Professional Nursing Documentation

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Purpose and Objectives

The purpose of this course is to present key topics related to nursing documentation. Complete and legal nursing documentation is a critical component of nursing practice that is legally and ethically sound.

After successful completion of this course, you will be able to:
1. State the goals of documentation.
2. Explain the role of organizational policies and procedures in guiding documentation.
3. Identify documentation practices that validate safe, effective, and high quality patient-centered care.
4. Identify documentation practices that create legal and professional risks.
5. Identify characteristics of nursing documentation that support a legal defense of nursing actions.
6. Identify employment and licensure implications of nursing documentation.
7. Explain nursing documentation requirements for specific aspects of care, including critical diagnostic results, medications, non-conforming patient behavior, pain, patient and family involvement in care, restraints, and prevention of falls, infections, pressure ulcers, and suicide.
8. Describe recommended documentation practices concerning communication with the patient's provider and provider orders, such as questioning orders and receiving verbal orders.
9. Identify precautions to observe when using electronic documentation.

Introduction

The most important role of the medical record is to assure that the high quality patient care you provide is documented in a clear and concise manner. This course presents universal documentation principles which apply whether your organization relies upon electronic documentation, paper-based documentation, or a combination of the two systems.

These principles are not new and lapses in applying these principles may create complications when documentation is presented as evidence to defend against allegations of malpractice, negligence, or failure to meet standards of care.

By concentrating on the principles of documentation in this module your documentation will reflect the quality care you provide and reduce the risks of a lawsuit.

One of the cardinal principles of legally defensible documentation is adherence to organizational policy and procedures (P&P), standards of care, guidelines, competencies, and any other organizational document that guides the care of patients. The reasons for deviation from these documents must be clearly supported in the medical record. Know the documentation expectations of the organization and the state in which you practice.

Did you know?

Litigation that will call upon your documentation often does not arrive in court for at least …
TWO YEARS AFTER THE
EVENT!!!

If you work in the fields of neonatology or pediatric, you can be called into court many years later;

up to when the patient reaches his/her 21st birthday.

How well do you recall the details of care you provided to a patient 2 years ago today? Take a minute to remember where you were working at that time.

Suppose your assignment included a patient who was admitted for a routine surgical procedure. He was alert, oriented and capable of self-care. You cared for him only briefly and provided pre-operative teaching. He never returned to your unit. He went from the operating room to PACU to ICU where he died.

Now, 2 years later in court, you must recall the details of the care you provided on the pre-operative evening when you had 5 other pre-operative patients. The only reference you will have to assist you is your documentation of the events of that evening. And, if the documentation is vague, judgmental, inaccurate, incomplete or untimely, it will not assist you in substantiating that you met standards of care. In fact, your documentation may be a witness for the plaintiff.

Make Documentation Your Ally
Documentation tells your story and reveals the care you gave to your patient(s).:Assists in organizing your thoughts
- Aids in identifying problem areas, planning and evaluating care
- Offers a means to communicate with other team members
- Provides a way to take credit for what you have observed and done
- Ensures reimbursement
- Affords legal protection to you and your employer
- May be used in research, to support decision analysis, and in quality improvement
(Lippincott, Williams & Wilkins, 2008)

Care Provision Documents: Your Best Friend or Worst Enemy

Your organization has established policies and procedures (P&P), standards of care, guidelines, and competencies among other care provision documents that incorporate federal, state, and local laws; reimbursement requirements; accreditation standards, and recommendations of various healthcare quality organizations. Your documentation serves as evidence of your compliance to these requirements. Ignorance of the content of these essential documents is not an accepted excuse for not using them.

Know what is in these documents and use them!

New policies, procedures, and guidelines develop continuously in response to clinical advances, federal and state legal mandates, and requirements of accreditation bodies. The care provision documents in your organization are revised at least every three years and reflect the most recent requirements for nursing practice. It is your responsibility to review the changes and incorporate the changes into your bedside practice.

Did you know:
That in any medical liability claim the organizational care provision documents are upheld as the standard against which your actions are judged.

Allegations Towards Nurses:

Why do we place so much importance on accurate/timely documentation? Did you know that two of the three most frequent allegations against nurses in medical liability claims deal with documentation?. The first relates to absence of documentation regarding treatment and the second relates to the timing of the documentation, e.g. late entries and the third relates to Chain of Command implementation. (Keris, 2014).

Documentation is the first thing scrutinized in medical liability claims dealing with nurses. The statement "if it was not charted, it was not done" is frequently argued by the plaintiff's legal team. Additionally, the plaintiff's team will argue that documentation that is entered hours or days after treatment is "self-serving" or different than what may have been charted at the time of treatment. Both of these legal arguments center on the nurse's credibility (Keris, 2014).

Documentation that is complete and timely is the nurse's best defense against litigation.

