The National Long-Term Care Ombudsman Resource Center

MODULE TEN

Documentation

TRAINER GUIDE

January 2025

Table of Contents

Module 10 State-Specific Information 2
Section 1: Welcome and Introduction 3
Section 2: Long-Term Care Ombudsman Program Reporting Requirements 9
Section 3: Accurate Documentation 16
Section 4: Conclusion 30

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Module 10 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a **bold, blue arrow (→)** and a brief description of what to include.

→ State-Specific Information

Section 2 Long-Term Care Ombudsman Program Reporting Requirements

- Include information your state collects if it is beyond federal requirements.
- Explain your state-specific process for documentation training. Include whether you use the NORS training and/or your own state program training session. Let the trainees know when additional training is offered and expected to be completed.
- Explain state-specific requirements for opening and closing a case, including timelines.
- Include state-specific staff and volunteer documentation requirements for activities. Explain the deadline representatives have for entering information into the system after an activity has been conducted (e.g., you have 10 days to enter completed activities, or all activities must be entered at the end of the month).

Section 4 Conclusion

- Add the next steps trainees can expect to take to complete the certification process.

Section 1:

Welcome and Introduction

Welcome

Trainer's Note: *Allow at least 15 minutes for Section 1.*

Begin the session by welcoming the trainees to the training session and thanking them for their interest in the program. Make sure everyone introduces themselves – even if they come late.

Welcome to Module 10 of certification training – ***Documentation.*** *Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.*

To begin, please share:

- *Your name*
- *Where you are from*
- *One thing you learned from Module 9 - something that really stuck with you or surprised you*
- *What you hope to learn since the last module*

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the timeframe of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 10 of certification training, ***Documentation***. Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.

Module 10 Agenda

Trainer's Note: *The timeframes for each Section are approximate. Allow at least 3 hours for Module 10.*

Section 1: Welcome and Introduction *(15 minutes)*
Section 2: Long-Term Care Ombudsman Program Reporting Requirements *(60 Minutes)*
BREAK *(15 Minutes)*
Section 3: Accurate Documentation *(60 Minutes)*
Section 4: Conclusion *(20 Minutes)*

Learning Objectives

Trainer's Note: *Go over the Module 10 learning objectives.*

After completion of Module 10 you will understand:

- The core National Ombudsman Reporting System (NORS) documentation requirements
- A case, a complaint, and information & assistance
- The Long-Term Care Ombudsman program documentation requirements
- The purpose of documentation
- How to document
- What information must be documented

Module 10 Key Words and Terms

The key words and terms are defined as they are specifically applied to the Ombudsman program and are found throughout this Module. Take a moment to familiarize yourself with this important information.

Abuse - Any willful mistreatment of residents by facility staff, resident representative/family/friend, other residents, or an outside individual. There are three categories of abuse: physical, sexual, and psychological. [1]

Administration for Community Living (ACL) – A division of the U.S. Department of Health and Human Services (HHS) that manages grant programs and serves as the federal focal point on matters concerning older adults.[2]

ANE – Abuse, neglect, and exploitation.

Case – Each case must have a minimum of one complaint. A case must contain a complainant, complaint code(s), a setting, verification, resolution, and information regarding whether a complaint was referred to another agency. For abuse, neglect, and exploitation, a perpetrator code is also required. [3]

Code – An alphanumeric assignment to a data element of a case (e.g., complaint code, verification code, disposition code, etc.).[4]

Complainant – An individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.[5]

Complaint - An expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.[6]

Complaint Disposition (Resolution) – Final resolution or outcome of the complaint.

Complaint Verification (Verification) – Confirmation that most or all facts alleged by the complainant are likely to be true.[7]

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[1] https://ltcombudsman.org/uploads/files/support/NORS_Codes_and_Definitions_2021.pdf
[2] https://acl.gov/
[3] CA-04 Table 1: Part A https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
[4] These codes are also referred to as “element numbers” in NORS Tables 1, 2, and 3. Links to NORS Tables are available here: https://ltcombudsman.org/omb_support/nors/nors-training
[5] https://ltcombudsman.org/omb_support/nors
[6] CA-04 Table 1: Part B - Complaint Data Components https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
[7] CD-07 Table 1: - Complaint Data Components https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf

Financial Exploitation (Exploitation) - The illegal or improper use of an individual's funds, property, or assets for another person's profit or advantage.[8]

Gross Neglect (Neglect) - The failure to protect a resident from harm or the failure to meet their needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms.[9]

Information and Assistance - Information provided to an individual or facility staff about issues affecting residents (e.g., residents' rights, care issues, services) and/or sharing information about accessing services without opening a case and working to resolve a complaint.[10]

National Ombudsman Reporting System (NORS) – The uniform data collection and reporting system required for use by all State Long-Term Care Ombudsman programs.

