Professional Documentation: Safe, Effective, and Legal

6 Contact Hours

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Acknowledgments

RN.com acknowledges the valuable contributions of…

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Purpose

The purpose of this course is to present key topics related to nursing documentation. Nursing documentation is a critical component in high quality patient care and safe, effective nursing practice that is legally and ethically sound.

Learning Objectives

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. State the purpose of the patient’s medical record.
4. Identify standards and principles of documentation as described by the American Nurses Association (ANA).
5. Explain nursing documentation implications of:
    - Centers for Medicare and Medicaid (CMS) regulations regarding Hospital-Acquired Conditions (HACs),
    - National Quality Forum (NQF) Serious Reportable Events (SREs) also known as Never Events, and

- Joint Commission Requirements.

6. Identify documentation practices that validate safe, effective, and high quality patient-centered care.

7. Identify documentation practices that create legal and professional risks.
8. Explain and give examples of the key elements of medical malpractice.
9. Identify characteristics of nursing documentation that support a legal defense of nursing actions.
10. Identify actions that constitute defamation.
11. Explain documentation implications of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
12. Identify employment and licensure implications of nursing documentation.
13. 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.
14. Describe recommended documentation practices concerning communication with the patient's provider and provider orders, such as questioning orders and receiving verbal orders.
15. Give examples of important nursing documentation in addition to the patient's medical record which might establish the nurse's competencies, presence, responsibilities, and compliance with policies and procedures.
16. Identify precautions to observe when using electronic documentation.
17. Identify crucial elements of documenting situations that require special documentation practices, including consents, unusual events, patient's personal property, and 24-hour record checks.
18. Identify selected specialty-specific documentation issues.

Introduction

The most important role of documentation is to assure high quality patient care. This course presents universal documentation principles which apply whether your organization relies heavily upon electronic documentation, paper-based documentation, or a combination of the two systems.

You will find that the principles are not new. However, lapses in applying these principles create problems 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 you will document the quality care you provide and fulfill your responsibilities. You will also reduce the risks of a lawsuit against you, the organization at which you are working, and any other employer, such as a temporary staffing agency.

One of the cardinal principles of legally defensible documentation is **strict adherence to organizational policy and procedure** (P&P). Know the P&P guidelines of the organization and the state in which you practice.

Make Documentation Your Ally

Documentation:

- 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)

Nursing documentation also aids careful assessment and guides nursing action by providing assessment tools, and tools for recording evidence-based procedures such as practice bundles.

P & P: Your Best Friend or Worst Enemy

Your organization has established P&P that incorporate federal, state, and local laws; reimbursement requirements; accreditation standards, and standards and recommendations of various healthcare quality organizations. You are accountable not only for adhering to P&P, but also for documenting compliance. Your documentation serves as evidence of your compliance.

New policies, procedures, and guidelines develop continuously – in response to clinical advances, federal and state legal mandates, and requirements of accrediting bodies.

Reduce your risk for legal and professional exposure. Make it your mission to orient yourself thoroughly in new situations and continuously update your knowledge of P&P and guidelines.

When you are new to the unit:

- Review the key points of the information presented to you in orientation. Ask yourself how practices in this organization differ from your previous position. Validate your assumptions about whether previous expectations apply in this setting.

During your first shift on the unit:

- Make a point of reviewing two or more medical records. Pay particular attention to nursing documentation and flow sheets. Are the instructions clear? If not, ask a staff member to clarify.

If and when you float:

- Make it a priority to familiarize yourself with documentation expectations unique to the unit to which you have floated.

Key Policies and Procedures

Failure to follow P&P is among the most frequent allegations against nurses in lawsuits (Croke, 2003). Know key policies and where to locate the rest. Before you begin your first shift, be sure you know the following:

- How to access P&P and guidelines, whether paper or computer-based
- Physical location and/or intranet access of all key nursing manuals for which you have responsibility
- Chain-of-command for addressing patient care issues
- All the medical record forms to be completed
- How to document an unexpected event – in the patient's record and on any other form
- Location of safety/disaster manuals and infection control procedures
- How to document issues that arise with friends and families of patients
- Forms to be completed for discharge
- System for providing discharge instructions

This key information will equip you to document appropriately and minimize your exposure to litigation. It also provides for the best communication between you and other staff members about the condition of your patients. Do not guess about expectations and standards. Know where to find the P&P.