Consider this:

"If you think of the medical record first and foremost as clinical communication that you documented carefully, you need not panic if the court subpoenas it. However, if you think only of legal implications or document to protect yourself, your part of the medical record will sound self-serving and defensive. Such documentation tends to have a negative impact on a judge and jury" (Lippincott, Williams & Wilkins, 2008)

Documentation: Medical Record

The medical record serves four major purposes.
- Communication among members of the healthcare team
- Compliance with standards of care of various accrediting organizations
- Compliance with standards for reimbursement by a third party payer
- Documentation of patient care

Medical Record: Electronic Health Records

The electronic health record (EHR) documentation in patients' rooms is a recent shift in technology use in hospitals. This documentation reduces inefficiencies, decreases the probability of errors, promotes information transfer, and encourages the nurse to be at the bedside.

Some research findings suggest that implementing a basic EHR may result in improved and more efficient nursing care, better care coordination, and patient safety (Kutney-Lee & Kelly, 2011). Other findings have indicated that the use of EHRs is associated with more frequent medication errors, fair/poor quality of care, and poor confidence in patients' readiness for discharge, but a decrease in "things falling through the cracks" (Kelley, Brandon,& Docherty, 2011).

Some have asserted that e-records create distance between nurses and patients and decrease time spent in direct care. Yet benefits appear to include accuracy and prompting, for example prompting

with assessment parameters and follow-up by the e-record (Laitinen, Kaunonen, &Astedt-Kurki, 2010).

Care should be taken to ensure that the data in the EHR is correct. Drop down menus and the ability to cut and paste may lead to error and to documentation of information that does not specifically relate to the particular patient (Kelley, et al, 2011).   While cutting and pasting may be perceived as a timesaver, if the information is not correct, was not corrected and the case goes to litigation, the time spent in depositions and court far outweighs the time it would have taken to chart the information accurately in the first place.

Consider the following scenario:
The nurse on the previous shift documented that the central line dressing had blood visible through the dressing. The oncoming nurse "carried forward" the previous documentation but neglected to change the status of the dressing to clean, dry, and intact after changing the dressing.

The policy requires that the dressing be changed every seven days or when it is soiled, loose, or with visible blood under the dressing.

Unfortunately, even though the nurse complied with the policy by changing the dressing, her documentation did not validate her actions.

Electronic Health Records cont:
The EHR dates and time stamps every time a person enters the electronic health record. It is important that you consider "your need to know" whenever you enter a chart that is not related to the patient you are caring for.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is designed to protect the privacy and security of the patient information, and guarantee patients access to their healthcare information and control over the disclosure of their information.

Consider the following scenario:
A physician, who you do not know, asks you to review the patient's EHR. When you ask him who he is and how he connected with the patient's care, he informs you that he is the uncle of the patient. You inform him that he cannot have access unless there is written permission in the Health Information Management (HIMS) office. He says he has never been told this before and demands you to allow him access to his nephew's chart.

What would you do?
    A. Allow him access to chart?
    B. Refer him to the HIMS office
    C. Report the incident to the Compliance Officer
    D. Do nothing

HIPAA requires that you protect the pertinent health information (PHI) from anyone without the proper authorization. Referring him and the parents of the patient to the HIMS office protects you and the organization from litigation. Reporting the incident to the Compliance Officer will facilitate physician education regarding HIPAA regulations as it concerns family members who are also patients.

Medical Records cont

Whether you use paper or electronic charting, errors in documentation occur. Each type of documentation has errors specific to the type of charting and there are errors common to all types of documentation. It is essential that the healthcare worker recognizes the pitfalls of documentation and strives to deliver complete and legal charting. The following slides delineate many common errors and the ways to avoid them. Additionally, guidelines for performing high quality documentation are demonstrated.

Documentation Standards

Healthcare organizations establish documentation policies based upon standards set by organizations:

- Centers for Medicare and Medicaid Services, Conditions of Participation
- The Joint Commission
  - National Patient Safety Goals
  - Conditions for Accreditation Manual-Hospital
- American Nurses Association
- Nursing Specialty Organizations
- State Nurse Practice Acts

All sources of documentation standards emphasize:

- Ongoing assessment
- Patient teaching, including the patient's response to teaching and indication that the patient has learned
- Response to all medications, treatments, and interventions
- Relevant statements made by the patient

ANA Standards of Practice

ANA Scope and Standards of Practice: include expectations concerning documentation and state that nurses document:

- Nursing process in a responsible, accountable, and ethical manner
- An outcome-focused plan-of-care, stating outcomes as measurable goals
- Implementation of the plan-of-care
- Evidence for practice decisions and modifications to the plan-of-care
- Problems and issues in a manner facilitates evaluation of outcomes
- Coordination of care and communication with consumers and team members
- Results of evaluation of care and outcomes
- Relevant data in a retrievable form
- Using standardized language and recognized terminology

(American Nurses Association (ANA), 2010a)

Both American Nursing Association's Standards of Practice and the Joint Commission's Patient Care Standards emphasize the importance of documenting activities and findings in all phases of the nursing process.
- Assessment
- Analysis
- Planning
- Intervention

- Evaluation

Research findings indicate that documentation of interventions and patient response is a weak link in documentation of nursing process (Paans, Sermius, Roos, Nieweg, & Cees, 2010).