Office of the State Long-Term Care Ombudsman (Office, OSLTCO) – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.[11]

Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word "Ombudsman" means the State Long-Term Care Ombudsman.

Perpetrator - Person(s) who appears to have caused the abuse, neglect, or exploitation.[12]

Referral Agency - The agency or agencies to which a complaint was referred as part of the Ombudsman program's plan of action for complaint resolution.[13]

Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) - As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.[14]

State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office

[8] https://ltcombudsman.org/uploads/files/support/NORS_Table_2_Complaint_Code_10-31-2024.pdf
[9] https://ltcombudsman.org/uploads/files/support/NORS_Table_2_Complaint_Code_10-31-2024.pdf
[10] https://ltcombudsman.org/omb_support/nors
[11] 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
[12] https://ltcombudsman.org/uploads/files/support/NORS_Training_Part_II_Principles_2021.pdf
[13] CD-06 Table 1 Part B – Complaint Data Components
https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
[14] 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule

and is responsible to personally, or through representatives of the Office, fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.

State Long-Term Care Ombudsman program (Long-Term Care Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.[15]

State Long-Term Care Ombudsman Programs Rule (LTCOP Rule) – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).[16]

Subsection Symbol (§) – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

[15] 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
[16] https://www.govinfo.gov/content/pkg/CFR-2017-title45-vol4/xml/CFR-2017-title45-vol4-part1324.xml

Section 2:

Long-Term Care Ombudsman Program Reporting Requirements

Confidentiality

Trainer's Note: *Allow at least 60 minutes for Section 2. State-specific policies and procedures related to confidentiality and disclosure were discussed in detail during Module 5. Remind trainees of the requirements if/when necessary.*

The State Long-Term Care Ombudsman (Ombudsman) is responsible for managing all files, records, and other information of the Ombudsman program, whether in physical, electronic, or other formats. **Such files are the property of the Office of the State Long-Term Care Ombudsman (Office).** The Ombudsman has the sole authority to make or delegate determinations concerning the disclosure of files, records, and other information maintained by the Ombudsman program.[17] Always follow your program policies and procedures pertaining to confidentiality and disclosure.

All files, records, and other information of the Ombudsman program must be kept confidential and only disclosed at the discretion of the Ombudsman or designee of the Ombudsman per program policies. Per the LTCOP Rule, "identifying information of **any resident** with respect to whom the Ombudsman program maintains files, records, or information, except as otherwise provided by § 1324.19(b)(5)-(8)" cannot be disclosed without informed consent of the resident or resident representative or in response to a court order.[18] Similarly, identifying information of **any complainant** cannot be disclosed without informed consent of the complainant or in response to a court order.[19] However, the Ombudsman may use discretion and disclose redacted files, records, or information that protects the identities of all residents and/or complainants.

IMPORTANT REMINDER

Although you are the one documenting case notes, they are the property of the Office of the State Long-Term Care Ombudsman (Office), not your property or the property of a local Ombudsman entity.

What does this mean?

- The Office must have access to all files, records, and other information at all times.
- You must follow state and federal requirements regarding disclosure.
- You must follow your program policies and procedures for confidentiality and disclosure.

[17] https://www.govinfo.gov/content/pkg/CFR-2017-title45-vol4/xml/CFR-2017-title45-vol4-part1324.xml
[18] 45 CFR Part 1324 Subpart A §1324.11(e)(3) Long-Term Care Ombudsman Programs Final Rule
[19] 45 CFR Part 1324 Subpart A §1324.11(e)(3) Long-Term Care Ombudsman Programs Final Rule

Documenting Information

Trainer's Note: *Explain whether volunteers have access to the state-approved database system to enter information and, if not, explain how volunteers are to send their visit notes to the LTCOP. Is there a standardized form volunteers are required to use, or do they write a narrative of their visits? If you wish, you could show forms staff and/or volunteers are required to use to document visits.*

The work of the LTCOP is significant, crucial, and necessary. Representatives improve the quality of life and the quality of care for residents daily. The only way to prove this is through timely and thorough documentation. Information is documented both informally, such as via pen and paper or electronic device, and formally in the state-approved electronic documentation system. Informal documentation is used to immediately record observations, interviews, and record reviews related to LTCOP activities and cases.

The information is then entered into a database system as a formal record of all LTCOP actions and is maintained by the Office of the State Long-Term Care Ombudsman.

The National Ombudsman Reporting System (NORS)

Based on the information recorded in the state-approved documentation system, the State Ombudsman is required to report specific information and activities to the Administration for Community Living (ACL), summarized in the uniform data collection and reporting system called the National Ombudsman Reporting System (NORS).

