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Risk Insights: Senior Living & LTC

Episode 26: Senior Living & LTC: Documentation and what defensible records require

Welcome to the Risk Insights: Senior Living & LTC podcast, hosted by Tara Clayton with Marsh's Senior Living & Long-term Care Industry Practice. Tara, a former litigator and in-house attorney, speaks with industry experts about a variety of challenges and emerging risks facing the industry.

Tara Clayton

Welcome to Risk Insights Senior Living and Long-Term Care, where we explore the intersection of care compliance and real-world impact in senior living and long-term care. I'm your host, Tara Clayton. Today's episode brings together two powerful perspectives on a topic that quietly shapes everything from daily operations to courtroom outcomes. And that's documentation. We're joined today by a clinical risk nurse who has lived at the front lines of resident care and regulatory expectations, and an industry specialized litigator who sees how those same records are interpreted when decisions are questioned and cases are billed. Together, we will explore how documentation can influence team communication, risk exposure and operations. And we're going to take a closer look at how expectations from outside the industry, whether it's from families, regulators or juries, are driving tension between what's required, what's expected, and what actually happens in practice.

So let's get into it. Our guests joining us today include Kayla Meek, who is the Vice president, Clinical Risk for the Marsh Senior Living and Long-Term Care Industry Practice. Kayla, thanks for joining us today.

Kayla Meek

Hey Tara, thanks so much for having me.

Tara Clayton

And then we have Jorie Zajicek, associate with Quintairos, Prieto, Wood & Boyer, Nashville, Tennessee, office. Jorie, thanks for joining.

Jorie Zajiczek

Excited to be here.

Tara Clayton

Awesome ladies. Kayla, I'm going to turn it over to you for just a couple of minutes if you don't mind just kind of introducing who you are to our listeners. A little bit about your background.

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Kayla Meek

Sure, I'd love to. So my experience is both in clinical operations and risk management. I am a nurse by background. I have spent the previous 15 years or so working in some aspect of senior living. On the senior living operations side, I've worked at both the community level as a day-to-day operator in multiple departments as well as at the corporate level as an executive level nurse for several multi state operators. And then in more recent years I've transitioned to the senior living and aging services insurance industry where I have supported clinical risk management at both the carrier and brokerage levels.

Tara Clayton

Awesome. Thanks Kayla. And then Jorie, can you tell us a little bit about your background?

Jorie Zajiczek

Yep. So I am also a registered nurse. I've been a nurse for almost 10 years now and I practiced on more of the hospital side for about nine years and I've now been an attorney for almost five years and my practice is now focused on health care liability and medical malpractice and defending both senior living and long-term care facilities.

Tara Clayton

Thanks. Well, clearly both of you all have real-world hands-on experience with our topic today. So, I'm excited to get into this discussion with you both. Kayla, I'm going to turn to you to kind of kick us off into the discussion. I feel like to get to talk about the question of expectation versus actual requirement when it comes to documentation. I think we first need to kind of step back and level set just a little bit and understand the fact that there are distinctions in what I would call an acute care space versus a post-acute setting. And even in that those settings there's differences of acuity and documentation requirements there. So, I think why don't we first start there and talk to us about those distinctions between the different settings and why that's important.

Kayla Meek

Yeah, sure. So, it does, it gets very complex, right? So senior living really refers to residential communities or housing options of some sort that are specifically designed to really meet the needs of an older adult population. Senior living, for me, I like to explain it as an umbrella term, right. It's all encompassing of several different senior living arrangements, if you will, which provide varying levels of support, social opportunities, but they're all really aimed at improving the quality of life of older adults while also supporting their independence and safety. So under that umbrella, senior living is most simply kind of broken down, I think into two groups. You have like your licensed group and your unlicensed. Independent living for example, is your unlicensed. And then you get into assisted living memory care skilled, where those license and regulations are starting to be introduced.

