Ladies & Gentlemen of the Jury,
We Present Nursing Documentation.....
2012
Definitions:

- **Point of Care Documentation** – charting at the bedside at the time of care, assessment and treatment.

- **Standards of Care** – guideline based on evidence based practice to individualize the care delivered to each patient.

- **Risk Management Notifications** – reports completed for unusual circumstance such as a fall or medication error.
Nursing Documentation: 
Critical Element of Patient Care

Nursing documentation describes the patient’s care and patient's response to care.

Point of care nursing documentation communicates accurate and timely data to physicians and other members of the health care team.
Purpose of Patient’s EMR

- Communication tool
- Record of Diagnostic and Therapeutic Orders
- Care Planning Record
- Tracks Patient’s Progress
- Quality Improvement data
- Legal and historical document
- Validates reimbursement issues
Method of Documentation

- Avera Queen of Peace uses the system of “Charting by Exception” which requires timely patient assessment and documentation of patient’s condition with changes that need to be communicated to rest of care team.

- It requires objective documentation to explain changes in level of care and/or patient’s progress based on standards of care.
Record Factual Information

- Head to Toe Nursing Assessment
- What is seen
- What is heard
- What is palpated
- What is done for the patient
- The patient’s response to the action
- The patient’s experience in quotes if indicated
- Document notification of physician, information reported and physician recommendations.
Quality Documentation

- Critical to defense.
- Malpractice cases are settled 2 – 5 years after the occurrence. Documentation refreshes your memory.
- Supports the care given and the decision making even when there was a negative outcome.
- Personal goal for professional nurses is to attain skillfulness in documentation by working closely with mentors that have achieved a high level of expertise in documentation.
Avoid documenting the following:

- Subjective statements (your assumptions or personal opinions)
- Generalizations and vague words
- Derogatory or discriminating remarks about the patient/family
- Staffing problems
- Alleged negligence by co-worker or statements regarding prior treatments
- Avoid use of “normal” in notes. Does normal blood pressure mean 90/60 or 160/90? Both can be normal so document blood pressure in numerical values.
Say This, Not That

**Objective**
Checked on rounds hourly, eyes closed, respiration’s regular

Patient repeatedly asking about length of stay, expected pain, and required time off from work

Drank 1000 ml water in past 8 hours

**Subjective**
“Slept all night”

“Patient is nervous”

“Drank fluids well”
Complete Documentation

- Reason patient is seeking care
- Assessment factors, clinical observations, baseline data
- Medications / treatments / education
- Response to interventions / medications / testing etc.
- Treatment plan / discharge plan
### General Questions

<table>
<thead>
<tr>
<th>Date Arrived on Unit</th>
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</thead>
<tbody>
<tr>
<td>Time Arrived</td>
<td>1540</td>
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#### History Provided by

- [ ] Patient
- [ ] Spouse/Sig Other
- [ ] Grandparent
- [ ] Parent/Guardian
- [ ] Friend
- [ ] Family
- [ ] Legal Representation
- [ ] Foster Parent
- [ ] Pre-Anesthesia
- [ ] Transfer Record
- [ ] Medical Records
- [ ] Unable to Obtain

#### Interpreter?

- [ ] Yes
- [x] No

#### Lives With

- [ ] Alone
- [ ] Child/Children
- [ ] Significant Other
- [ ] Spouse
- [ ] Friend/Roommate
- [ ] Parent
- [ ] Guardian
- [ ] Grandparent
- [ ] Sibling/s
- [ ] Other
- [ ] Mother
- [ ] Father
- [ ] Foster Care
- [ ] Assisted Living
- [ ] Prison
- [ ] Nursing Home

#### Chief Complaint/Onset

- [ ]

#### Trauma Chief Complaint

- [ ] NA
- [ ] Burns
- [ ] Motor Vehicle Crash
- [ ] Motorcycle Crash
- [ ] Pedestrian
- [ ] Falls
- [ ] Watercraft Crash
- [ ] Aircraft
- [ ] Assault
- [ ] Gun-shot wound
- [ ] Sharp Penetration Wound
- [ ] Other