Data collected through NORS includes:

- The number of cases
- Types of complaints
- Federally required LTCOP activities
- Program information

The data is available to the public and is often used to justify funding and to represent the important work completed by the Long-Term Care Ombudsman program. NORS data also helps track current trends related to complaints and LTCOP activities. It is the only system that tracks data collected regarding problems faced by residents. Some states require representatives to document additional information as discussed later in this Module.

Data Reporting – The Bigger Picture

Your documentation translates into data. For example, the number of complaints and cases, and the instances of information and assistance provided all add up to paint a picture of the effectiveness of the program.

The Ombudsman uses data collected to show the State Unit on Aging (SUA) and the Administration on Aging (AoA) the impact of the work conducted by the LTCOP. The data is also used to show Congress – the law makers – what trends are apparent, where the system is lacking, and what laws need to be modified or created.

Overall, the data demonstrates the need for funding to continue to do the necessary work and to increase federal and state support when a program lacks funds and staff to achieve state and federal requirements.

> ***Your day-to-day work not only makes a difference for the residents with whom you are working, but also for all residents across the country.***

Ombudsman Program Activities

→ ***Include information your state collects if it is beyond federal requirements.***

Trainer's Note: *NORS does not capture all program activities. States may choose to collect additional data on training, facility visits, survey participation, participation in resident and family councils, community education, and more.*

In addition to complaint data, activities documented for the purposes of NORS include LTCOP actions required by the Older Americans Act (OAA) and the Long-Term Care Ombudsman Programs Final Rule (LTCOP Rule). Further information about documenting activities can be found in NORS Table 3: State Program Information.[20]

Activities required to be documented include:

- Facility visits
- Information and assistance
- Training for representatives of the Office
- Training for facility staff
- State survey participation
- Resident Council and Family Council participation
- Community education

[20] https://ltcombudsman.org/uploads/files/support/NORS_Table_3_Program_Information_10-31-2024.pdf

While you are required to enter all facility visits into your program's system, some activities conducted during visits may need to be documented separately. Those activities include providing information and assistance, conducting training for facility staff, survey participation, and attendance at Resident Council and Family Council meetings. Any work on complaints is documented in the case file section of the electronic system, discussed below.

Information and Assistance

The most frequent LTCOP activity conducted is providing information and assistance. Information and assistance, as defined by NORS, is when the LTCOP provides information about issues impacting residents (e.g., residents' rights, care issues, services) and/or provides assistance **without opening a case and working to resolve a complaint**. Representatives provide information and assistance most often by phone calls and during facility visits to anyone who may have a question or a concern.

Ombudsman Program Cases

Cases are comprised of at least one complaint. A case must also include the complainant, complaint code(s), a setting, verification, resolution, and information regarding whether a complaint was referred to another agency. Cases regarding abuse, neglect, and exploitation (ANE) also require the type of perpetrator (i.e., person(s) who appears to have caused the abuse or neglect or exploitation).

Additional case documentation requirements include case notes, proof/denial of consent to act, proof/denial of disclosure, and any other actions taken by the LTCOP.

You will learn more about case documentation definitions and requirements in NORS training[21] and/or your state program's documentation training. Additional information about what to include in a case can be found in the NORS Table 1 Part A-Case Data Components.[22]

→ ***Explain your state-specific process for documentation training. Include whether you use the NORS training and/or your own state program training session. Let the trainees know when additional training is offered and expected to be completed.***

[21] https://ltcombudsman.org/omb_support/nors/nors-training#training
[22] https://ltcombudsman.org/uploads/files/support/NORS_Table_2_Complaint_Code_10-31-2024.pdf

A **complaint** is an expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.

A **complainant** is an individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.

A **complaint code** is the alphanumerical assignment as defined by NORS to identify and label complaint types. There are 60 NORS complaint codes.[23]

Trainer's Note: *Tell the trainees they will learn more about the complaint codes during additional documentation training. Indicate if your state tracks more than the 60 complaint codes required by NORS.*

A **setting** is the facility type or setting for the case (nursing facility, residential care community, other setting).

Verification is confirmation that most or all facts alleged by the complainant are likely to be true. A complaint is either "verified" or "not verified."

A **referral** occurs when action is needed by another agency as part of the Ombudsman program's plan of action for complaint resolution. All case documentation must include whether a complaint was referred.

Disposition is the final **resolution** or outcome of the complaint.

Opening and Closing a Case

→ ***Explain state-specific requirements for opening and closing a case, including timelines.***

Trainer's Note: Explain to the trainees that they are not expected to memorize or remember the codes.

Complaint

Once a complainant shares their concern and wants you to take action, the concern becomes a complaint, and you open a case.

Occasionally, you may hear from multiple people about the same problem. However, NORS only allows one complainant per case; the first person who makes a concern known to the LTCOP is listed in the case record as the complainant and cannot be changed during the investigation.