Recognize that in any lawsuit, accreditation survey, or disciplinary action, organizational P&P will be upheld as the standard against which your actions are judged.

Policies with Documentation Implications

All organizational P&P are important. From the legal, accreditation, and regulatory perspective, documentation validates or proves compliance with P&P. Certain policies have particular implications for documentation. Some of these include:

- Abbreviations: Do Not Use List
- Admission, Transfer, and Discharge
- Advance Directives
- Patient Assessment
- Cardiac/Respiratory Resuscitation
- Chain-of-Command
- Crash Carts
- Hazardous Materials
- Incident Reports
- Infection Control and prevention of specific infections such as catheter-associated urinary tract infections (CAUTI), central line-associated bloodstream infections (CLABSI), and ventilator-associated pneumonia (VAP)
- Medication Administration
- Medication Reconciliation
- Pain Management
- Patient Fall Prevention
- Rapid Response Team, or other system to respond quickly to deteriorating patient condition
- Restraints
- Safe Medical Devices
- Sedation
- Sentinel Events
- Suspected Abuse
- Skin Care
- Workplace Violence

The Patient's Medical Record

"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).

The medical record, also called the patient's record or the chart, serves four major purposes. The record:

1. Acts as a vehicle for communication among members of the healthcare team.
2. Documents compliance with standards of care and standards of various accrediting organizations such as TJC and the state health department.
3. Documents compliance with standards that must be met for reimbursement by a third party payor such as Medicare, Medicaid, or another insurance carrier.
4. Documents that patient care meets safe, effective, and legal requirements.

Common Charting Errors

Common charting mistakes to avoid include the following:

1. Failing to record pertinent health or drug information
2. Failing to record nursing actions
3. Failing to record that medications have been given
4. Recording in the wrong patient's medical record
5. Failing to document a discontinued medication
6. Failing to record drug reactions or changes in the patient's condition
7. Transcribing orders improperly or transcribing improper orders
8. Writing illegible or incomplete records

Nurses Service Organization, 2008, pp. 4 – 5

Did you know?

Judges, juries, accreditation surveyors, supervisors and other interested parties take the position, **"If it wasn't documented, it wasn't done."**

Documentation Standards

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

- American Nurses Association (ANA) publishes the Scope and Standards of Practice: Nursing and ANA's Principles for Nursing Documentation
- Nursing Specialty Organizations publish standards of practice and competencies
- Center for Medicare and Medicaid (CMS), when processing claims, requires evidence that certain infections and injuries for which reimbursement is sought were not acquired in the healthcare organization
- National Quality Forum (NQF) has identified a list of 29 Serious Reportable Events (SREs), also known as Never Events
- The Joint Commission (TJC) develops Accreditation Standards and National Patient Safety

Goals (NPSG)
- State Nurse Practice Acts
- Federal, State, and Private Insurance Reimbursement Guidelines

All aspects of care that standards mandate must be documented as evidence that care was provided.

All sources of documentation standards and requirements 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.

Your organization's P&P are the standard against which your practice is judged in a court of law or in any disciplinary proceeding.

More info:

Not Documented, Not Done

- Be specific; avoid general terms and vague expressions.
- Read and act upon progress notes of the previous shift.
- Document complete assessment data, even when not related to the chief complaint or patient need you are addressing. For example, if the patient complains of constipation while you changing a dressing on a leg ulcer, you will certainly assess the patient with respect to constipation. Assure that you document your assessment.
- Document interventions and the status of the patient following any intervention. Always document the patient's response to medications and interventions, especially any unexpected response.
- Document each observation. Failure to do so suggests that you neglected the patient.

ANA Standards of Practice

ANA Scope and Standards of Practice: Nursing (ANA, 2010a) includes competencies for each standard. The competencies contain 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
- Evidence of competence and lifelong learning in professional records

Your documentation must bear witness to your actions in all phases of the nursing process:

- Assessment
- Analysis
- Planning
- Intervention
- Evaluation

ANA Standards of Practice

Both ANA Standards of Practice and TJC Patient Care Standards emphasize the importance of documenting activities and findings in all phases of the nursing process. Research findings indicate that documentation of interventions and patient response is a weak link in documentation of nursing process (Paans, et al., 2010).