<table>
<thead>
<tr>
<th>Date Injury Occurred</th>
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<td>Time Injury Occurred</td>
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Statement regarding chief complaint/onset

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<tr>
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<td>Parent/Guardian</td>
<td>Friend</td>
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<td></td>
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<td>Child/Children</td>
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<tr>
<td>Spouse</td>
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<tr>
<td>Parent</td>
<td>Assisted Living</td>
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<tr>
<td>Guardian</td>
<td>Prison</td>
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<td>Sibling/s</td>
<td>Foster Care</td>
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<tr>
<td>Other</td>
<td>Mother</td>
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<tr>
<td></td>
<td>Father</td>
</tr>
<tr>
<td>Chief Complaint/Onset</td>
<td>dizziness, weakness, &quot;afib&quot;</td>
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<tr>
<td></td>
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<tr>
<td>Trauma Chief Complaint</td>
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</tr>
<tr>
<td>NA</td>
<td>Motor Vehicle Crash</td>
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<tr>
<td>Burns</td>
<td>Bike/Cycle</td>
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<td>Falls</td>
<td>Pedestrian</td>
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<td>Other</td>
<td>Assault</td>
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<td></td>
<td>Gun-shot wound</td>
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<tr>
<td></td>
<td>Sharp Penetration Wound</td>
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</table>
Assessment/clinical observations

Whenever there is a change in patient condition, document the following:

- Notification – MD, supervisor, family
- Action plan
- Treatments / intervention
- Monitoring

*Whenever a wound is assessed, document the size of wound and the care given.*
Accurate Documentation

- Double check patient name/date of birth
- Verify all reports, results and documentation
- Reread your entries
- Verify you are charting in the correct medical record
- Use only acceptable abbreviations
- Correct mistakes appropriately
- Follow facility documentation standards:
  - Frequency – do you adhere to policy and orders?
  - Do not leave charting until the end of the shift – too much can be omitted; rest of care team will not have access to your nursing assessment and patient’s response to treatment during your shift.
Make Accuracy Your Priority

Templates can add efficiency and consistency if assessment unchanged.

1. Clicking and dragging
2. Uses recall values without rechecking your entries for accuracy.
3. Lacks notes about patient’s progress and condition which indicates lazy documentation.
4. Such entries should be kept to a minimum.
Timely Documentation

- Chart as you go — even though you are busy, the briefest of notes preserves credibility and increases accuracy.

- Point of care documentation is a must in the electronic medical record as physicians and the rest of the healthcare team are trusting that the EMR contains up-to-date vital signs and a timely nursing assessment.
Untimely Documentation

Point of Care Documentation:
Vital Signs must be charted in a timely manner:

<table>
<thead>
<tr>
<th>Date Done</th>
<th>Time Done</th>
<th>Done by</th>
<th>Entered</th>
<th>Entered by</th>
<th>Assessment</th>
<th>Signatures</th>
<th>Type</th>
<th>Note Link</th>
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<td>05/11/2011</td>
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<td></td>
<td></td>
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<tr>
<td>05/11/2011</td>
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<td>05/11/2011 0424</td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td>05/11/2011 0007</td>
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<td>05/10/2011</td>
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<td>05/10/2011 2002</td>
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<td></td>
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<tr>
<td>05/10/2011</td>
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<td></td>
<td>05/10/2011 2002</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Care giver name defaults here

Care giver name defaults here

Immediate Post Op Vital Signs must be charted in a timely manner:

<table>
<thead>
<tr>
<th>Date Done</th>
<th>Time Done</th>
<th>Done by</th>
<th>Entered</th>
<th>Entered by</th>
<th>Assessment</th>
<th>Signatures</th>
<th>Type</th>
<th>Note Link</th>
</tr>
</thead>
<tbody>
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<td>05/10/2011 2008</td>
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<tr>
<td>05/10/2011</td>
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<td></td>
<td>05/10/2011 2002</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Care giver name defaults here

Care giver name defaults here
Legible Documentation

- Check for poor grammar in medical record
- Check for misspelled entries in medical record
- Recheck your entries or ask colleague to review your entries for spelling errors, errors in grammar and if it is appropriate.
ER – fell few days ago, intoxicated & found broken ribs, right side, found passed out 7/24 on lawn by his brother.

