting on the floor and providing care. Often the nurse will let you know if there is a patient that should be monitored more closely for whatever reason; taking notes would help remind you of the need for closer monitoring, etc. Or perhaps you noticed something while taking care of a patient and you shared that information with the attending nurse, but nothing ever was done about the information you provided. If you had documented that note, you would have verification that in fact you did advise about the patient's status. Notes can be very valuable to anyone who cares for another individual.

After getting some actual experience with documentation, it will become easier to do. Remember the value of documentation and the legal issues that come with it. In almost all cases, there should be someone available to assist with documentation, so if you are not sure, you should ask for assistance.

**Daily Tasks the CNA should chart on:**

Everyone is very aware of the fact that the CNA spends a lot of time in the patient's room providing miscellaneous care. What the CNA documents, is very important, and that is why it is imperative to consider accuracy, timely documentation, impartiality, avoiding fraud, using acceptable terms and charting one's own work.

The common duties that typically expect to be gathered about the patient by the CNA include:

- Patient's **level of consciousness** - is the patient alert or confused or anxious?
- Patient's **vital signs** - BP, Temp, pulse, respiratory rate, and pulse oximetry if available
- Patient's **fluid intake** - is the patient taking in enough fluids or too much fluids?
- Patient's **urinary output** - is the patient urinating adequately? (Greater than 30mls/hour?)
- Patient's **bowel activity** - is the patient having diarrhea, constipation or bloody stool?
- Patient's **oral intake** - is the patient taking in < 50% of meals or asking for extra snacks?
- Patient's **color and skin turgor**- is the patient pale or diaphoretic? (Clammy)?
- Patient's **behavior** - are there indicators that make you worried?
- Patient's **information** - does the patient use a walker, or is he/she blind or hard of hearing?
- Patient's **weight**- daily weights are generally expected on every patient
- Patient's **activity level** - can the patient get up to the bathroom, is he/she wheelchair bound?

**Health Insurance Portability and Accountability Act of 1996— HIPAA**

HIPAA is a Federal law enacted to:

- Protect the privacy of a patient's personal and health information.
- Provide for the physical and electronic security of personal health information.
- Simplify billing and other transactions with Standardized Code Sets and Transactions
- Specify new rights of patients to approve access/use of their medical information

Do the HIPAA laws apply to you?

The Health Insurance Portability & Accountability Act (HIPAA) requires that all employers train their staff regardin HIPAA policies.

What are the HIPAA requirements?

- To protect the **privacy *and* security** of an individual's Protected Health Information (PHI)
- To require the use of "**minimal necessary**"
- To extend the **rights of individuals** over the use of their protected health information

*What* Patient Information Must We Protect?

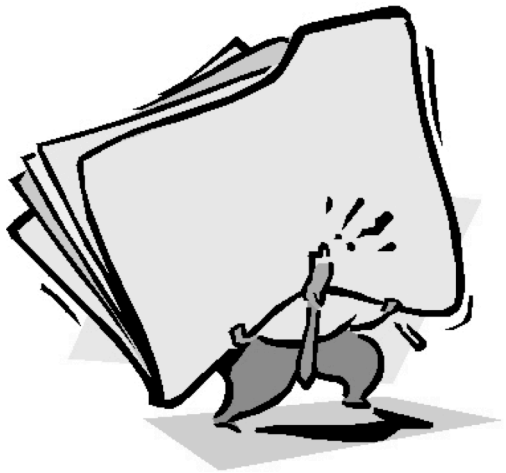
We must protect an individual's personal and health information that…

1. Is created, received, or maintained by a health care provider or health plan
2. Is written, spoken, or electronic
3. And, includes at least one of the 18 personal identifiers in association with health information

Health Information with identifiers = Protected Health Information (PHI)

Protected Health Information (PHI) includes the following 18 identifiers defined by HIPAA:

- Name
- Postal address
- All elements of dates except year
- Telephone number
- Fax number
- Email address
- URL address
- IP address
- Social Security number
- Account numbers
- License numbers
- Medical record number
- Health plan beneficiary #
- Device identifiers and their serial numbers
- Vehicle identifiers and serial number
- Biometric identifiers (finger and voice prints)
- Full face photos and other comparable images
- Any other unique identifying number, code, or characteristic



HIPAA specifically allows:

The Entity - to create, use, and share a person's protected health information for healthcare operations such as:

- Treatment
- Payment
- Operations, including teaching, Medical staff activates, disclosures are required by law and governmental agencies
- Reporting
- But only if the Entity ensures that each patient receives a copy of its- Notice of Privacy Practices

In order for a Healthcare Provider to use or disclose PHI:

- The Healthcare provider must give each patient a Notice of Privacy Practices that:
- Describes how they may use and disclose the patient's protected health information (PHI) and -
- Advises the patient of his/her privacy rights

The provider must attempt to obtain a patient's signature acknowledging receipt of the Notice, EXCEPT in emergency situations. If a signature is not obtained, the provider must document the reason.