So for today's conversation we can kind of go up the ladder and talk about all those varying like levels of regulation and then therefore the charting requirements. So, we'll start by discussing the least restrictive and that is independent living. At its base independent living, you can kind of think about it as an apartment complex for older adults there with a few additional amenities and services of sorts. It's designed for seniors who generally are healthy, they're able to live independently, but maybe they want the convenience or like maintenance, free lifestyle, some social activities, some access to additional amenities like transportation, housekeeping. Think of it as somebody who's looking for reprieve for maintenance of their environment. We call those in the industry IADLs or independent activities of daily living, transportation, laundry, maintenance, etc.

Typically what you see independent living is that it's private pay no care, services are provided directly by the community or the operational entity and it is strictly a hospitality model. After independent living, if you kind of go up the ladder a step. The next level of service is assisted living. So I guess for the purposes of today we can kind of group in memory care because it falls under that assisted living license. Also you can see this sometimes called enriched housing or personal care or some other state-specific term. They're all one and the same. But assisted living really provides support with all those IADLs that we already covered independent Living, but also ADLs which are activities of daily living and that's dressing, grooming, showering, toileting.

Think of independent living or assisted living as someone who may want help with both their environment and their person. They want support with maybe some medication management, they want support with reminders for showering, something along those lines. Assisted living communities also provide those things like social programs. But at the end of the day it's important to really call out that they do have some very limited nursing services which are dependent upon their state regulations, typically private pay. Again those state regs. And they are what I would consider to be a hospitality model with a bit of a care overlay, if you will. The intention is really to serve individuals who have stable health conditions that do not need continuous care. And that continuous nursing care is really where skilled kind of comes in, which takes us to our next little level on our ladder.

So long term care, skilled nursing homes, those terms are also interchangeable. And this is where that 24-hour medical care, some rehabilitation services for individuals with significant health needs, maybe they're recovering from like a surgery or an illness, they provide for everything that IL&AL does, those IADLs, ADLs and then some. So this is where that nursing service gets tacked on. So maybe wound care, vitals monitoring, complex antibiotic treatments or infusions, those sorts of things, it can be private pay, but most, except like Medicare, Medicaid, they do follow federal CMS guidelines and they are very much a medical model.

Tara Clayton

Great, thanks, Kayla. And I think that, I think you've kind of laid out the setting very well and you've talked a little bit about not just the different types of services which is going to play into documentation requirements, but also licensure, reimbursement models, staffing models. Right. All that is a factor that plays out into in the real world, what does the documentation practices look like? So knowing that, and I'm going to stick with you for just another minute, Jorie, I promise I'm coming to you, but let me stick with you for just a moment, Kayla. So knowing this distinction between the different types of post-acute care settings.

Kayla Meek

Yeah, it's an interesting concept, right? Because as you are a baby nurse and you're going through nursing school, you hear it all the time, right? It's, it's how you set yourself up for success. It's how you protect yourself as a nurse is you have to document everything. If it didn't, if you don't document it didn't happen. And that's the challenge, I think as that applies to senior living. Flaw of that really originates with the application of the concept that within senior living the standard for documentation has historically been you chart by exception. And we can, I guess we can start by defining what is to chart by exception. It's really this clinical documentation method where care providers record only deviations from the established like resident norm.

Assuming that the resident day is going about as expected or as planned, everything is within their normal limits. A caregiver may not chart much. Right. A caregiver wouldn't really be expected within a senior living environment to chart things like the completion of dressing, grooming, showering, toileting, because those are all a part of the standard care plan. It's all a part of their normal day. But when they would really begin to chart or place entries into the medical record is when some sort of variation of the standard is established. For example, the resident is beginning to refuse or decline care. Their care needs are increasing. Maybe there's some sort of incident. In skilled nursing, like other medical models, documentation is proof of care. If it happened, it's in the chart. If it didn't happen, it's not in the chart.