7/25D – Dilaudid for pain. Ativan for CIWA, score 2–3. skin tear R hand. confused @x’s. weak, walks in hallway, Dr discussed tx. Doesn't want to go. Dr talking to family. Up & down alot, found in hall. Started Valium. 7/27D – Dr says he declared him mentally incompetent. Waiting for family to draw up POAs, then will decide where he needs to go. Dr says not approp for stepping stones, SS wondering about DCI consult for depression, 7/28 persistant rib pain, pharmacy inc dilaudid & started toradol will get toradol prn. Stepping stones saw today awaiting placement acceptance, ?if pt will voluntarily go, Dr. enc pt to go voluntarily – pt was quiet. BP continues to be elevated, Dr. informed. Wanted AM dose of lopressor to be given early. 7/31D pt says brothers will be here tomorrow for a meeting with dr about discharge plan 8/01 D: Walked frequently on hallways – stable. Seems very calm today. Ask for pain med – about every 4–5 hours. Contact SS or they will contact you with any DC changes. Pt. does not want to go any where just home. SS to talk with Lawers in a.m. again. If he leaves I guess you will need to have him sign AMA sheet and then call the police due to him being a danger to himself if he drinks. 8/2 BP remains high, lopressor given early.
Refusal of Care

Document

- Document education provided to patient and family on the risks and benefits of receiving and not receiving care and treatment.
- Document discussion of the consequences of “refusal” and patient’s response in quotes if received.
- Nursing actions
  1. **Compromise** – is there an alternative to reduce potential adverse effects of refusal
  2. **Notify** – MD, supervisor, family if not present
  3. **Complete Nursing Forms**–AMA Release and Patient Refusal for Treatment/Intervention or Elopement AMA
  4. **Complete Quality Risk Management notification**
Documentation Strategies

1. Verify the document belongs to the right patient prior to entering data.
2. Never leave blank fields unless per policy.
3. Be consistent in documentation habits & data entry.
4. Be specific about your patient.
5. Read previous charting.
7. Use only approved symbols & abbreviations.
8. Follow policy on correcting a documentation errors and clarification or making late entries.
Documentation Strategies – Perform your own “chart audit”:

✓ Did you recheck your documentation?

✓ Does it tell the complete story? Is it accurate?

✓ Are all entries spelled correctly?

✓ Is the meaning of all abbreviations obvious?

✓ Are there inappropriate comments regarding patient, family, other providers

✓ Does medication administration record reflect physician orders? Treatments?

✓ Is patient response recorded?
Nursing Documentation

“Pitfalls Red Flags”
The key reasons for maintaining high documentation standards and expectations are as follows:

- To record correct and comprehensive information, to communicate and coordinate care
- To avoid legal and fraudulent liabilities
- To avoid claims denials and to meet regulatory and accreditation standards.