Your organization may use slightly different terms to capture the nursing process. Whatever terms are used, make these elements clear. Complete your organization's specific forms for initial and follow-up assessments: particularly respiratory, circulatory, and neurological systems and wound, fluid, and pain status assessment. If you fail to record your findings – normal and otherwise – someone might allege that you did not assess and monitor the patient.

If a form or flow sheet calls for assessments that do not apply to your patient, indicate "Not Applicable." Use forms according to policy. **DO NOT LEAVE BLANK SPACES.**

Identify the assessments that are critical for your patient's situation and be sure that you document your findings: as provided on your organization's forms, flow sheets, or in nurses' notes or progress notes.

More info:

Not Documented, Not Done

In an out-of-court settlement of injury due to IV extravasation, no nursing progress notes documented that the IV site was checked q 30 minutes per hospital policy. Experts were prepared to testify that checking the site at least every hour is the national standard of care. The nurse's initials were marked for the IV every 30 minutes on the ICU nursing flow sheet but no findings related to the site were documented (Legal Eagle Eye, 2007a).

Documentation Characteristics

High quality documentation is:

- Accessible
- Accurate, relevant, and consistent
- Auditable
- Clear, concise, and complete
- Legible/readable (particularly in terms of the resolution and related qualities of EHR content as it is displayed on the screens of various devices)
- Thoughtful

- Timely, contemporaneous, and sequential
- Reflective of the nursing process
- Retrievable on a permanent basis in a nursing-specific manner

ANA, 2010b

Documentation Entries

Entries into organization documents or the health record (including, but not limited to, provider orders) must be:

- Accurate, valid, and complete;
- Authenticated; that is, the information is truthful, the author is identified, and nothing has been added or inserted;
- Dated and time-stamped by the persons who created the entry;
- Legible/readable; and
- Made using standardized terminology, including acronyms and symbols.

ANA, 2010b

High Stakes Documentation

- Documentation to support CMS requirements, which include evidence that certain conditions such as infections and injuries were not acquired in the healthcare organization, is vital to the organization's reimbursement. Go to this website to view the CMS list of hospital-acquired conditions (HACs): https://www.cms.gov/hospitalacqcond/06_hospital-acquired_conditions.asp
- Documentation and reporting of National Quality Forum (NQF) Serious Reportable Events (SREs) which are also known as Never Events. Go to this website to view the 2011 SRE List: http://www.qualityforum.org/Publications/2011/12/Serious_Reportable_Events_in_Healthcare_2011.aspx
- Documentation to support the organization's compliance with TJC requirements is vital to maintaining the organization's TJC accreditation. Many TJC requirements support professional (ANA and nursing specialty) standards, CMS requirements, and NQF reporting requirements.

"Nurses will need to be prudent regarding their documentation of the assessment of their patients' clinical status. More than ever, nursing documentation will be a key driver in the amount of reimbursement that's provided to their organization"
(White, 2008, p. 42).

The Centers for Medicare and Medicaid Services (CMS) Payment System: Hospital-Acquired Conditions (HACs)

Your organization's fiscal health depends upon CMS reimbursement. Beginning in October 2008, CMS denies reimbursement for specific hospital-acquired conditions (HAC):

- Air embolism
- Blood incompatibility
- Falls and trauma:
  - Fractures

    - Dislocations
    - Intracranial injuries
    - Crushing injuries
    - Burns
    - Electric shock
- Foreign object retained after surgery
- Manifestations of poor glycemic control:
    - Diabetic ketoacidosis
    - Nonketotic hyperosmolar coma
    - Hypoglycemic coma
    - Secondary diabetes with ketoacidosis
    - Secondary diabetes with hyperosmolarity
- Stage III and Stage IV pressure ulcers
- Catheter-associated urinary tract infection
- Surgical site infection following:
    - Coronary artery bypass graft (CABG) surgery
    - Orthopedic Procedures:
        - Spine, neck, shoulder, elbow
    - Bariatric surgery:
        - Laparoscopic gastric bypass
        - Gastroenterostomy
        - Laparoscopic gastric restrictive surgery
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following:
    - Total knee replacement
    - Hip replacement
- Vascular catheter-associated infection

Carefully observe organizational policies, procedures, and documentation guidelines related to HAC.