Documentation: Common Charting Errors

Common charting mistakes to avoid include the following:

1. Failure to record pertinent health or drug information
2. Failure to record nursing actions
3. Failure to record administered medications
4. Documentation in the wrong patient's medical record
5. Failure to record discontinued medications
6. Failure to record drug reactions
7. Failure to record changes in the patient's condition
8. Transcription errors
9. Illegible or incomplete Records

   (Nurses Service Organization, 2008)

Documentation Characteristics

High quality documentation is:
• Accessible
• Accurate, relevant, and consistent
• Auditable
• Authenticated/Author identified
• Clear, concise, and complete
• Date and time stamped
• Legible/readable
• Thoughtful
• Timely, contemporaneous, and sequential
• Reflective of the nursing process
• Retrievable on a permanent basis in a nursing-specific manner

(ANA, 2010b)

Researchers have identified the following 7 essential components of quality nursing documentation.

1. Centers on the patient
   A. Documentation reflects the patient's concerns, responses, and perspective and does not simply list nursing tasks accomplished.
2. Reflects the actual work of nurses
   A. Includes education, psychological support, and other nursing care for patients that are often passed among nurses orally, but never documented.
3. Reflects the objective clinical judgment of nurses
   A. Describes findings and reaches conclusions, that is, not "appears" or "seems," but reports data and conclusions.
4. Proceeds in a logical and sequential manner, especially when evaluating a problem
5. Is recorded concurrently with events

6. Records variances in findings and in care.
   A. Does not duplicate information to be found in other parts of the record. Does not list tasks.
7. Fulfills legal requirements.

(Jeffries, Johnson, & Griffiths, 2010)

FACT Criteria

Another way to look at documentation is to use **FACT** criteria to give you an outline to critique and improve your documentation.

F = Factual

A = Accurate

C = Complete

T = Timely

Factual
- *Only* information you see, hear, or otherwise collect through your senses
- Describe, don't label
  - Describe behavior, not conclusions such as "confused," "drunk," or "violent"
- State facts, not value judgments such as "No change" "Ate well"
- Be specific
- Use neutral language
- Avoid bias
- When you make an error:
  - State exactly what you did or failed to do
  - State that you notified the patient's provider, and the provider's response
  - Do not state "by mistake" or explain how the error occurred
  - Report this occurrence on the incident report (or form your organization uses for error documentation) and to relevant staff members

Accurate
- Be precise
- Quantify whenever possible
- Be sure to make clear who gave the care
  - When countersigning with a student or another nurse, review the content of the documentation and document your own follow-up assessment, interventions if any, and the patient's response

Complete
Include:
- Condition change
- Patient responses, especially unusual, undesired or ineffective response
- Use of chain-of-command
- Communication with patient and family
- Entries in all spaces on all relevant assessment forms
  - Use N/A or other designation for items that do not apply to your patient
  - DO NOT LEAVE BLANKS

- o   Blanks are hazardous because they permit entries above your signature
- o   Others may make entries in such blanks by mistake or to purposely falsify records

Timely
When a medical record is examined in a malpractice or negligence case, date and time are critical in establishing a timely response to a patient need.

- Resist the temptation to leave documentation until the end of the shift
  - You may forget key pieces of information when rushing
  - Charting as your shift progresses will help keep your documentation accurate
  - Professionals in other disciplines and nurses who provide temporary coverage need to have up-to-date information available in the record
  - Other professionals who access the record need to have up-to-date data to guide care
- Computer entries are automatically date-and-time stamped:
  - o   When your entry refers to earlier events, note the time to which you are referring
- NEVER document in advance
  - o   **This practice is illegal falsification of the record**

(Warne & McWeeny, 1991)

Documentation: Avoid Value Judgments

It is easy in the moment of stress to add words that imply value judgment about the patient, family member, other nurses, or physicians. It is imperative that the medical record reflect what happened without subjective interpretations.

- Document what was said in quotation marks
- Document what happened using objective terminology
- Refrain from using the following words, which might reflect negatively on your nursing care:
  - Accidentally
  - Apparently
  - Appears
  - Assume
  - Confusing
  - Could be
  - May be
  - Miscalculated
  - Mistake
  - Names of others (roommates)
  - Somehow
  - Unintentionally

Here are some typical statements found in nurses' narrative documentation.

For each statement, think of a more accurate and descriptive statement for the medical record.

Click on the statement to compare the alternative you thought of with one suggestion for improvement.

Statements to show   Link to this information for each statement

Appears confused	Patient found in lobby, stated he thought he was at the airport
Medicated for pain (30 minutes later): Reports relief	Patient states incisional pain at a level 7, on a 1-10 scale Patient medicated 1/2 hour later, patient states pain at a level 2
Voiding qs	Voided 300 mL clear yellow urine
Pedal pulses present	Peripheral pulses in both legs 2+/4+
Taking oral fluids well	(1200) Drank 1,000 mL since 0700
Nervous	Asked several times about length of hospitalization, expected discomfort, and time off work
Breath sounds normal	Breath sounds clear to auscultation all lobes Chest expansion symmetrical – no cough Nail beds pink
Ate well	Ate all of soft diet at breakfast

Documentation: **Abbreviation Use**

Abbreviations are commonly used among healthcare workers as a time saving methodology. Unfortunately, abbreviation use is responsible for increased errors. Your institution should provide you with a list of acceptable abbreviations for use in documentation.