**Preventative Actions:**
1. Document at the same time as your assessment and/or treatment.
2. Avoid gaps in the medical record.
3. Follow your facility's documentation policies
4. Document adverse events properly.
Documentation Pitfall # 1

Inconsistent Documentation by Care Team Members

EXAMPLE #1 – Functional Limitations

Documentation found in this record’s admission assessment and physician orders included:

- Requires maximum assistance and specialized transportation
- Repair of fractured femur with internal fixation
- Physician Orders: Patient to be homebound during recuperation
- Restrictions: Up as tolerated, No restrictions

Noted on the ongoing visit/progress notes:
- **Physical Therapy** – Gait training with a standard walker 100’ x 2;
  can access elevator independently with walker
- **Social Work** – Patient reports they are confined to bed
- **Nursing** – Maximum assist needed for bed to chair transfer

Preventative Actions:

1. Periodic Chart Audit
2. Key problematic areas should be included in the
   Interdisciplinary Team or Case Management/Care Coordination meetings.
Documentation Pitfall # 2
Use of Unapproved and/or Unidentifiable Abbreviations

EXAMPLE #2 – Approved Abbreviations Should be Used
The following are examples of abbreviations that have been used in the patient medical records.

<table>
<thead>
<tr>
<th>DO NOT USE</th>
<th>POTENTIAL PROBLEM</th>
<th>USE INSTEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4”, or “cc”</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (international unit)</td>
<td></td>
<td>Write “international unit”</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write “daily”</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d., qod (every other day)</td>
<td>Period after the Q mistaken for “I” and the “O” mistaken for “I”</td>
<td>Write (“every other day”)</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg) **</td>
<td>Decimal point is missed.</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td>Decimal point is missed.</td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write “morphine sulfate&quot; or &quot;magnesium sulfate”</td>
</tr>
<tr>
<td>MSO4 and MgSO4</td>
<td>Confused for one another</td>
<td>Write “morphine sulfate&quot; or &quot;magnesium sulfate”</td>
</tr>
</tbody>
</table>

Preventative Actions:
1. The organization should have a Approved Abbreviations list.
2. Periodic Chart Audit.
Documentation Pitfall #3
Timeliness and Legibility of Documentation

With timeliness and legibility, two divergent documentation problems appear. The first is a delay in completion of required documentation. The second is that while the required documentation appears to be present, it is illegible.

Real Time Documentation

DO’S OF DOCUMENTATION
• Have the patient’s name on every sheet
• Make entries in chronological order
• Write neatly, legibly with black ink
• Use concise phrases & patient’s quotes
• Use approved abbreviations
• Be objective, describe
• Document action following indication

DON’TS OF DOCUMENTATION
• Rely on memory to chart the entire shift
• Tamper with notes previously written
• Chart in advance
• Understate
• Chart for anyone else
• Add extraneous remarks
• Exaggerate

Preventative Actions:
The Organization has well defined policies and procedures that include time frames for completion of documentation, and a concurrent review process.
Documentation Red Flags

Waving Red Flags
An attorney in a professional negligence case will examine the medical record for evidence that will help prove the case, such as:

- Entries that aren't timed or dated or that appear out of sequence
- Entries that indicate delays or failures in initiating treatment orders
- Entries that show the care provided was substandard or inappropriate
- Entries that show care rendered that wasn't supported by a healthcare provider's prescription
- Unexplained late entries
- Lack of documentation of patient education or discharge instructions
- Entries made with different ink or pen (if the record is handwritten)
- The statement "Completed an Event Report," which can serve as a red flag that something went wrong during the patient's care.
The following pointers may help to guide the nurse in documenting completely and accurately while avoiding some common mistakes:

- **Never document an acute abnormality found during assessment without documenting the intervention initiated.** Example: Document assessment, intervention (such as implementing an order for nitroglycerin administration), & physician notification if applicable.

- **Never document the intervention initiated without documenting the evaluation/response of the patient.** Example: For a patient with chest pain, the intervention that's documented should be followed by an evaluation as to the efficacy of the intervention. Was the nitroglycerin successful at relieving the chest pain?

- **Never document a body system abnormality without elaboration.** Example: If a patient presents post-motor vehicle accident with a neurologic deficit in the lower extremities (possible spinal cord injury), it's vital to note the details.

