Purpose and Objectives
The purpose of this course is to present key topics related to CNA’s documentation for medical records.

After successful completion of this course, you will be able to:
1. Explain why documentation is necessary.
2. List the kinds of documentation CNAs complete.
3. Describe how CNAs can document correctly.
4. Tell what activities and observations should be documented.
5. Explain why some documentation should be done immediately.

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Acknowledgements
RN.com acknowledges the valuable contributions of...

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Introduction
Documentation is needed to provide high quality patient care.

This course presents general documentation principles. Your facility has specific standards for documentation.

Whether your facility uses computers for documentation or paper forms, you will find the same principles apply.

Documentation can be used as legal evidence to defend you and your facility. It can protect against allegations of malpractice, negligence, or failure to meet standards of care. It also is a key communication tool to other care providers.

Policies And Procedures
From the moment you begin working as a CNA, policies and procedures (P&Ps) play a key role in your documentation.

Make it your mission to orient yourself thoroughly with the P&Ps in your area. Different areas of a hospital may have different ways of doing things.

- If you are new to a unit, ask yourself what parts of your job are different from your previous position. There is generally some variation between different facilities. There may even be differences in documentation between units.
- During your first shift on the unit, look at two or more medical records. Pay particular attention to flow sheets. Are the instructions clear?
- If and when you float, familiarize yourself with the new documentation expectations.

Failure to follow policies and procedures is a frequent allegation against healthcare providers in lawsuits (Austin, 2006). CNAs who fail to follow policies and procedures can also lose their job. Learn the key policies that affect you, and know where to locate all polices. They may be online or in a policy manual.

Documentation shows your work was done according to your facility’s policies and procedures.

Before Beginning Your Shift
- Before you begin your first shift, be sure you know how to find the policy and procedure books and any manuals you might need. Where to find all the medical record forms to be completed.
- How to document an unexpected event.
- When you should give an immediate verbal report to your supervising RN, in addition to written documentation.
- How to document issues that arise with friends and families of patients.

Remember, the P&P manual may be a hard copy, on the computer or on the facility intranet.

True or False?
A CNA cannot be sued for giving poor care.
False! A CNA can be sued for care that is below the standard for your state.
What is a CNA Accountable For?
No matter how skilled a CNA you are, it is very important to accurately document the care you give. Accurate and thorough documentation will protect you, the facility and your patient.

Your patient's medical record is a legal document that tells the story of his encounter with you and other healthcare professionals. It should provide a complete and accurate account of your patient's condition and the care given (Austin, 2006).

As a CNA, you can be held legally accountable for:
- Mistreating or abusing patients
- Neglecting to do parts of the job
- Abandoning patients in need of care
- Acting inappropriately or unprofessionally
- Performing care or tasks that are outside the scope of a CNA's job
- Giving poor care that is below the standard for your state
- Not respecting patients' privacy rights and violating confidentiality

Documentation Guidelines
Think of the medical record as communication between healthcare workers. It should provide information about what happened on your shift. If you think of documentation only as a way to protect yourself from legal action, your records will sound self-serving and defensive (Lippincott, Williams & Wilkins, 2003).

Medical records serve three major purposes:
- They are a way for healthcare workers to share information.
- They document compliance with standards of care. Standards of care are established by the American Nurses Association, other specialty organizations, the Joint Commission, the Center for Medicare and Medicaid, federal and state reimbursement guidelines, state nurse practice acts, and facility policy and procedures.
- They show that patient care meets safe, effective and legal requirements.

True or False?
Medical records document compliance with the standard of care.
True! The medical record can show that your care met the standard of care established by professional agencies, reimbursement agencies, and government guidelines.

What Should Be Documented?
What should a CNA document?

Activities you need to document are:
- Baths and daily hygiene.
- Skin care.
- Turning and repositioning.
- Range of motion exercises.
- Walking patients.
- Any important conversations you have with patients.
In addition, you should observe and document:

- Changes in patients’ awareness and mental state.
- Vital signs.
- Urinary output.
- Bowel movements.
- Skin color and warmth.
- Unusual behaviors or things that patients say that are important for others to know about.

Document what you do and what you see or hear.

**FACT Criteria**

Use the mnemonic **FACT** to help you document comprehensively.

**Factual**

- Only information you see, hear or otherwise collect through your senses.
- Describe, don’t label.
- Be specific.
- Use neutral language.
- Avoid bias.
- One of the most common errors in documenting is stating value judgments and not facts: e.g., “Ate well.” “Slept well.” These notes fail to describe the facts. Instead they evaluate.
- When you make an error, state exactly what you did, or failed to do.