When opening a case, include all necessary information required by NORS and your state. Information will be added as you continue with the

[23] https://ltcombudsman.org/uploads/files/support/NORS_Codes_and_Definitions_2021.pdf

investigation. Usually, the pertinent information gathered at intake is sufficient when opening a case.

All cases must include a referral agency code. Sometimes a referral is necessary as part of the Ombudsman program's plan of action for complaint resolution. There is a code for cases in which no referral is made. Referral agency codes are:

01-Licensing, regulatory, or certification agency

02-Adult protective services

03-Law enforcement or prosecutor

04-Protection and advocacy

05-Legal services

06-No referral was made

99-Other

Cases are closed when the investigation is complete and there is nothing further that can be done by the Ombudsman program. Completion of a case includes:

- Complaint verification status has been documented
- A referral agency code has been assigned
- Each complaint has been assigned a disposition code
- Closure dates for all complaints within the case have been entered
- All documentation has been entered into your state-approved system

The disposition code is based on the satisfaction of the resident, or the resident representative or the complainant if the resident cannot communicate their satisfaction. Disposition codes are:

01 - Partially or fully resolved

02 - No action needed or withdrawn

03 - Not resolved

State Documentation Requirements

→ ***Include state-specific staff and volunteer documentation requirements for activities. Explain the deadline representatives have for entering information into the system after an activity has been conducted (e.g., you have 10 days to enter completed activities, or all activities must be entered at the end of the month).***

Section 3:

Accurate Documentation

Purpose of Case Documentation

A major part of each case record is the narrative describing the essential information from intake, the complaints(s), the investigation, and the resolution process.

Figure 1

PURPOSE	HOW IS THIS ACHIEVED?
PROVIDES A FACTUAL ACCOUNTING	• Documents the interactions and observations in a clear and factual manner. • Does not include impressions, emotions, and preconceived ideas. • Documents in a manner that enables a representative to pick up where another left off.
TRACKS THE PROGRESS OF THE CASE	• Allows for a review of actions completed. • Documents the timeframes of actions to be completed. • Records all actions needed to achieve resolution.
MONITORS THE PERFORMANCE OF THE OMBUDSMAN PROGRAM	• Provides a formal record which verifies to your supervisor, the State Ombudsman, residents, the courts, or others that the LTCOP has complied with the Older Americans Act (OAA) and the Long-Term Care Ombudsman Programs Final Rule (LTCOP Rule).
PROVIDES AN OFFICAL RECORD OF COMPLAINTS	• Demonstrates and tracks violations of residents' rights and facilities' poor practices that can be used to help bring about systems change that may create better quality of life and/or quality of care for residents.

Watch this video on obtaining and documenting resident consent which is called How to Obtain Consent (Long-Term Care Ombudsman). [24] The first part of the video, which focuses on consent, was shared in Module 7. The second part of the video describes the importance of documentation.

Based on the video, finish these sentences:
"If it's not in the database_____.
Answer: *it didn't happen.*
"Documentation is proof that the Ombudsman has _____.
Answer: *fully served the resident.*

[24] Empowered Aging https://www.youtube.com/watch?v=v72Dt1CBsNI

What to Document

Most representatives take informal notes during or immediately after interviews, observations, record reviews, and any actions taken. Those notes must be transferred into the state-approved electronic documentation system. When taking informal notes, keep in mind the information you need to complete a proper investigation and to complete the required case documentation that becomes the formal record.

The foundation of all documentation starts with the **Five Ws – who, what, where, when,** and **why**. Document only the information related to the issue or the strategy to resolve the problem. For documentation to be complete, there are also certain topic areas that must be recorded.

Just the Facts

The Five Ws are the facts of the case. These are the same types of questions used when interviewing individuals during the Ombudsman Program Problem-Solving Process, which was covered in Modules 7 and 8. The facts of the case are:[25]

1. **Who** is involved? Include names, titles, relationship to the resident.
2. **What** exactly is the complaint (what happened or is happening) and what information is/was obtained related to the complaint?
3. **Where** does the problem occur?
4. **When** does the complaint take place? Include dates and times.
5. **Why** does the complaint arise? Include the root cause.

NOTE TAKING

When taking notes in front of a resident, family member, or resident representative, make sure to let them know your notes are confidential, you won't share them with anyone, and you are doing so to assist with your memory.

Consider these examples:

"What you are saying is really important. I'm writing it down to help me remember your points, wishes, etc."

"Thank you for sharing this information. I'm taking notes to make sure I understand exactly what you are saying. I cannot share anything you say to me without your permission."

Topic Areas for Case Documentation

For a complete accounting of the case, certain topic areas must be clearly described. Those areas include: the problem, the resident, permission(s) granted, actions taken, evidence, resolution/outcome, and follow up.