But, for purposes other than treatment, payment and medical teaching, the Healthcare provider must obtain authorization and use only the minimum necessary:

- Patient Authorization - allows for Healthcare provider to disclose information for other purposes
- Minimum necessary applies to all uses and disclosures

Keep it simple:

All personal and health information that exists for every individual in any form:
- Written
- Spoken
- Electronic

This includes HIPAA protected health information and confidential information under State laws**.**
- To the patient, it's **all** confidential information.

Why Me?
I do not provide Patient Care…do I Need Training?
I do not use or have contact with Patient health or financial information… do I need training?

And……..

Isn't this just an Information Technology Problem?

Who Uses PHI?

- Anyone who works with or may see health, financial, or confidential information with HIPAA
- PHI identifiers

- Everyone who uses a computer or electronic device which stores and/or transmits information

Such as:

- Medical Center employees
- Campus staff who work in clinical areas
- Human Resources
- Facility Volunteers
- Students who work with patients
- Research staff and investigators
- Accounting / Payroll staff
- Almost *Everyone* – at one time or another

Why is protecting privacy and security important?

- We all want our privacy protected
- It's the right thing to do
- HIPAA requires us to protect a person's privacy
- The Facility requires everyone to follow the Facility's privacy and security policies

When should you?

- Look at PHI?
- Use PHI?
- Share PHI?

**HIPAA Scenario #1**

I work in admitting. A friend who works in the ER told me that she just saw a famous movie star get on the elevator. My friend read in the paper that the movie star has cancer and asked me to find out what floor the star is on because we know which floors are where cancer patients are treated.

Should you give your friend this information?

Ask yourself these questions:

- Do you need to know which floor the movie star is on for you to do *your job*?
- Does your friend need to know if the movie star has cancer for her to do *her job*?
- Would you want strangers to have *your private information?*

**HIPAA Scenario #2**

I am a file clerk. While opening lab reports, I saw my manager's pregnancy test results. Her pregnancy test was positive! That night at a holiday party, I saw her with some friends, and congratulated her on her pregnancy. Later I heard that she did not know about the test results. I was the first person to tell her!

Did I do the right thing?

Ask yourself these questions:

- Did you need to read the lab results to do your job?
- Is it your job to provide a patient with her health information — even if the individual is a friend or fellow employee?
- Is it your job to let other people know an individual's test results?
- Should a Facility employee look at another employee's medical information?
- How would you feel if this had happened to you?

Do not look at, read, use or tell others about an individual's information (PHI) unless it is a part of *your* job.

Remember:

- Use only if necessary to perform job duties
- Use the minimum necessary to perform your job
- Follow the Facility's policies and procedures for information confidentiality and security.

HIPAA Violations Can Carry Penalties:

Criminal Penalties

- $50,000 - $250,000 fines
- Jail Terms up to10 years

Civil Monetary Penalties

- $100 - $25,000/ fines
- More $ if multiple year violations

Fines & Penalties – Violation of State Law Facility's corrective & disciplinary action:

- Written warning, suspension
- Up to & including job loss

How Can You Protect Patient Information: PHI / ePHI /Confidential:

- Verbal Awareness
- Written Paper / Hard Copy Protections
- Safe Computing Skills
- Reporting Suspected Security Incidents

Patients can be concerned about:

- Being asked to **state out loud** certain types of confidential or personal information
- **Overhearing conversations** about PHI by staff performing their job duties
- Being asked about their private information **in a "loud voice"** in public areas, *e.g.*
  - In clinics, waiting rooms, service areas
  - In hallways, in elevators, on shuttles, on streets

Protecting Privacy: Verbal Exchanges
Patients may see normal clinical operations as violating their privacy (*incidental disclosure*)

Ask yourself- "What if it were my information being discussed in this place or in this manner?"

Incidental disclosures and HIPAA:

"Incidental": a use or disclosure that cannot reasonably be prevented is limited in nature and occurs as a by-product of an otherwise permitted use or disclosure.

- Examples: discussions during teaching rounds; calling out a patient's name in the waiting room, or sign in sheets in hospitals and clinics.
- Incidental uses and disclosures are permitted, so long as reasonable safeguards are used to protect PHI and minimum necessary standards are applied.
- Commonly misunderstood by patients

We need to protect the entire lifecycle of information:

- Intake/creation of PHI
- Storage of PHI
- Destruction of PHI
- For any format of PHI

Do you know where you left your paperwork?
Shredding bins**….** work best when papers are put inside the bins. If it's outside the bin, it's …

- Daily gossip
- Daily trash
- Public

Be aware that PHI is everywhere!

Resources with Privacy and Confidentiality can be found through:

- Your Supervisor/Manager
- Facility Policies
- HIPAA website: http://www.facility/hipaa

**Resident's Rights:**

Resident's of long-term care facilities have rights just like any other patient and as a healthcare provider you should be familiar with these rights.

Patients have the following rights:

- A quality of life

- A quality of care
- A Bill of Rights
- An ability to make decisions
- A right to privacy, and
- A right to financial status

**Quality of Life**

Quality of life for a patient should be enhanced to help the patient with their medical problems. This also includes patient's rights to dignity, choice and freedom. This can be managed through the facility where a written plan has been established.