That's really where we can fall back on that. If it's not documented, it's not done. But as our explanation of charting by exception in assisted living, it can't be applied the same way. That theory isn't applicable. So the care record is not exhaustive in senior living. It's simply a narrative that's intended by design to really capture exceptions honestly. And with the lack of licensed and trained nurses in senior living, we have limited time. Maybe there's some staffing challenges. There's just some difficulties in establishing and holding individuals accountable to getting documentation into the chart itself at all.

Tara Clayton

Jorie, I'm going to turn to you, and I want to get into some specific examples, but before I do that kind of staying on this concept of if it's not documented, it wasn't done, and the challenge that kind of creates of this expectation of overdocumentation, maybe in some situations, but then also kind of how it plays out with the under. What are some of the issues that you see from that?

Jorie Zajiczek

So I think one of the biggest things is if you're talking about being in, you know, an assisted living facility where there's very little documentation, then when those events do happen, it's so much more important that it's a thorough, concise, objective documentation of what happened, because you don't have as much context as you

might have if you were documenting in a skilled nursing facility. And so, you know, it would never be enough if someone fell. Probably, you know, say resident fell, assess, put back to bed, you know, yes, I'm glad we documented that there was a fall, because that's always step one. There might be some things that you can take away if that was in a skilled nursing facility.

But when you're looking at assisted living, you have no other documentation really surrounding that, so you have less of a baseline of what was going on, you know, in the days leading up to that. So, it just becomes even more important that, you know, it's a thorough assessment of exactly, you know, where did you find the resident? How do you know that the resident fell? Were they ambulating on their own? Were they, you know, using an assistive device, you know, what were. What were the next steps? Because while you want to do that across the board, there's some things that can fill in the blank if you're doing, you know, less documentation and skilled nursing. Whereas when you're in assisted living and that's all you're left with, there's you. You start grasping at straws. You don't know.

And time goes by and people don't remember.

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Tara Clayton

I think that's a great point, Jori. And it kind of gets to that once this record is in your hands, you know, at the hands of the defense attorney who's trying to defend the care provided, you have to be able to tell the story. And I think to your point, if you only have one notation in a chart, a lot of times we don't have great memories about the event from the witnesses. It makes it really challenging. So, I want to keep that narrative going and kind of maybe get a couple of examples of where you've seen maybe good and bad, but where you've seen this issue of documentation play out in a claim, specifically, like how it's impacted the outcome of a claim. Can you kind of talk to us about a couple of case examples?

Jorie Zajiczek

Yeah. So, you know, I think falls are an easy way to go because those really apply very heavily to both assisted living facilities and skilled nursing facilities. And, you know, a lot of times the resident, it's not one fall, or if it is only one fall, it's an awfully bad fall. And that's what's leading to the claim. But more so, especially on the assisted living side is, you know, especially on the memory care, you have residents that are, you know, progressively getting more weak and they have, you know, a point that, you know, it starts coming that, oh, are they even appropriate to be here? And, you know, I can look at multiple cases and think, this is going to go well for us, and this is not going to go well for us.

And even comparing that there are multiple fall cases and, you know, I'll give one example where the family was resistant to everything the facility wanted to do, from sending them out to picking up the pain medications that they were needing, Everything was met with resistance. And the facility did an amazing job of documenting objective data of every call that they made to the family member to say, hey, this is what's going on. And they were specific enough that you could. They said what's going on in the note and exactly how the family member responded. For example, at one point, he had errands to run and didn't have time to go pick up the pain medication. And that's documented. I think it was probably in a quote in the chart.

So when it came about that he tries to deny it, and you have all of these quotes and, you know, he's referencing a surgery he had on his shoulder. It's hard for him to actually be believed when he's saying, “Oh, no, I didn't say any of that.” This timely, objective documentation was all made up in that moment because that's when it was documented. And so I look at that, and while there was a serious injury in the case, it was really the facility that was advocating for this resident. They were saying, you know, they're in too much pain, they need to go out. You know, they went and picked up the pain medications and that's all reflected in the chart.

So even though you had a broken hip and the patient went on hospice and you know, died very close in relation to that fall, people fall, but the documentation surrounding it gave very good defenses to the fall.