[25] Ombudsman Case Documentation Module Developed for the Long-Term Care Ombudsman Program by Sara Hunt, Consultant

Figure 2[26]

Topic Area	***Description***
The problem	**Define the nature and extent of the problem.** Starting with intake, explain the problem from the complainant's point of view; when the resident is not the complainant, also provide an explanation of problem from the resident's perspective.
The resident	**Describe relevant facts about the resident gained through observation, interviews, and possibly record reviews**. This information is especially important when the resident's ability to communicate informed consent is in question.
Permission(s) granted	**Explain exactly what permission(s) the resident has granted you.** This includes permission to act as well as consent to talk to others and disclose confidential information. • Name each person to whom the resident gives you consent to release their identity and talk about the problem. If the resident gives permission to speak with "anyone who can help" - document that statement. Make sure to note anyone to whom the resident explicitly told you *not* to talk. • Document permission received or not received to disclose records and be specific about the information allowed to be disclosed or not disclosed within such records. Include who gave permission – the resident, the resident representative, and/or the Ombudsman. • Clearly state the plan of action and include the agreed upon actions each party will take, including yourself, the resident, the resident representative, the complainant, and anyone else involved.
Actions taken	**Document all actions taken**. This may include interviews, observations, face-to-face visits, phone calls, emails, record reviews, referrals, a change in the plan of action, etc.
Evidence	**Provide information gathered during the investigation.** Document evidence that verifies or does not verify the

[26] Figure 2 and the above paragraph are adapted from Ombudsman Case Documentation Module Developed for the Long-Term Care Ombudsman Program by Sara Hunt, Consultant

	problem. Include relevant federal/state regulations when necessary.
Follow-up	**Document all follow-up actions.** Include other actions that need to be taken or if the case is ready to be closed.
Resolution/outcome	**Describe the resident's perspective of the outcome of your advocacy.** Is the problem resolved? If so, to what extent? Include a statement about the resident's level of satisfaction.

How to Document

During an investigation, you will often gather a lot of information and it may seem overwhelming at times. Knowing how to record it in the formal case record helps you to organize information in a way that clarifies the facts of the case, assists with tracking your work, and helps plan for further action on the case.

Dos and Don'ts of Documentation

Trainer's Note: *When going through the Figure 3 chart, give brief examples of documentation you have experienced (good and bad), or use the examples provided below the chart. Inform the trainees that lengthy documentation does not equal effective documentation. Documentation should only consist of the necessary facts (e.g., we don't need to know the resident was wearing blue pants and a red shirt with white flowers while they sat on their bed eating a candy bar – unless it is somehow related to the complaint).*

Effective documentation clarifies the information gathered and can have an impact on the investigation strategy. Documentation must be factual, objective, and consistent. Your case documentation should be clear enough so that another representative can pick up where you left off.

Figure 3

Effective Documentation is:	**Effective Documentation is NOT:**
Chronological	Out of chronological order
Complete and accurate	Incomplete or inaccurate
Concise and organized	Unnecessarily wordy and disorganized
Clear and free from uncommon abbreviations	Difficult to understand
Confidential	Available to anyone outside of the LTCOP

Inclusive of necessary facts	Opinionated or full of useless information
Entered as soon as possible into the system	Delayed

Which of the following examples would you consider to be effective or ineffective documentation? Why?

Trainer's Note: *Optional - If you have time, you could ask the trainees to individually rewrite numbers 1 and 2 using the documentation skills learned so far. It would be interesting to see how different everyone's notes are based on their interpretation of the initial information. It is a good way to demonstrate the importance of clear and concise documentation.*

1. "When I entered the facility the activities director stopped me and was so excited about the upcoming fair she was organizing for the residents. She invited me to the event. Since Sharon has a complaint about activities, I brought it up to Kim and she said it was resolved."

   Answer: *This is ineffective documentation. Information about the fair is not necessary. It doesn't clarify who Sharon or Kim are – is one of them the Activities Director? The activities complaint is not explained. It is not clear who determined the complaint was resolved since there are two females and the word "she" is used.*

2. "I have followed up with resident, Ralph, two times and both times he seemed uncertain of what he wanted to do about moving home. I think he is being influenced by his son."

   Answer: *This is ineffective documentation. It does not say when or how the representative followed up with Ralph. The words "seemed uncertain" are vague. The writer also expresses an opinion about Ralph being influenced by his son with no facts to back up the statement.*

3. "When entering White Oaks Assisted Living the morning of May 26, 2021, I saw several staff assisting residents out of the building. I spoke with resident Mel Jackson who said they think the fire alarm was pulled by a resident, but he did not know which resident. Another resident named Rosalee said she smelled smoke on the first floor, but no alarm went off. The manager, Bill, came over and said they were "looking into it" then immediately went back into the building. I talked with other residents outside who all said they weren't sure what was going on and did not hear the fire alarm. They expressed concern about a potential broken alarm and asked if I would look into it. I stayed outside of the building and after about 10 minutes, the fire trucks arrived. I observed the situation for another 15 minutes and saw no other concerns. I will call the manager this afternoon."