The Institute for Safe Medication Practices, devoted entirely to prevention of medication errors and safe medication use, developed a list of error-prone abbreviations. This list is endorsed by the Joint Commission, The Federal Drug Administration, and the National Council for Medication Error Reporting and Prevention.

For a complete list go to https://www.ismp.org/tools/errorproneabbreviations.pdf

Documentation: Situational

The rest of the module will focus on situations that are "red flags." When a patient or family enters a medical liability claim, litigation can focus on these areas; especially when the documentation is vague or non-existent.

Change in Patient's Condition

The hospitalized patient's condition may change rapidly, what you document or fail to record in the medical record influences the outcome of a medical liability claim.

Essential Documentation:
- Include the full name of the provider
- Note the exact time that you notified the provider
- State the specific laboratory result, symptom, or other assessment data that you reported
- Record the provider's response to your report, using exact words if possible
- Include any orders which the provider gives.
- If the provider gives no orders, note this especially if you anticipated an order
- Include the commitment for necessary follow-up by provider
- Include symptoms and parameters such as changes in vital signs, level of consciousness, or pain that the provider defines as indicators for nurses to use in deciding to call the provider again.
- It is essential that you document your own actions
- If a provider fails to respond to a page, a telephone message, or fails to order an intervention and

thereby creates a risk for the patient, pursue the chain-of-command and notify your direct supervisor. Document your actions.

Reising, 2012

Chain-of-Command

Chain-of-command is a sequence of persons to contact when you need assistance to protect patients, ensure quality care, and ensure your own safe practice. This sequence of events should be instituted when:

- A provider responds with extreme anger, hostility or inappropriate behavior
- A provider is reluctant to or does not respond to your concerns
- You are not successful in reaching the provider in a timely manner
- You are concerned that the provider's orders are unsafe or inadequate to manage the situation or deviate from standards of care and the provider persists with the current orders
- You have concerns related to patient safety or your own safety, including dangerous staffing levels and violent behavior

Most organizations have delineated the Chain-of-Command (COC) sequence and may have more than one dependent on the situation. For example; each unit, department (nursing, respiratory, medical) may have an individual COC. It is important to know which COC sequence to follow in each situation. Review your organization's COC sequence(s).

When you need to initiate the COC, notify your immediate supervisor who will help facilitate getting the resolution you need. If the situation remains unresolved, continue to pursue the chain-of-command.

Documentation of the steps you take and the response at each juncture will protect you in the event a patient suffers because ineffective medical action or no medical action was taken.

More info box:

An ICU nurse noted mottling in the feet of post-operative patient who was recovering from a radical neck dissection and laryngectomy. The nurse reported the findings to the surgeon who saw the patient and ordered a vascular surgery consult. Two hours later, when the vascular surgeon had not responded, the nurse contacted the family physician who ordered Doppler studies. When the vascular surgeon arrived, 6 hours after the initial contact, the patient's circulation was so badly impaired that bilateral above-the-knee amputations were necessary. The nurse and the hospital were not found negligent because of the nurse's persistence in monitoring and communicating and documenting the events. The report of this case does not identify whether the nurse pursued the chain-of-command, but pursuit of the chain-of-command would have been appropriate in this case (Legal Eagle Eye, 2011a).

Plans of Care

Plans of care are an essential documentation tool. With the advent of the electronic medical record, many organizations have implemented templated and standardized plans of care. While this reduces the amount of time the nurses use to document, care must be taken to individualize the plan of care to the specific patient needs.

Consider the following scenario:
A teenager was admitted to a behavioral health unit for an eating disorder. The nurse chose the

"failure to thrive" standardized plan of care template. This plan of care provided the essential steps to care for a patient who was not thriving. However, the plan of care was written for an infant, and included instructions to consider breast feeding. Additionally, the nurse did not customize the plan for the teenage patient.

What do you think a Joint Commission surveyor would have said if this was found during an accreditation visit?

What do you think a lawyer for the defense would do with this in a medical liability claim?

Standardized templates are great timesavers, but only when individualized to the specific patient.

Charting by Exception (CBE)

With the advent of flow sheets, checklist documentation, and the EHR, charting by exception was developed. Charting by exception is a method of charting designed to minimize clerical activities; a notation is made only when there is a deviation from the baseline or expected outcome, or when a procedure or expected activity is to be omitted (Mosby's, 2013) . Well-defined guidelines and standards of care must be in place as CBE implies that all standards have been met with a normal or expected response unless otherwise documented.

When in doubt about whether an observation should be documented, err on the side of caution and document.

Charting in Advance

Charting in advance equates to falsifying the medical record. If examined as evidence in a malpractice case, a falsified record jeopardizes the nurses involved and the case for the defense. Once the nurse admits under oath that certain events were documented before they occurred, the entire record and the nurse's credibility is questioned.

If you identify documentation tools and policies that seem to encourage the practice of charting in advance bring this to the attention of your Nurse Manager. Charting in advance is a serious safety risk. Tools, policies and unit routines may need to be adjusted to prevent this dangerous practice.