- **Always document the patient's baseline mental status (if known).** Example: A patient who presents with altered mental status who's normally altered should be evaluated for the specifics of his condition.
Don't confuse visual, audible, and tactile assessment.
**Example:** Nurse documents exactly the sensory method used in assessment. If the patient has a normal breathing pattern as evidenced by sight, then the nurse shouldn't document that bilateral breath sounds were clear to auscultation unless a stethoscope was used to reveal evidence by hearing.

Reconcile mismatched objective and subjective assessment findings.
**Example:** Pain is a subjective assessment when stated by the patient. If a patient reports a 10 on a pain scale of 1 to 10, this reflects that he's in severe pain. But, if he's sitting up in bed playing cards with a family member at the bedside, this picture is drastically different than if he were diaphoretic and writhing in pain. In both scenarios, the patient may report pain as a 10 out of 10. To track changes in the objective data, the nurse should reconcile via documentation when subjective and objective data don't match.

Don't become complacent with check-off assessments. Every facility has some sort of check box system for documenting the patient assessment. It's vital that documentation be reflected as accurately as possible.
**Example:** There's no single way to undermine credibility in court more powerful than documenting that a patient with a right below-the-knee amputation has bilateral pedal pulses that are strong and equal. All other parts of the assessment will have doubt shed on them related to the nurse's error in accurate documentation of this issue.
Use Approved Abbreviations

- Avera Queen of Peace follows Stedman’s Abbreviations, Acronyms, Symbols Book for approved abbreviations

- Unapproved Abbreviations…..Huh?
  - Pt. c/o Hs SOB. S 3 pk.
  - D. HA ‘73, Apd ‘75, ANK, PN ‘78, ‘80. No NVDV.
  - Fr T ‘81, Ac ‘83, R 7,8 &9
  - Fr. BL Dia M. Ty/AR
What is Required to be in the Record?

- State/Federal Laws and Regulations determine largely what must be documented.

- ANA, Joint Commission, HCFA (CMMS) require documentation of initial & ongoing assessments, teaching, responses & patient statements.

- Reimbursement depends on patient’s care needs reflected in the record.
Poor Grammar Examples:

- Respirations deep & regular– No BS
- Pt was X-rated & sent home
- Lover functions were abnormal
- Pt has 2 teenage children but no other abnormalities
- Vaginal packing out – Dr in
- Pt constipated most of her life till her divorce in 1999
Watch Spelling

What is spelled incorrectly in each statement?

- NG Tube attacked to low Gumco
- Fecal heart tones
- Pt has a linguini hernia
- No brewery heard in rt arm
- Dr’s odors received
- No penis pulses
- MD Order: Walk in hell
Do Not Document

* Admissions of Guilt
  “Pt mistakenly given 15 units of Insulin instead of 5 units….”

* Lack of Patient Care
  “As usual, lab wasn’t drawn again this AM.”

* Inappropriate Comments
  “If Doctors would return phone calls promptly, there would be fewer deaths on this unit.”

* Words Associated with “Error”
  Mistake, somehow, unintentionally, accidentally, miscalculated, etc.
Admitting Mistakes Continued

Nursing Notes: “Late on all AM meds due to an admission and total of 6 pts this AM.”

1. Complete a Medication Notification Reports
2. Do not mention incident report or notification in the medical record.

“Pt fell, Dr. notified, attempt to call family, no answer. Patient was moved to room 2241. See notification report for further details.”
Communication Tools

HAND-OFF COMMUNICATION TOOLS ARE USED FOR SAFE TRANSITIONS IN PATIENT CARE
Remember

Rule of Thumb

If it wasn’t documented,
It wasn’t done.
References:

- Website: www.nursetogether.com
- “Ladies of the jury, I present the nursing documentation”, Nursing2006, Vol. 36, No. 1
- “Stay out of court with proper documentation”, Nursing2011, Vol. 41, No. 4
- Vicky Burbach, RN, MMIC Group, Avera Queen of Peace Liability Insurance Carrier
References:

- Avera Queen of Peace Clinical Care Coordinators
- Avera Queen of Peace PCS Team
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