National Quality Forum (NQF): Serious Reportable Events (SREs)

NQF has identified 29 Serious Reportable Events (SREs), also known as Never Events. These events are considered largely preventable. For some of the events, injury or death of staff as well as patients is included. The events are categorized as:

- Surgical or invasive procedure events, such as wrong site surgery, unintended retention of a foreign object
- Product or device events, such as intravascular air embolism, death or disability resulting from contaminated drugs or use of devices
- Patient protection events, such as suicide, leaving a healthcare organization without permission (elopement)
- Care management events, such as death or disability resulting from medication errors, unsafe use

of blood products, falls, or failure to follow up on diagnostic results, hospital-acquired Stage III and Stage IV pressure ulcers, and certain maternal and neonatal events

- Environmental events, such as death or disability caused by burns or electric shock; death or disability associated with use of restraints or bedrails, incidents involving oxygen or other gases
- Radiologic events – death or serious injury associated with introduction of a metallic object into the MRI area
- Criminal events, such as impersonation of a licensed healthcare provider, abduction of a patient, sexual assault on a patient or staff member, death or serious injury resulting from physical assault

Many states require reporting of these events. Many of the events are included in TJC requirements and in CMS HACs for which reimbursement is reduced. Follow carefully your organization's policy and procedure related to preventing, reporting, and documenting Never Events (NQF, 2011).

TJC and Communication

TJC has identified communication as a leading root cause of sentinel events. TJC defines the communication root cause to include oral, written, and electronic communication among staff, with/among physicians, with administration, and with patient or family. During the time period 2004 through third quarter 2011, communication ranked third overall as a root cause of sentinel events.

Communication ranked:

- First in events related to: delay of treatment, elopement, or fire.
- Second in maternal and perinatal events; operative and post-operative events; restraint-related events; suicide; transfer-related events; wrong-patient, wrong-site, wrong-procedure events.

Most sentinel events result from multiple root causes. Prior to 2009, communication had been the leading root cause overall. Perhaps the improvement is related to communication tools and protocols such as "time out." Bear in mind that sentinel events include only situations of death, serious injury, or risk thereof. Many other less serious errors, near-misses, and threats to patient safety also result from communication breakdown (TJC 2011a).

TJC Requirements

TJC collects and analyzes data related to sentinel events. Based upon the frequency of occurrence of specific untoward outcomes and the factors which contribute to them, TJC has formulated National Patient Safety Goals (NPSG) and accreditation standards. TJC requires TJC-accredited organizations to document compliance with NPSG and accreditation standards.

TJC requirements address comprehensive aspects of patient care and a broad range of situations that threaten patient safety. TJC revises accreditation standards and NPSG annually. Often aspects that have been in place as NPSG are developed into accreditation standards. For this reason, this course addresses NPSG and accreditation standards together as TJC requirements.

Go to this website to keep up-to-date with the current NPSG:
http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/

Your organization has established policies for documenting compliance with TJC requirements. Remember that your organization's P&P are the standard to which you will be held in any legal action. Remain alert for new documentation policies, procedures and practices that your organization may

have put in place to comply with requirements of TJC and other accrediting and regulatory bodies.

Did you know?

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome”(TJC, 2011b).

TJC and Documentation in High-Risk Situations

Documentation policies of your organization include elements related to these specific situations and aspects of care mandated by TJC requirements:

- Abbreviations, use of only facility-approved abbreviations and avoidance of “Do Not Use” abbreviations
- Anti-coagulant therapy, including patient teaching
- Blood transfusion, use of identifiers
- Change in a patient’s condition
- Rapid response team, or other system of early recognition of and immediate attention to deteriorating patient condition
- Contacting a provider when needed
- Critical laboratory results
- Patient fall reduction
- Infection control, including prevention of surgical site infection, catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), and multidrug-resistant-organism infection
- Medications – collection of accurate information and reconciliation of discrepancies
- Patient and family involvement in safety
- Procedures – use of universal protocol (“Time Out”)
- Sedation and anesthesia monitoring
- Restraints, including reassessment for safety of eliminating restraints
- Skin care
- Suicide prevention

TJC and Documentation in High-Risk Situations

Know your organization’s policies, procedures, and forms related to these situations and aspects of care.

TJC requires not only documentation of patient care, but also documentation of staff education on related topics.

Many of these same aspects of care, especially related to hospital-acquired infections, pressure ulcers and skin assessment, and patient injuries due to falls or unusual incidents, have implications for Medicare and Medicaid reimbursement as determined by CMS. Complete documentation may have implications for reimbursement your organization receives.