Late Entries

When the medical record is unavailable or when you remember further information to document, you will need to make a late entry. Your organization's Risk Management Department has guidelines or policies which help the nurse decide if making a late entry should be done. In the event of a late entry document:

- The time of your entry
- The time of the occurrence to which you are referring

Entering pertinent information late should be done as soon as you remember you have not documented the occurrence; within the same shift or the next day you work. Follow your organization's policy for making late entries.

The safest, most legally defensible practice is to document at frequent intervals, and particularly after any emergency, unusual, or complicated events. When you absolutely cannot do so, make notes and document carefully into the medical record at your earliest opportunity.

Consider the Following Scenario:

A patient fractured her femur in a fall at a skilled nursing facility and 16 days later died in a hospital. The Administrator directed nurses to "update" the patient's record.

The "updates" included:

- Notes by a nurse whose time sheet indicated that she was working on another unit on the day of the entry
- Notes by a nurse whose time sheet indicated that she did not work on the day of the entry
- Other nurses made entries for days after the patient had been transferred to the hospital

What do you think the outcome of litigation would be?
Would you "update" the chart?
What recourse would you have if you chose not to "update" the chart?
Would you start the Chain-of-Command Sequence?

Critical Diagnostic Results

Making sure that critical results are reported to the provider in a timely manner has become a crucial documentation issue. Your institution has developed a list of critical tests and critical results and values. Ensure that you are aware of the contents of this list. Additionally, guidelines for reporting the results to the provider are provided.

Documentation of a critical result includes:

- The date, time and name of the person receiving the critical result
    - This information is documented in the department providing the critical result
- The date, time and name of the provider who is given the results by the nurse
    - This information is documented in the patient's medical record
- Measures taken to correct the critical result, if any
- Response to treatment
- Measure, assess, and if needed, improve timeliness of reporting critical test results to the responsible caregiver.

Medications

Medication errors have been in the news over the past few years. Regulatory agencies and your institution have taken many steps to reduce the risk of medication administration errors. Be sure to know and follow the policies of your organization.

- Use only organization-approved symbols and codes on the MAR

- Document date, time, initials/name of the person administering medication

- Document independent double check of medication and dose and obtain double signature where appropriate

- Document patient response to medications

- Document your patient teaching related to medications

- Document any adverse drug reaction

    - Document the provider's name and response to the advisement of the adverse drug reaction

- Document treatment and response to treatment

Actions which have led to medication errors include:

- Failure to check the medication administration record (MAR) against the order
- Use of banned abbreviations
  - Leading to administration of a wrong drug or dosage
- Mistaken interpretation of illegible penmanship
- Failure to obtain clarification as needed, and transcription errors
  - Failure to document a dose, leading to a duplicate dose when another nurse administers a dose.

Technology has offered a way to decrease medication errors:
- Barcoding: Compares order with medication and medication with patient
  - Some barcoding programs can also verify dose

Reconciliation of Medications

When a patient enters the hospital discrepancies may arise between medications prescribed, over-the-counter medications, and nutritional supplements taken at the time of admission. As part of the admission process, medication reconciliation must occur. Your facility will indicate which discipline is responsible for completing this task.

All medications that the patient is using at the time of admission is recorded and compared to the ordered medications. This process ensures that essential medications that are taken at home, which do not interact with the ordered medications, are continued in the hospital.

At the time of transfer between units or facilities, medication reconciliation is performed and documented.

At the time of discharge, medication reconciliation is performed, documented, and a copy is given to the patient/family and medical provider to ensure continuity of care.

Non-Conforming Patient Behavior

To assure a safe environment for patients, we expect patients to comply with rules and the plan of care. Though patients have a right to refuse treatment, you have a responsibility to clarify the rationale for treatment, notify others as necessary, and document the situation.

Non-conforming behavior comprises a variety of situations, including:
- Refusing to answer assessment questions
- Refusing to cooperate with the plan of care
- Possessing unusual and prohibited items such as alcoholic beverages, tobacco, medications, firearms, and certain electrical or electronic devices
- Tampering with equipment
- Consuming foods or other substances prohibited by the dietary order

When documenting non-conforming behavior:
- Limit your entries to the facts of the situation
- State your actions to clarify the rationale for rules or treatments, including contacting the provider or other personnel to clarify with the patient

Pain Assessment

Your entries in the patient's record must give evidence that you have met the standards for pain management, including evidence of:
- Assessment and effective management of pain in every patient

- Assess cultural factors that may affect response to pain
- The patient's involvement in managing his pain
- The patient's self-assessment of intensity of pain and pain goals
- Intensity per pain scale, location, character, frequency, pattern, onset and duration, alleviating and aggravating factors, current pain interventions and effectiveness, and acceptable level of pain
- Pain management history, including effects of pain in the patient's daily life, such as upon eating, walking, and sleeping
- Use of age/developmentally appropriate pain scales
- Pain assessment at least as frequently as other vital signs
- Pain reassessment after every intervention (pharmacologic or nonpharmacological)

Documentation in the health record includes:
- Date, time
- Patient behavior
- Pain scale rating
- Intervention
- Pain scale rating after intervention
- Education provided to patients and families regarding pain including:
  - Importance of pain management
  - Reporting pain
  - Assessment process
  - Risk for pain
  - Pain management methods, limitations and side effects – if appropriate, including alternative and complementary methods, such as guided imagery, heat, cold, and massage therapy
  - Patient's role in process
- Discharge planning:
  - o Address patient's pain management needs
- End-of-life care
  - o Physical, psycho-social/emotional, and spiritual comfort
- The patient's response to interventions and modifications of the plan if needed

RN.com's course "Acute and Chronic Pain" provides a great review of pain assessment, prevention, and documentation (RN.com, 2010a).