Answer: *This is effective documentation. It is in chronological order, factual, concise, contains names and titles, free from unknown abbreviations, and includes next steps.*

Fact or Opinion?

Individuals have a natural tendency to simplify descriptions by using perceptions or opinions instead of stating the facts. For example, a statement such as, "the resident was sad" is an assumption due to seeing a resident crying.

The habit of "opinionating" may influence your interpretation of a situation and could negatively impact factual documentation. It is important to avoid allowing personal feelings, preconceived notions, prejudices, or interpretations to influence documentation.

What is the difference between the two examples of the same situation below?
Trainer's Note: *The difference is that the first one uses opinions instead of facts and the representative allows preconceived notions to filter into the documentation. The second example is simply factual.*

1. *Of course, the manager yelled. He always gets mad when I bring problems to him.*

2. *The manager raised his voice saying he was tired of constantly getting complaints from the LTCOP.*

Objective or Subjective?

When documenting, use objective language instead of subjective language.

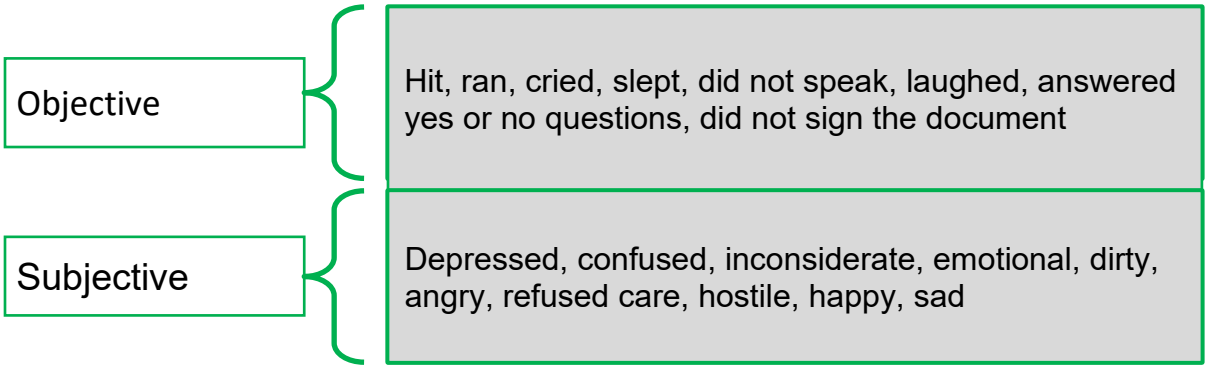
Objective language is not influenced by personal feelings or opinions, and it is used to clearly communicate facts. When objective language is used, two people reading the description will have the same understanding of what happened.

"*Travis stood up from his chair, shook his head, and said he needed a break. He left the room and walked down the hall*."

Subjective language is based on personal opinions, interpretations, emotions, and judgements. It is open to different interpretations. Two people can describe or understand the meaning in different ways.

"Travis became angry and stormed out of the room."
"Travis was anxious and tried to leave the facility."

Trainer's Note: *Explain the difference between the two examples above. The first example uses sentences that are clear and factual. The two sentences in the second example make implications that may or may not be true and are not followed up by facts.*



- **Objective language describes behaviors.**
  "The Care Plan Coordinator said she had no comment when asked to reschedule the care plan conference. She raised her hands in the air and stated she had another appointment to get to and that the conversation was over."
- **Subjective language labels behaviors.**
  "The Care Plan Coordinator was rude and unresponsive to my question."
- **Objective language describes observations.**
  "During a visit, I saw stains and crumbs on the resident's shirt."
- **Subjective language interjects opinions.**
  "During a visit, the resident's shirt was dirty, and he looked like he hadn't been cleaned since breakfast. Staff are obviously not doing their jobs."

Putting it All Together

Activity

Role-Play: Jo Phillips[27]

Trainer's Note: *To conduct the role-play, you will need four trainees to volunteer - one narrator; one representative, Alex; one resident, Jo; and one manager. Make sure the trainees who are observing the role-play have a pen and paper or another means to take notes during this activity by answering the Five Ws questions listed after the role-play.*

Narrator*:* The door to room 110 is open. The representative can see a resident sitting in a recliner reading the newspaper. The representative knocks on the door.

Resident: Come in.

[27] Modified from the Illinois Long-Term Care Ombudsman Program "Regular Presence Visit Training."