And you know, and I would compare it to. We have, you know, another case where it was actually two falls and two major broken bones within about two months of each other. And when I read one of the notes, which wasn't even specifically about the fall, it was about a blood sugar that wasn't reported as soon as we would have liked to the family. And one of the other caregivers put in a note that the other caregiver failed to follow policy that they've talked about it with her before and she should have known and basically made a list of everything she failed to do in relation to this.

And it was just an eye-opening moment that it tells not only that there's some inner turmoil going on between people, but it also says that when they get in and are being questioned on these things, that's how they're going to be responding. You know, when they're questioned and you know, the documentation surrounding the actual falls, I was left with more questions than answers by the end. But it's just night and day. And it's not only about what you do include, but honestly, what you don't include is also important. And I think the back and forth between co-workers is usually a pretty hard line of you don't want to include it's not relevant and it's not the place.

Kayla Meek

I like what you shared there, Jorie. Cause I think on the operations side there's always that question of where's your sweet spot? Right. There's potential implications for charting too much because if you're expected to chart every single shower, bathing, dressing, toileting, that's a lot of charting, right? And then if one shift does it and the other doesn't, there's some inconsistencies there. And then, but then there's that real fear, right, that if you're under-documenting, it removes your quote-unquote proof that you did, you completed your task or that care had occurred.

Jorie Zajiczek

And I think kind off of that too. It's always ironic to me that, you know, people really get into the copy and pasting and it's really apparent when there's typos and you know, like slight like spacing irregularities or a space before you put the comma and it's like that's clearly copy and paste, which I prefer not to see it at all. But I really don't like to see it when all of a sudden the resident wasn't even in the facility and they were just copying and pasting it or you know, there's this acute change and they're copying and pasting it and then it makes you think, well can I trust any of that documentation? Because this clearly was just copied and pasted. So I don't know at what point was that not them actually assessing it and the actual data from it.

So I'm a big believer. If you are going to document it, make sure have a purpose to, you know, what you're saying. They shouldn't just be words. If you're basically just documenting what is seen everywhere else in the documentation, then you're really not adding much. But also acute events, acute incidents, there's a lot to say on a day-to-day basis. You don't need to say, you know, like you said, every single little thing that happened, that's not realistic. No one, it can't be done. Not if you're actually doing the things that you're saying you're doing. Because that amount of documentation would just take too much time apart from everything else.

But if you are going to document, you know, make it thorough, make it concise and be objectionable because as long as you know, you don't need to add in your conclusions, I'd rather know all of the bad facts and you put them in the note as long as there's no conclusions drawn and then we're all on the same page and it's there. Then having to sit there and question, well how'd that happen? Like this doesn't make sense. All of a sudden there's a stark change and I can't explain it because all of the notes say yeah, there was this benign fall and no complaints afterwards. And then next thing I know they're being sent out and their hip’s dislocated. And for the last five days from the fall there's no complaints of pain.

Tara Clayton

It's to me this, I think you guys, your conversations underscoring just how challenging this concept of what is the right documentation is because there's the issues of under sharing just like both of you pointed out. And there's also the issue with oversharing or sharing the wrong information that, you know, conclusionary findings. When we don't have all the information but yet we've made a conclusion, sometimes even we're practicing medicine without a license and making conclusions, type language or it's defensive. We see a lot of that defensive documentation. There's a lot of personnel issues that get played out through documentation. That's problematic.

And I think though, Jorie and you were starting to talk about this, and Kayla, I wanted to ask, you knowing it feels like when we're litigating the claims, I think, Jorie, you kind of hit it well of how the documentation is really used to attack the credibility of the frontline staff and the community. Knowing that there's this expectation of everything relevant to every event that happened to this resident should have been documented, but it's not. How do we balance that need to defend ourselves and be able to tell our story if something turns into a claim with we need to provide care to the resident. Right. That's our primary focus, is providing care and services to the resident, not documenting after the fact that care and service was provided.