**Visitors**

Resident patients have the right to have visitors. These visitors can be family members, physicians, legal representatives, or social committees. Nursing home residents have the right to spend private time with visitors at any reasonable hour. The nursing home must permit family to visit a resident at any time, as long as the resident wishes to see them. A resident does not have to see any visitor they do not wish to see. Any person who provides a resident assistance with their health or legal services may see the patient at any reasonable time. This includes the resident's doctor, representative from the health department, attorney or family and friends.

**Quality of Care & Ability to make decisions**

Patients also have a right to participate in their own care, therefore, be informed of any change of health status, routine, and/or planning. They also have the right to review their own medical record for accuracy and correctness. These patients have the right to make their own choices in life, such as: what to wear, what to eat or drink, who they want as their physician, and the right to participate in any or out of any resident activity.

Resident patients have the right to an informed consent for treatment. This includes the risks, benefits and alternatives for each procedure, service, or living arrangement. This must also be given to the resident in writing.

Quality of care should not be jeopardized just because the patient is in a resident facility. The highest level of care should be given to the patient. This includes looking for all signs of infection, abuse and neglect, and having open communication with the facility and the patient.

**Leaving the Nursing Home**

Living in a nursing home is a resident's choice. They can choose to move to another place at anytime, for any reason. However, the nursing home may have a policy that requires the resident to notify them before planning to leave. If the health of a resident allows and the resident's doctor agrees, the resident can spend time away from the nursing home visiting friends or family during the day or overnight. This is called a leave of absence. Nursing home staff should prepare medication and care instructions for the resident in these circumstances.

**Protecting Against Unfair Transfer or Discharge**

Nursing home residents cannot be sent to another nursing home, or made to leave the nursing home unless:

- It is necessary for the welfare, health, or safety of the resident or others,
- The resident's health has declined to the point that the nursing home can't meet their care needs,
- The resident's health has improved to the point that nursing home care is no longer necessary,
- The nursing home hasn't been paid for services received by the resident, or
- The nursing home closes due to bankruptcy, substandard care, etc.

Except in emergencies, nursing homes must give a 30–day written notice of their plan to discharge or transfer the resident. The resident has the right to appeal a transfer to another facility. A nursing home cannot make the resident leave if they are waiting to get Medicaid. The nursing home should work with other state agencies to get payment if a family member or other individual is holding the resident's money.

**Bill of Rights**

A Bill of Rights packet is given to each patient as they enter into a long-term care facility. This document is most often in written pamphlet form. It states that each patient will not be discriminated against in any form, that each patient has the right to dignity, and that the caregiver cannot give or accept personal gifts for the care of a patient.

**Abuse & Restraints**

All patients should be treated fairly, and should not be subject to any type of punishment, such as restraints, chemical, physical, and/or mental abuse. Federal law interprets physical and chemical restraints as follows:

Physical restraints –defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to your body that you cannot remove easily and which restricts freedom of movement or normal access to your body. Physical restraints include but are not limited to, hand mitts, soft ties, andrests, wheelchair safety bars, bed rails, or chairs that prevent rising. Also included as restraints are facility practices such as tucking in sheets so tightly that a bedbound resident cannot move or placing a wheelchair bound resident so close to a wall that it prevents the resident from rising.

Chemical restraints – The use of psychopharmacologic drugs utilized for discipline or convenience and not required to treat medical symptoms.

Resident patients also have the right to complain to the resident staff about what they do not like at the facility without fear of repercussions.

**Right to Privacy**

Personal decision-making is another right that long-term care patients have. Patients need to be informed of their health, plan of care, frequency of visits, and the right to refuse treatment if they so choose.

Right to Privacy and Confidentiality is a resident's right as well. This falls under HIPAA regulations where every person's health information is de-personalized and cannot be shared with other members in the community. This includes social, financial and personal identifiable information such as the social security number, phone number, account information, etc.

Nursing home staff should never open the resident's mail unless specifically authorized to do so by the resident. Residents have the right to use a telephone and talk privately. The nursing home must protect the

resident's property from theft. This may include a safe in the facility or cabinets with locked doors in resident rooms. If a resident lives in the same nursing home with a spouse, the couple is entitled to share a room (if both spouses agree to do so).

**Right to Financial Status**

Patients have a right to inquire about their financial information as well. They may inquire about the charges due from a procedure, what has and has not been paid for through insurance, and has a right to obtain duplicate bills and an explanation of what was paid out-of-pocket or by an insurance company.

**Conclusion:**

The health record is an important source of data of the care provided to the patient in the healthcare setting. This record also becomes a legal document that can be released upon request to various parties. In addition to the legal aspects of proper documentation, this record validates adherence to standards and becomes a resource to the clinical team for care planning and education purposes. Accuracy of medical record documentation is also imperative to the insurance industry to ensure that payment will be received for services that are rendered to a client. Privacy of the client's information must be strictly enforced under the guidelines of HIPAA policy. The healthcare system in the United States is constantly changing and evolving and it is a responsibility of all members of the healthcare team to focus on accuracy and privacy of patient medical records while ensuring the protection of their rights.