Representative: Good morning. My name is Alex Smith, and I am a resident advocate with the Ombudsman program. What is your name?

Resident: I'm Jo Phillips. It is nice to meet you.

Representative: It is a pleasure to meet you as well. Are you familiar with the Ombudsman program?

Resident: No. What is it that you do?

Representative: I am an independent resident advocate. My goal is to work with residents in long-term care facilities like this one to make sure the rights of residents are protected. If you have any problems with the facility or anyone else, I will work with you to try to resolve those problems. Here is a brochure with more information as well as my phone number.

Narrator*:* Resident Dave Samuel wanders into Jo's room, opens the bathroom door, looks around, and then walks back out into the hallway. Dave is wearing a baseball hat, t-shirt, and shorts.

Resident: Boy, that sure is annoying. I hate it when he does that. People have no respect for others anymore.

Representative: Does he do that often?

Resident: About once a day, usually after breakfast. I tell him to get out, but he doesn't seem to hear me. I don't know what to do.

Representative: Have you talked to staff about it?

Resident: Yes, but they say, "That's Dave. You know he's harmless." I tell you what, they wouldn't want someone just walking into their house uninvited. I told them that too. It still didn't do any good.

Representative: You have a right to privacy. Is this something you'd like my help with? We could try talking to staff together or another option would be to discuss it at the Resident Council meeting.

Resident: You know, I think I would like your help. It isn't a huge deal, but it's really starting to get on my nerves when he just walks in uninvited. Do you have time to talk to the manager right now?

Representative: Yes, I do. Before we go, let's talk about a plan to present to the manager. Would you like to share the problem from your perspective? I will be there to support you and to make sure your rights are understood and upheld.

Resident: Yes, I can take the lead but if the manager doesn't listen to me, will you take over?

Representative: Yes, I can do that. What are your expectations for the meeting? Is your goal to always have Dave stay out of your room, or are you okay with an occasional visit? What do you want staff to do if they walk by and see him in your room?

Resident: I want them to take me seriously. I like visitors, but I want to invite them in. I don't want anyone coming in without my approval. Maybe I can give the staff a thumbs up or a thumbs down if they walk by and see Dave in my room. If I give them a thumbs down, they should come in and get him out of my room.

Narrator: The representative and the resident agree on the plan and go to the manager's office.

Resident: I have a problem with Dave Samuel always coming into my room every day after breakfast. I'm not telling you how to do your job, but somebody needs to do something about this.

Manager: I had no idea this is a problem for you. You should tell staff when you are bothered by something.

Resident: I have been complaining, but nothing ever changes. Staff just tell me he's harmless.

Manager: I will talk to staff, but I can't share information about Mr. Samuel with you. We can't discuss his health issues.

Narrator: Jo looks at Alex and nods.

Representative: We are not asking you to share confidential information about any resident. We are asking for the facility to honor Jo's right to privacy. While we do not need to know your plan about how to keep Mr. Samuel out of Jo's room, we do appreciate knowing that you are following up on Jo's complaint.

Resident: I just don't want anyone to enter my room without my permission. I was thinking that when staff walk by, I could give them a thumbs up or a thumbs down and then they would know if they should come in and get Dave out of my room.

Manager: That sounds like a good idea. I'll talk with the staff and see what we can do about Dave coming into your room uninvited. I'll also check to see if there are any activities Mr. Samuel may want to participate in after breakfast.

Narrator*:* A week later, the representative follows up with Jo who is working on a puzzle alone in the activity room.

Representative: Good afternoon Jo! It's Alex from the Ombudsman program. I'm visiting to follow up on your concern from our last visit. How are you?

Resident: I'm okay. Up until two days ago, Dave was still coming into my room. I'm not sure if the concern is resolved.

Representative: Have you utilized the thumbs up or thumbs down approach with staff?

Resident: No, I didn't see any staff walk by when he was in my room. I ended up going to the manager again to complain. We'll see if that works. I have your number and will call you if the problem continues.

Representative: Okay, and I will check in with you on my next visit to see how things are going.

Trainer's Note: *Tell the trainees this case is not ready to be closed, but the representative must document the two visits. Allow trainees to finish answering the questions below and ask those who participated in the role-play to begin to answer the Five Ws questions. After they have written down their answers, go through each question and ask them what their responses are. Make sure the correct answers are discussed.*

Using the Five Ws, answer the questions below.

Who is involved? Include names, titles, relationship to the resident.

Answer: *Resident and complainant, Jo Phillips; resident Dave Samuel; and the manager.*

What exactly is the complaint and what information is obtained related to the complaint?
Answer: *Jo Phillips does not want anyone entering Jo's room without being invited. Mr. Samuel comes into Jo's room uninvited every day after breakfast. Jo has told staff, but they don't acknowledge it as a problem.*

Where does the problem occur?

