



Optimizing Documentation to Improve Patient Outcomes and Mitigate Risk

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ABOUT THE SESSION: This presentation reviewed overview of fall-related litigation risk, including common drivers of claims, key legal exposure areas, and practical strategies to reduce organizational liability. Attendees will learn how incident trends, documentation, and post-fall response practices impact legal outcomes, and how proactive prevention efforts can strengthen safety and defensibility. This session was part of the **Advancing Excellence March Spotlight Series** designed to help providers understand the opportunity to optimize documentation to improve outcomes.

Advancing Excellence offers its members a forum for discussing diverse perspectives, policies, regulations, and environmental trends that affect post-acute and long-term services and supports (LTSS).

Why Documentation Matters

Documentation is the foundation of safe, high-quality care.

Documentation serves as:

- The primary communication tool across disciplines
- The legal record of care provided
- The evidence of clinical decision-making
- A driver of quality outcomes and survey success

Key Principle: If it is not documented, it is not considered done

Documentation and Resident Outcomes

Strong documentation supports:

- Early identification of clinical risks
- Timely interventions and care planning
- Consistent team communication
- Ongoing evaluation of effectiveness

Poor documentation can lead to:

- Missed or delayed interventions
- Inconsistent care across shifts
- Increased risk of adverse events (e.g., falls, pressure injuries)
- Negative survey outcomes and citations



High Risk Focus – Falls

Falls remain one of the most common and high-risk areas in long-term care.

Common contributing factors include:

- Cognitive impairment (e.g., dementia)
- Changes in mobility or strength
- Medications
- Environmental hazards
- History of prior falls
- Inadequate supervision or staffing

Why documentation matters in falls:

- Demonstrates proactive risk identification
- Supports individualized interventions
- Shows ongoing monitoring and reassessment
- Provides evidence of appropriate response after a fall

Falls are rarely viewed as “unavoidable” without clear documentation showing:

- Risk was assessed
- Interventions were implemented
- Interventions were evaluated and adjusted

What is Defensible Documentation

Defensible documentation clearly demonstrates that appropriate care was delivered.

It should be:

- Accurate – reflects what actually occurred
- Timely – documented as close to the event as possible
- Specific – avoids vague or generic statements
- Consistent – aligns across disciplines and shifts
- Clinically relevant – shows reasoning behind decisions

Strong documentation answers:

- What was the resident’s risk or condition?
- What interventions were implemented?
- How did the resident respond?
- What changes were made based on that response?

Using Data to Improve Care

Effective facilities use documentation and data to identify trends and drive improvement.

Examples of useful data sources:

- Incident and accident reports
- Fall logs and tracking tools
- Grievances and complaints



- Quality Measures (QMs)
- MDS data
- Survey results

Key actions:

- Identify patterns and repeat events
- Focus on high-risk residents
- Analyze root causes
- Implement and monitor targeted interventions
- Respond before surveys, not just as a survey problem

Risk Reduction Strategies

Improving documentation supports broader clinical and operational improvements.

Key strategies include:

- Completing thorough and ongoing risk assessments
- Maintaining accurate, individualized care plans
- Ensuring clear communication across disciplines
- Monitoring effectiveness of interventions
- Addressing environmental and system-level risks
- Strengthening staff education and accountability
- Conducting post-incident reviews and follow-up

The Role of the Interdisciplinary Team

Optimizing documentation is a shared responsibility.

All team members play a role:

- Nursing: Assessment, monitoring, and clinical documentation
- CNAs: Observations and reporting of changes in condition
- Therapy: Functional status, mobility, and safety recommendations
- MDS/Case Management: Care plan accuracy and regulatory alignment
- Leadership: Oversight, auditing, and process improvement

Consistency across the team ensures that the resident's story is complete and accurate.

Key Takeaways

Documentation is a critical component of resident safety and quality care

- It directly impacts survey outcomes and legal risk
- Falls are a high-risk area where documentation is closely scrutinized
- Defensible documentation must be clear, timely, and clinically meaningful
- Data should be used to identify trends and drive improvement
- Documentation is a shared responsibility across the interdisciplinary team