**Accurate**

- Be precise.
- State amounts or times.

**Complete**

- Be sure that you include:
  - Condition change.
  - Patient responses, especially unusual, undesired or ineffective responses.
  - Who you told about this. (Supervising RN, for example.)
  - What the patient and family said. Make entries in all spaces on all relevant assessment forms. Use N/A or other designation per policy for items that do not apply to your patient.

**Timely**

When a medical record is examined in court, date and time are critical. It establishes timely response to a patient need. Some facilities make timely charting easy by keeping the record near the patient. Computer entries automatically note time. If your entry refers to earlier events, be sure that you note the time you are talking about.
Keeping Time On Your Side
The best and safest practice is to document as soon as possible after an event. With busy shifts and heavy patient loads, you can be tempted to leave your documentation until the end of your shift. Resist the temptation because:

- You may forget key pieces of information when rushing at the end of the shift.
- Managing a load of many patients may cause you to confuse or forget details.

HOWEVER, avoid documenting beforehand. This practice is illegal. It contributes to errors and confusion. NEVER document in advance! Documenting in advance is falsification of a legal record. It can have serious consequences in a legal action.

True or False?
It is legal to document before an event occurs if you know it is going to happen.
False! Never document before an event. Even if you are sure you are going to help a patient take a walk, do not document about it until after the walk.

Handwriting
Clear communication is threatened by messy handwriting or handwriting in which all letters look alike.

Ask a colleague to read your work. Are the letters you wrote the letters that your colleague sees in your writing?

You may need to slow down to write more clearly. Or, you may need to resort to printing rather than cursive writing.

When you encounter illegible handwriting of others, do not guess the intended meaning. Get clarification!

Keep your writing legible.

Risky Words
Some words are vague and misleading and should be avoided in your documentation.

Try not to use the following words in your documentation:
- Mistake
- Accidentally
- Somehow
- Unintentionally
- Miscalculated
- Confusing
- Apparently
- May be
- Could be
- Assume
- Blank Spaces: Do not leave any blank spaces in your notes. If you are starting a new page, be certain there are no blanks on the page before. Follow your facility guidelines for what to do with blank spaces at the end of a page.

Venting Frustrations
You may experience occasional frustrations in your job. This may be due to short staffing, or communication problems.

In some facilities you may experience chronic frustration when problems go unresolved. Find out how to handle these concerns.
Do not reflect your frustration in a patient's medical record.

If you are in situations you think are unsafe for yourself or patients, talk to your supervisors about it. After you report your concerns, use your most effective stress management techniques.

Follow up with whomever you reported to. Check on progress being made in addressing the problem.

**Corrections & Late Entries**

**Corrections**
Correct errors by drawing a single line through them. Write “mistaken entry,” “error,” or whatever is required by your facility. Follow with the date and your initials. Never erase an entry or use correction fluid or “white out.” If you need to replace several words, use an addendum sheet and follow the procedure for late entries.

**Late Entries**
The medical record may be unavailable when you want to write on it. Sometimes you may remember further information to document. Then you will need to make a late entry. Document the time of this entry but also indicate the time of the occurrence to which you are referring. Do your best to avoid late entries since they raise suspicion. However, it is better to document important information late than never.

**Flow Sheets & Charting By Exception**

**Flow Sheets**
Many facilities use flow sheets. Blank spaces in flow sheets may look like evidence that nurses failed to give care or make observations. Follow facility policy on using flow sheets. Indicate when items do not apply to a particular patient. When you report for your first assignment on a unit, or float to a unit, ask to be oriented to the flow sheets in use.

**Charting by Exception (CBE)**
You may use a documentation system called Charting by Exception (CBE). CBE implies that all care was given and received as normal unless otherwise documented. In order for the system to stand up to legal challenge, well-defined guidelines and standards of care must be in place. If your facility uses CBE, review the pertinent policies, standards and guidelines carefully. If you have concerns, consult with your direct supervisor. When in doubt about whether to document or not, err on the side of caution and document. Courts assume that care was not done if it was not documented.

**Documenting Unusual Events**
Document any unusual events in the patient’s medical record. Stick strictly to the facts when documenting. Do not include your personal assumptions about what might have occurred or contributed to the event.

Include the following information:

- Your observations of the event.
- How you responded in the event.
- 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).
- Full names of personnel you notified of the event.
An unusual event should also be documented separately in an incident report. An incident report is not part of the patient's medical record and is maintained for internal facility use only. There is no need to refer to an incident report in the patient's record.