What are some recommendations you have for providers listening of how to kind of walk that tightrope?

Kayla Meek

Yeah, that's like putting on my risk manager hat of sorts isn't it? For me, it all really starts with developing and implementing a care documentation policy that your organization can really fall back on. Right. And share why those practices were implemented. And then it can trickle down through every individual that's practicing with care within the organization. So those documentation standards really don't necessarily need to be exhaustive as much as they really just need to be consistent, meaningful, and connected to some sort of actionable item. So a good, I guess, good quote, unquote, care documentation policy for me really minimally kind of captures three major things. I really look for a nice definition or some sort of standardized reason that would prompt documentation. What are you teaching training to care staff members that's going to trigger a red flag in their brain:

"Oh, I need to put that in the chart." Some typical items would be admissions transfers. Maybe you had some sort of communication with your resident representative or the resident's care provider. Maybe there was an incident. You're inserting some sort of incident follow up where you've reviewed or evaluated skin or their mentation or something along those lines. So that standardized reason is number one. Number two, I really look for good training. Right. So you can have the best policies in the world. But if you're not training your team members to what those policies say and how to then implement them in a day of the life, then really that's fallen short. Right. So that

training should really also be more than just a review. It should have some sort of validation, skills checks and then lastly is to include some sort of monitoring. Right.

Who's reviewing the records? At what intervals is there some sort of review audit of sorts that would red flag or pinpoint, maybe a particular type of charting that is starting to occur that we should pull back and re-educate staff on and other sorts of trends that start to establish? So it's really not about documenting everything as much as it's just really about establishing those clear, consistent patterns that can then allow for the care to happen. Right, because that's exactly what you said, Tara. Our days are fast and furious in senior living and our main focus is to provide the highest quality of care as possible for the individuals in which we serve. And while yes, charting is a major aspect of ensuring quality care, the hands-on services are really where we hang our hat in senior living. Right.

That's why individuals choose to move in and it's because they've deemed it the appropriate time in their life where they're looking for some additional support.

Jorie Zajiczek

And I think what's also important with that is, you know, everything that we're talking about here isn't necessarily changing. You know, each facility is going to have their policy and it should be conforming with state and federal regulations as far as what things need to be documented, how often they need to be documented. So, you know, defer to that. But when you are doing the documentation, it needs to be put in an objective light that's basically all patient focused. I think if you're reading back a note that you're writing and you start talking about kind of third-party issues and it stops being directly about the resident and the care being provided, then you probably don't need to include it in your note. But those policies that dictate when you're going to document, you're going to follow those. You're just wanting to do it in a very objective, concise and thorough way. And that will usually cover, you know, the documentation that you need to defend these cases. It's not additional documentation per se.

Tara Clayton

Jorie, you mentioned earlier, you gave kind of two contrasting examples of where you've seen it done right versus where you've seen it not done right. On the documentation side, and having worked with several communities at this point, what is it about those that get it right? What is it that you think they had in place that enabled them to have that documentation that was helpful?

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Jorie Zajiczek

Helpful, honestly, I think it truly does start with those policies. But a policy that no one reads or no one teaches someone is not worth anything. It's really great to have really great policies, but it's not doing much if people aren't following the policies. And I think that ultimately starts at the top. And you know, you can go outside of the direct facility, but really the D O in there, the administrator and you know, I gave these two contrasting stories. But to be clear, neither one of them didn't have much good, but the other one still, it's not that it was perfect documentation and that everything was, you know, documented exactly right at the exact time that it was supposed to be and nothing missed. That's never going to happen. That's not the expectation.

So having leadership that can educate their staff as well as, you know, being understanding, like we said, patient care comes first. So yeah, we might have a policy that says, you know, you need to do this immediately, you need to notify someone or do this or that. But it's a lot different when you're actually there providing care. You know, the case that they made a list basically of everything that went wrong and it was about blood sugar. The nurse ended up doing a late documentation on it and she explained exactly what she did and what she was doing. Although it wasn't documented, which is, you know, still important was she was there actually providing care. She had continued to check the blood sugar, making sure it was coming up, you know, providing snacks.