Correcting a Documentation Error
Your organization should have a policy regarding error correction. The important factors to remember when correcting a documentation error is to be very clear what the error was and what the correct information should be.

Electronic records:
- Each system has specific methods for correcting errors. Assure that you know the proper procedure for the system that you are using.

Paper records:
- A single line should be drawn through the error
- The correct information should be entered legibly
- The date, time, and initials of the person correcting the documentation should be present

Documentation: Error Prevention Technical Tips

- Use the appropriate form or screen.
- Document in ink.
- Verify that the correct patient's name and ID number are on every page of the chart.
- Record the complete date and time of each entry.
- Use only standard, organization-approved abbreviations, acronyms, and symbols.
- Use a medical term only if you are sure of its meaning.
- Document symptoms by using the patient's own words.
- Document objectively.
- Write legibly.
- Locate and orient yourself to all interdisciplinary forms, progress notes, and flow sheets.
- If you replace a page on which information has been recorded, retain the original and place it in the medical record according to policy.
- Write on every line. Leave NO blanks.
- Sign your full name and title.
- Chart any omission or late entry as a new entry. Do not backdate or add to previously written notes.
- If you chart on the wrong chart, omit information, or need to amend a chart at a later time, carefully follow your organizational policy for performing these activities.

Unprofessional Documentation

- **Venting Frustrations in the Medical Record**

  Use the proper forum to express concerns about working conditions, poor rapport with team members, and other issues of concern to you. The patient's record is not that forum. It is critical that you do report such issues to the proper individuals according to procedure, and that you follow up.

  If a record containing such comments was brought into evidence in a suit, the documented system problems would make the organization appear to be at fault.

  Inappropriate comments in a medical record will also create an avenue for complaints by the organization against the nurse. The organization can claim that the inappropriate documentation led to the filing of the claim and/or the inability to defend against claim.

- **Acronyms Intended to be Humorous**

Some individuals have used acronyms in their documentation to represent insulting and inappropriate descriptions of patients, their families, and prognoses. Not only is this unethical and unprofessional behavior, but it could also have adverse consequences if a record was called into evidence in a lawsuit.

Restraints

Reports of patient injury and death in restraints have decreased in recent years (TJC, 2011c), in part due to more careful monitoring and use of restraints as a last resort. Within the last three years, CMS has added a more stringent documentation requirement (Centers for Medicare & Medicaid Services (CMS), 2012).

Typical documentation requirements include:

- Verification of the written order for restraint or seclusion
- Name of provider who ordered the restraints
- Reason for restraint
- Least restrictive alternatives attempted
- Type of restraint (violent self-destructive or non-violent/non-self-destructive)
  - Soft limb restraints
  - Neoprene restraints
- Monitoring requirements for each type of restraint
- Assessment requirements for each type of restraint and age of patient
- Documentation requirements for each type of restraint
- Order intervals
- Face to face assessment intervals for providers
- Reassessment for need to continue restraints

RN.com's course "Restraints: The Last Resort""" provides a great review of the complex standards for restraint use and documentation (RN.com, 2010b).

Skin Care

Many organizations use a standardized risk-assessment tool such as the Braden Scale or Norton Scale. Familiarize yourself thoroughly with the skin care and assessment documentation.

TJC standards include skin assessment and pressure ulcer prevention. Under guidelines of the Centers for Medicare and Medicaid Services (CMS) Payment System, facilities receive reduced reimbursement for treatment of hospital-acquired pressure ulcers.

It is imperative that a thorough skin assessment and pressure ulcer risk assessment be completed and documented on admission. Any pressure ulcer discovered and documented on admission is not considered a hospital acquired condition.

Hospital acquired pressure ulcers are reportable to many state agencies. Your documentation of the site, the level of breakdown, treatment received, and response to treatment will help ensure that the agency receiving the report has the information it needs to determine whether this injury was preventable or not. High grade pressure ulcers are reportable and can convey hefty fines to the reporting institution.

RN.com's course "Pressure Ulcer Assessment: Prevention and Management" provides a great review of the skin care, prevention, and documentation (RN.com, 2012b).

Suicide

Suicide ranks 5th among sentinel events reported to TJC 1995 – 2010 (TJC, 2011c). Your organization may have a specific policy regarding suicide risk and documentation.

Most institutions have a question on the admission assessment regarding self-harm, ideation or attempts. It is essential that this question be asked and documented. Additionally, if the question is answered in the positive, there are supplementary questions that need to be documented at least once a shift.

Document:

- The patient's behavior and statements
- Your further assessment of the patient's intent
- The date, time, and full name of the person to whom you reported your concern and the person's response
- The items removed from the room that present a danger to the patient
- Education provided to the patient and family members

RN.com's course "Hope Against Suicide: A Care Guide for Healthcare Providers" provides a great review of the suicide assessment, prevention, and documentation (RN.com, 2012a).