Incident Reports
The purpose of this report is to alert administration to an incident that may result in a lawsuit. Administrators then decide whether or not to investigate the situation.

Avoid laying blame in the incident report. Some patients create incidents by their own actions. Some incidents happen when patients fail to follow instructions. Be sure to include any such details in your report of the incident. If you did not observe the patient’s action but the patient tells you about it, document this statement. An example is: “I know I’m supposed to ask for help to get out of bed, but I really felt strong lying here. I thought I could get up OK.”

Do not indicate that you completed an incident report or notified the risk management department. The incident report should never be referred to in the patient's record.

Additional Important Records
In addition to the medical record, other facility documents may be used to show compliance with standards of care.
These documents may include:
- Time Sheet
- Schedule
- Assignment Sheet
- Education records
- Competency checklist

Special Situations: Consents & Restraints
Consents
The physician takes responsibility for obtaining signed consents required for treatments and procedures. When a staff member witnesses consent, this person is only confirming that the individual named in the consent is the person who has actually signed in that capacity. Your facility policy will indicate if a CNA can be a witness to consents.

Restraints
Reports of injury and death from restraints rank tenth among sentinel events reported to the Joint Commission (Joint Commission, 2010). Follow your facility’s restraints policy scrupulously. There are specific guidelines for the use of restraints in all patient care settings. The RN in charge and the physician will be involved in any decision to use restraints. Documentation requirements are usually spelled out clearly and often facilities provide a form for the purpose. Your documentation should tell when restraints are used, when they are released, and any statements the patient makes about them.

True or False?
Your patient keeps trying to get out of bed without assistance. It is not acceptable for you to restrain the patient.
True! You must follow strict guidelines regarding the decision to restrain a patient. The RN in charge and the physician will be involved in this decision.
Special Situations: Pain, Falls & Skin Care

Pain
Entries in the patient’s record must give evidence that your facility has met the Joint Commission standards for pain management. Pain is considered the 5th vital sign. It must be measured on admission and throughout a hospital stay. Your part in pain management is to observe for and report changes.

Falls
Reports of patient falls resulting in injury or death rank tenth among sentinel events reported to The Joint Commission (The Joint Commission, 2010). Follow facility policy in documenting patient falls. Be sure to state the facts, and only the facts. If you did not observe the patient falling, state only how, when, and where you found the patient, and actions that you took in response.

Skin Care
Your facility may have developed forms for documenting skin condition and skin care. Find out whether special forms are to be used for patients who are at risk for skin breakdown.

Documenting Personal Property
Patients’ missing personal property is a frustrating problem. Dental appliances, prostheses, and jewelry disappear from patient units at an alarming rate.

Always encourage patients to send personal possessions home if possible. Keep only necessities on the unit.

The security department may provide safekeeping for valuables. Make sure that personal property stays in the patient’s unit. Do not accidentally discard it with soiled linen or used dietary trays.

Complete your facility’s personal property inventory form carefully and update as needed.

If a patient says that an item is lost on the unit, do a reasonable search. If you can’t find the item, document and report the loss promptly.

Documenting Suicide Risk
Your facility may have a specific policy regarding suicide risk and documentation. Patient suicide is the second most commonly reported sentinel event (Joint Commission, 2010).

If you have any reason to suspect that a patient may attempt suicide, report your concerns to your direct supervisor.

Document the patient’s behavior and statements that caused your concern.

Also document the date, time, and full name of the person to whom you reported your concern.

Documenting Difficult Behavior
Difficult patients can be challenging to deal with, and non-conforming behavior needs to be accurately and thoroughly recorded and documented.
Some examples of non-conforming patient behavior can include:

- The discovery that your patient has alcohol or a firearm in his or her possession, while receiving care. You should tell the patient that these items are prohibited, and follow your facility policy for removing the items. Document your actions.
- Your patient refuses to answer questions or cooperate with the care plan. Find out if this patient understands the reasons for what you are trying to do. Remember that the patient has the right to refuse treatment. Do not make your explanation sound like a threat. Document the patient’s refusal and the discussion around it. Report this behavior to your supervising RN immediately.
- Your patient tampers with the equipment. Caution the patient about the dangers of doing so. Document the incident. Report this behavior to the supervising RN immediately.
- The patient or family members fail to comply with the dietary prescription or other aspects of care, document their specific actions and statements. Report this behavior to your supervising RN.

**Conclusion**

Documentation is an important part of your job.

It allows other healthcare workers to find the information they need for their jobs. It protects you and your facility from lawsuits.

Most importantly, it makes high quality patient care possible.

**References**


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