Answer: *It occurs in Jo's room.*

When does the complaint take place?

Answer: *It occurs every day after breakfast.*

Why does the complaint arise?

Answer: *At this point, the answer is unknown.*

Case Notes Checklist

Trainer's Note: *Tell the trainees to use this checklist or if your program uses another checklist, use your state-specific form when determining if they have included all pertinent information in the case notes.*

In general, did I…

- ✓ Record all events in chronological order by date and approximate time?
- ✓ Use quotes, when possible, especially to capture the speaker's attitude, opinions, or observations?
- ✓ Limit the use of abbreviations to those that all representatives would understand, or initially define an abbreviation when questionable?
- ✓ Use names and titles of individuals and not "he," "she," "they"?
- ✓ Use objective language?
- ✓ Attach all required documents?

Documenting intake information, did I include…

- ✓ The description of the problem as presented by the complainant?
- ✓ Steps the complainant has already taken to resolve the problem?
- ✓ A statement about the complainant's opinion of the resident's ability to communicate informed consent (if the complainant is not the resident)? **NOTE**: The complainant's opinion may or may not be accurate, but it is important to document their opinion. In later entries, you may need to include your own observations on this matter.
- ✓ A statement about permission to reveal the complainant's identity?

Documenting the remainder of the investigation, did I include…

- ✓ The resident's perception of the problem(s)?
- ✓ The resident's desired outcome?
- ✓ The initial plan of action, including all involved parties?
- ✓ Each step taken in the investigation process, including interviews, observations, and record reviews?
- ✓ All actions taken to resolve the complaint(s)?
- ✓ A statement about the resident's satisfaction with the resolution?
- ✓ Follow-up communication with the resident or other relevant parties?

Using the narrative for the role-play and documentation checklist, write case notes for both visits with Jo Phillips.

Trainer's Note: *Give the trainees at least 20 minutes to write the case notes. Ask the trainees to use the narrative for the role-play and the documentation checklist to write case notes for both visits regarding Jo Phillips.*

After the trainees have written their case notes, explain the common mistakes below and relate them to the notetaking exercise by going over the last three paragraphs in this section. The role-play intentionally has unnecessary information to determine if trainees can distinguish between relevant information and pointless information for documentation purposes.

Common mistakes made with documentation include:

- Writing unnecessary information - long notes do not equal good notetaking
- Leaving out essential information
- Using unclear or confusing language

If you wrote about Jo sitting in a chair reading the newspaper, Dave's clothes, or Jo putting a puzzle together…**you wrote too much**. None of these details are related to the complaint.

If you left out names and titles, the complaint from Jo's perspective, steps taken to resolve the concern prior to the LTCOP's involvement, the initial plan of action, Jo's desired outcome, steps taken towards resolution, the manager's response, or the follow up visit, **you left out vital information**.

If you used words such as "he" or "she" or subjective language, or if you did not document in chronological order, **your notes might not be clear**.

Trainer's Note: *Ask the trainees to make corrections to their notes based on the comments you just covered. Determine if you want the trainees to turn in their revised notes to you, or to their direct supervisor to review for feedback.*

Next Steps

Documentation Training

Trainer's Note: *Explain next steps to receive additional documentation training.*

Developing documentation skills and routines is essential and requires time and effort to achieve. Accurate and timely documentation strengthens your skills as an advocate and aids in the success of the LTCOP.

Additional documentation training will teach you how to code cases and activities per state and/or ACL requirements. Depending on your state's documentation training requirements, you will either attend state-specific documentation training and/or will complete the National Ombudsman Reporting System (NORS) training available through the National Ombudsman Resource Center.

The NORS four-part training reviews basic principles, definitions, codes, and activities.

Part I: Case, Complaint, Complainant, and Information and Assistance Basic Principles
Part II: Complaint Coding Basic Principles
Part III: Verification, Disposition, Referral, and Closing Cases Basic Principles
Part IV: Ombudsman Program Activities Basic Principles

NORS four-part training can be found here.[28]

State-Specific Next Steps

→ ***Add the next steps trainees can expect to take to complete the certification process.***

[28] https://ltcombudsman.org/omb_support/nors/nors-training

Section 4:

Conclusion

Module 10 Questions

Trainer's Note: *Allow approximately 15 minutes for this section. Tell the trainees to complete these questions individually. Ask for volunteers to share their answers. Encourage the trainees to talk about their responses with their supervisor.*

1. What questions do I still have?

2. What confuses me?

3. What am I excited about?

4. What am I going to do next?
    a. Visit the webpages in my manual
    b. Re-watch videos
    c. Research the resources
    d. Read the trainee manual
    e. Go on a facility visit with an experienced representative
    f. Complete certification paperwork
    g. Other_____