And by the end of her shift, the blood sugar was back to normal. It's, you know, she did exactly as far as what she was actually doing exactly what you wanted. There was just a little bit falling short as far as the communication and the documentation. But when you have the people above you not being understanding of that at all and not saying, “Hey, well, what was going on that you weren't able to get this documented or, you know, you didn't do XYZ, did you know that this is what you're supposed to do first? And if so, like what was in the way that you weren't able to do that?” Because they could have, you know, worked with her and skipped the whole documentation of everything she did wrong. Because that really wasn't about the patient anymore.

That was about some inner argument that was clearly going on. But I think it really matters both that you have the policies and then you have people there to implement the policies and have a real-world understanding of it that can relate to the actual caregivers providing the care.

Tara Clayton

Yeah, I think that's super important and too the other, I think a third piece that I hear you saying, Jorie, is that it's important for those that are doing the documentation, not just having the policy kind of telling them what the expectation is and having leadership that understands real world how this plays out. So the policy matches that. But I think the third thing that I'm hearing is that they're also being trained on the why. Like, why. Why the documentation is important, but also why the words you're putting in are important. Right? Getting at why that objectionable or that objective, factual information. That's what we need to understand what happened with the resident so we can continue providing the right care and services that resident needs.

But also, you know, if we're ever in a situation where you have to explain what you did, now you've got a record that we can easily. You can easily look at and say, oh, yeah, I remember exactly, here's what I did. And boom, boom. You’ve checked the box.

Jorie Zajiczek

And I think one good way to look at it is, you know, if you have your quality team looking back at this fall in the documentation surrounding it, are they going to be able to evaluate what happened or, you know, factors that might have contributed to the fall so that they can then form the conclusions? You don't need to include the conclusions, but you need to include the data so that those other people that are looking back at it can say, oh, you know, if there wasn't tubing on the floor or the lighting was a little bit better, then, you know, maybe this fall wouldn't have happened. Now, if you're not there watching the fall, even if there's, you know, oxygen tubing laying across, you can't really say that's what they fell on.

I want to know that oxygen tubing was there. I'd rather have that in the documentation than be figuring it out later and have a bunch of people, some people remembering that and being like, where'd this come from? I don't see anything on it. You know, what you don't need to do is if you don't know that they tripped on it, don't say they tripped on it. But you can include all of those details so that it's objective and someone can look at it and figure out- what might have happened and what needs to be changed for also to prevent future falls.

Tara Clayton

That's a great point. And I want to kind of go with this narrative of not making conclusions. But, you know, we talked at the beginning about kind of unrealistic expectations around documentation, and to me, making the wrong conclusion kind of falls in that bucket. But I'm going to fast-forward into the courtroom where we see a lot of the same narrative play out, right, with the, you know, the plaintiff attorney. A lot of times judges and juries, they don't understand those different care settings Kayla laid out at the beginning. And so jury, you knowing that, knowing we kind of keep having this uphill battle of being able to defend ourselves, do you have any kind of pointers that or best practices?

Because we have, you know, a lot of in-house counsel or even, you know, outside counsel that listen in some best practices for attorneys defending to help address this wrong narrative. That, and it's not always intentional. Sometimes there is the belief that, oh, it's, you know, seniors live there, so it's a nursing home. Right. But that's not, 90% of the time that's not the correct statement. And there's differences of the standard that's required in that setting. So what are some pointers you have for those defending us?

Jorie Zajiczek

I mean, for starters, I think it starts with the complaint, meaning a lot of the complaints filed are fairly boilerplate in that they are making the same allegations. And when you look at them and you're saying, “Oh, well, this is an assisted living facility,” and then you're looking at the allegations in the complaint that are clearly setting forth a standard that is only applicable in a skilled nursing facility, I think that should start raising some alarm bells because you know that is the route plaintiff's counsel is then going to be taking intentionally or unintentionally. And so, at some point, you're going to have to educate plaintiff's counsel and then continue on educating everybody else.