Documenting Oral Communications with the Patient's Provider

Certain situations call for particularly careful attention to documentation. These include:

- Receiving and documenting verbal orders
- Questioning a provider's order

Receiving Verbal Orders

Follow organizational policy concerning documentation of orders and diagnostic test results received orally in person or via telephone. TJC requires read-back of verbal orders.

Verbal Order Guidelines

- Receive the verbal or telephone order directly and not through a third party
- Write down the order exactly as the provider gives it and the date and time
- Sign the entry
- Read back the order to the provider.
    - Assure that you have the same understanding
        - state, "five-oh" rather than saying "fifty" which could be misunderstood as "fifteen"
    - If there is any question, spell, or ask the prescriber to spell drug names
        - When spelling, assure that sound-alike letters are correctly interpreted, state "B as in ball'"
- Obtain confirmation from the provider that the order is correct as you have read it back

More info box

A neonate in the NICU had a PICC line inserted in the axilla. The neonatologist gave a verbal order to observe the site for signs of infection. The nurse failed to transcribe the order. Swelling and seeping began at the site two days after insertion, but no action was taken for another two days. The arm became necrotic and was amputated. The infant died of sepsis 36 days after birth. Regardless of the failure to transcribe the order, nurses were accountable for observing the site but no documentation indicated that the nurses monitored the site or took action. (Legal Eagle Eye, 2011d).

Documenting Verbal Orders

- Record the order in the patient's record as soon as reasonably possible.

- o   Note date and time and then the order verbatim
- The EHR system will have specific steps to take to ensure the telephone order is processed correctly.
  - o   Follow directions to ensure accuracy

Questioning Provider Orders

If you think that your patient's provider has written an order that may be a mistake, or may jeopardize the patient's status, you have a responsibility to seek and document clarification. Similarly if you think the provider has forgotten or failed to order a test, medication, treatment, or other aspect of care that is indicated, you have a responsibility to seek and document clarification.

Discuss your concern with the provider and document the discussion. If the discussion does not resolve your concerns and the provider insists that you carry out the order, you have the responsibility to start the COC sequence.

Controlled Substances

Your institution has policies that guide controlled substances use and documentation. Controlled substances use and storage are controlled and monitored by outside agencies. Deficiencies in documentation lead to fines, litigation, and loss of accreditation depending on the severity of the deficiency.

As a healthcare provider, it is imperative that you follow the documentation rules. In recent years, with the advent of automated medication dispensing systems, it has become easier to comply with the rules. However, the healthcare provider still has a responsibility to document their actions:
- Controlled substance waste
- Beginning and ending medication count
- Resolution of variances

Special Situations

Certain situations call for particularly careful attention to documentation. These include:

- Consents
- Unusual Events (Incident Reports)

Consents

The medical provider takes responsibility and is held accountable for obtaining signed consent for those treatments and procedures which require consent.

When a nurse witnesses consent, the nurse is attesting only to the fact that the individual named in the consent is the person who has signed in that capacity.

Assure that you inspect any signed consents to verify that the consent is completed and signed properly before checking off on another document, such as a pre-operative checklist, that the consent is completed.

An unsigned consent, incomplete consent, or one that is incorrect implies no consent. Review the consent for abbreviations, the correct surgical site has been indicated, date and time, surgeon's complete name, and all the blanks are filled in or marked through. If you find any discrepancies,

rewrite the consent prior to witnessing the patient signature.

Documenting Safety Events

Safety events are documented in the patient's medical record, document just the facts. Include no assumptions about what you think probably occurred or contributed to the event. In the patient's record include:

- Your observations of the event
- Your specific interventions with the patient and the patient's response
- Any statements by the patient concerning the event
- Be sure to identify in quotation marks as patient statements, making it clear that this is the patient's description and not your observation
- Any change in the medical or nursing care plan because of this event, including changes in monitoring or medications
- Full names of personnel you notified of the event

Do NOT indicate in the patient's record that you completed a safety report or notified the risk management department.

Safety Reporting

Each organization will have a specific terminology for safety reporting. Commonly used terms are:
- Occurrence reports
- Incident reports
- Safety reports

Regardless of the title of the report, these reports alert the Risk Management Department to occurrences that occur that may be detrimental to the patient. This reporting system is not just for occurrences that harm the patient; near misses that do not reach the patient should also be reported. The purpose of a safety reporting system is to identify and rectify issues at the system level that may be adversely influencing the safety of the process. The safety system also identifies issues with individual staff or groups of staff. This system is not meant to be punitive; it is a process of discovery.

Safety reports, performance improvement, quality improvement, and peer review documents are protected from discovery. However, if you document that you submitted a safety report, the safety report can now be requested by the defendant's attorney to be used as evidence of an error.

Each state has specific regulations regarding the discoverability of safety reports. Work with your Risk Management Department to learn what your state requires.

If the patient's actions or failure to comply with instructions contributed to the incident include any such details in your safety report. If you did not observe the patient's action but the patient tells you "I know I'm supposed to ask for help to get out of bed, but I really felt strong lying here and I thought I could get up OK" document this statement and the patient's statement of what happened.

Tips for Completing a Safety Report

Include	Avoid
Date, time and place of the incident	Hearsay from other staff members or other individuals. Other staff members should initiate their own incident reports. Non-staff member witnesses may

	be contacted during the ensuing investigation.
Names of persons involved	Your opinion re: prognosis or who is at fault.
Names of witnesses	Conclusions or assumptions about what caused the incident.
Facts about what happened	Assumptions about any circumstances you did not directly observe, such as what occurred immediately prior to your discovery of the incident. If you did not observe a patient fall, but found the patient sitting on the floor, state only that you found the patient sitting on the floor.
Consequences to the person involved	Suggestions about how the incident could have been prevented, or might be prevented in the future.
Your response to the incident including all assessment you performed and care provided to the patient.	Filing the report in the medical record. Instead, file the report immediately according to organizational policy. Most report forms include instructions for filing the report.
Full name of the provider notified	Documenting in the medical record that an incident report was completed. Instead simply document your observations and actions in the situation.

Universal Protocol

Regulatory agencies have focused on procedural error prevention within the recent past. Wrong site, wrong patient, and wrong surgery among other situations have prompted stricter regulations for procedures and surgeries.

In the past, a "time out" was required to verify the correct patient, correct site, and correct procedure. Despite this "time out" untoward outcomes still occurred. In order to reduce the poor outcomes, the regulatory agencies identified several other components that should be verified prior to a procedure or surgery commencing; hence the implementation of the "Universal Protocol."

The Universal Protocol requires documentation of the following:

- Pre-procedural verification process
  - o Address missing information or discrepancies before starting the procedure
- Mark the surgical site
  - o At a minimum, mark the site when there is more than one possible location for the procedure and when performing the procedure in a different location could harm the patient
- Perform a Time Out
  - o The procedure is not started until all questions and concerns are resolved

For more complete information regarding the Universal Protocol, review the Joint Commission's Universal Protocol Poster at http://www.jointcommission.org/standards_information/up.aspx

Your Documentation Takes the Witness Stand

Good and accepted practice is most often defined as care that would have been provided by the ordinarily prudent nurse practicing in the particular circumstances. The care need not have been the best care or even optimum care. Furthermore, when there is more than 1 recognized method of care, a nurse will not be deemed negligent if an approved method was chosen, even if that method later turns out to be the wrong choice. As long as the defendant nurse provided care that was consistent with accepted practice, the nurse will not be found negligent, regardless of outcome (Giordano, 2003).

Will your documentation testify that you . . .?

- Observed and monitored a patient according to accepted standards of care
- Documented and communicated a significant change in a patient's condition to the patient's provider or other appropriate members of the healthcare team
- Followed up appropriately on any calls to providers or other team members
- Effectively communicated with the patient's provider and subsequently documented efforts to get help for a patient from that provider and the provider's response, including new orders
- Noted a patient's response to any interventions initiated in response to change in condition
- Recorded a complete nursing history
- Formulated, individualized and followed a plan of care
- Performed nursing treatments and procedures according to accepted standards of care

How Does Your Documentation Testify?

Each patient record is unique in that it is contemporaneous to the events and is usually created at a time when there is no interest in a legal outcome (Giordano, 2003).

Your documentation is evidence that you:
- Provided a safe environment and protected the patient from avoidable injury
- Executed providers' orders correctly and promptly
- Administered medications correctly
- Observed the patient's response to medications
- Managed the patient's pain effectively
- Took proper safety precautions with any patient who was restrained
- Prevented an infection
- Reported the fact that a patient did not receive proper care from a provider to a person who could intervene and obtain the appropriate help
- Used equipment properly
- Used only equipment that was in proper working order
- Made prompt, accurate entries in a patient's medical record
- Corrected any error in your documentation according to policy
- Followed hospital policy and procedure
- Made any late entries as soon as possible and in a clear fashion

Consider this scenario:

A patient claimed injury from an indwelling urinary drainage catheter inserted prior to a Cesarean section. The patient had been in labor expecting to deliver vaginally. The nurse documented and described blood-tinged urine draining from the catheter "urine in the bag with little specs of blood in it." The nurse testified, based upon 25 years of labor and delivery experience that the finding was not unusual in the circumstances and if dark red blood had been present she would have notified the obstetrician. She further testified that it was her practice to carefully examine the urinary drainage bag before, during, and after a Cesarean section (Legal Eagle Eye, 2011b).

A nurse's complete documentation resulted in the dismissal of charges of malpractice.

Summary

Complete and legal documentation provides the nurse with the story of the hospitalization. The EHR is a communication tool that delineates the hospitalization stay years after the memory of the patient has faded.

Utilization of the care provision documents created by your institution provides the staff with the guidance necessary to perform complete and legal documentation. These documents define the current standards of care and regulatory requirements.

Although poor documentation does not cause a patient's injuries, it can result in an unfavorable outcome for the nurse in a malpractice case.

Conclusion

This course has presented key topics related to nursing documentation, a critical component high quality patient care and safe, effective nursing practice that is legally and ethically sound.

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