And I think the easiest way to do that, yes, you have your pleadings, but plaintiff's counsel might know when you're talking to your witnesses and you're preparing them, that's who they're really going to be hearing from, as far as, you know, your judge, your jury. And you'll have experts come in and say, you know, it's a skilled nursing facility, but you weren't tracking their weights closely enough. They should have been daily weights. And it's like it's an assisted living facility. Like, that's simply not the standard. But if you have witnesses that aren't prepared and don't maybe even fully themselves understand what those differences are, you're going to be creating a record that then is creating blurred lines.

So, you know, to the extent that your witnesses are speaking with you and want to cooperate, that's the easiest way to make sure to start off on the right foot as far as making a clear division between the expectations that you should see in an assisted living facility versus say, a skilled nursing facility, and make sure that they're able to discuss that and don't fall into those traps of, you know, starting to admit that, oh, maybe we should have done that. You know, be confident you shouldn't have done that. That's not the standard. And if they truly needed that, then they would have been in a higher level of care or needed to be in a higher level of care.

But I think it starts first identifying when the plaintiff is clearly going to use those tactics, and then making sure that the witnesses that you're putting forth, to the extent you're able, are well prepared to kind of discuss and lay those differences out.

Tara Clayton

I have a closing question for both of you as we near the end to wrap up. Kayla, I'm going to come to you first because I've been with Jorie now for a little bit. What potential impact do you see technology having as it relates to, quote, the standard for documentation in our space?

Kayla Meek

Yeah, that's interesting, because in senior living, I guess technology may not necessarily be so new to us. Electronic health records have been around for a little while now. However, there is quite a new feature with AI that's becoming integrated into a lot of various electronic health record organizations, and that is starting to change the way people look at documentation. It's shifting, pushing the standard. So one thing I always would kind of really encourage individuals who make those decisions surrounding electronic health records to investigate is primarily on AI, is how are those prompts written? How are the scripts pushing through recommendations? Who has the opportunity to review those recommendations, validate them? Is it, in fact, something that really does need to be in the medical record? And is the person who's validating that information a licensed professional? Does it fall within your policy?

Tara Clayton

Jorie, same question to you. Where do you see technology potentially playing a role in and defending the standard of documentation?

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Jorie Zajiczek

You know, documentation is already so highly scrutinized, and I think it's going to make it even easier for that to be done. I think just the ability to have, you know, almost an extra set of eyes and AI eyes, in a way, being able to look and see well, when were certain people working? When was this documentation done? When was the patient there? Are we documenting when they're not there? I think that there's going to be programs that are going to be much more equipped to kind of parse those issues out, that it's going to be looked at even closer. And I think that we just need to be aware of that and make sure that we are documenting timely and concisely so that those issues don't become a growing problem.

Tara Clayton

I think there's a lot on the horizon. And, you know, documentation, it's always been a topic that I know we see at all the conferences we go to. And it's very important for a number of reasons and I think will continue to be an important topic that we're frequently talking about. But, Kayla, thank you so much for joining us for the conversation today.

Kayla Meek

Thanks so much. It was a pleasure.

Tara Clayton

And Jorie, I appreciate you hopping on and talking with us too.

Jorie Zajiczek

Thanks for having me.

Tara Clayton

Thanks. Well, that brings us to the end of today's conversation. What I learned is that while documentation may never be perfect, it can always be more intentional and moving past unrealistic expectations, but instead focuses on what's actually sustainable while educating all parties, from families to juries. We can create systems to support, not further stress for teams. As always, if you have any questions about today's topics or how the Marsh team can help, please email us at the email address in the Show Notes. Be sure to subscribe so you don't miss any future episodes. You can find us on your favorite podcast platforms, including Apple and Spotify. Thanks so much for listening and stay tuned for our next Risk Insight.

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