Abbreviations, Acronyms, Symbols, and Safety

TJC has endorsed the Institute for Safe Medication Practices List of Error-Prone Abbreviations. The ISMP list is also endorsed by the Federal Drug Administration (FDA), and the National Council for Medication Error Reporting and Prevention (NCCMERP).
Go to this website to view the list: http://www.ismp.org/Tools/errorproneabbreviations.pdf

The ISMP List of Error-Prone Abbreviations includes a large number of abbreviations, including:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation

Consider the following as a "Do Use" list:

- Use **mL** instead of **cc.**
- Write out the word: **unit**.
- Use **mcg** instead of: **µ.**
- Use **less than** and **greater than** instead of **<** and **>.**

Your organization has developed a list of approved and do not use abbreviations in compliance with TJC requirements. Adhere to these P&P.

Change in Patient's Condition

TJC directs healthcare organizations to develop a mechanism for early recognition and response to a worsening in a patient's condition, especially situations that may signal impending respiratory or cardiac arrest.

Some organizations have created a team, often called the Rapid Response Team (RRT), which can be summoned to respond when a patient's condition worsens. Your organization may use a RRT or another process/team to respond to critical changes in patient condition. Learn the protocol for contacting the team before you need to use it. Assure that you document any calls for the team according to organizational policy.

Regardless of whether a call to the team was truly needed, or whether they achieved a positive outcome with the patient, your documentation will support that you recognized a deteriorating condition and obtained a response.

Chain-of-Command

The main focus of the TJC requirements related to recognizing and responding to deterioration in a patient's condition is the use of some type of quick response team. However, additional evidence of obtaining needed assistance on behalf of patients includes recognition of situations that may not call for the rapid response team, but do indicate a need for notifying the provider and obtaining new orders.

Document the observations and findings that caused you to contact the provider, your contact with the provider, and the provider's response.

If the provider does not respond in a timely manner, you must activate the chain-of-command according to organizational policy. The first step in most chain-of-command procedures is to report the situation to the charge nurse or your immediate supervisor.

You are responsible for pursuing the chain-of-command to obtain assistance for your patient.

When to Use the Chain-of-Command

The 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. It starts with your direct supervisor and defines whom you contact next if the issue is not resolved. Pursue the chain-of-command when:

- A provider responds with extreme anger, hostility or inappropriate behavior.
- A provider is reluctant to 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.

If these or other threatening situations arise, persist in obtaining the assistance you need. You have an ethical and legal responsibility to advocate for your patients.

It is not enough to merely notify your supervisor. If the situation remains unresolved, continue to pursue the chain-of-command. This can be an incredibly uncomfortable position, especially if you are new to the organization. Unfortunately, the courts will not see your discomfort with taking action as a reasonable excuse if a patient suffers because ineffective medical action, or no medical action, was taken.

Notifying the Provider of a Change in Condition

When you notify a provider of a change in condition:

- 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. For example, "Dr. Sara Jones informed of oral temperature of 104o F. No orders received." In your complete note of the event, include the patient's other vital signs, relevant

observations and any nursing interventions you performed.

- Include the commitment for necessary follow-up by provider, such as, “Will visit patient at 0600.”
- 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 to assist the patient in addition to documenting your contacts with the provider.
- 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

More info:

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).

TJC and Documentation of Quality of Care

TJC focuses heavily upon patient safety and is also concerned about improving overall quality of patient care. Documentation must support the accomplishment of key aspects of high quality care which TJC identifies, including:

- Complete initial assessment, what is included, and the required timeframe
- What data is collected and reassessed
- The patient’s perception of effectiveness of care, patient goals, and involvement of patient and family in care
- Individualized plan-of-care revised as needed, including pain management, fall prevention, and detection of abuse or neglect
- Need for special services to facilitate communication, to address alcohol or substance abuse, or to address behavioral or emotional disorders
- Early initiation of discharge planning
- Hygienic care including oral care and cleaning after incontinence
- Assessment and action related to nutritional needs and preferences
- End-of-life care including comfort, dignity, and psychosocial, emotional, and spiritual aspects
- Patient education explaining medications, equipment, nutrition, pain management, oral health, fall reduction, and rehabilitative techniques

Your organization has developed P&P pertinent to these key aspects of care. Assure you comply.

Researchers (Jeffries, et al., 2010) have identified 7 essential components of quality nursing documentation.

Quality Nursing Documentation: Over and Above Requirements

Quality Nursing Documentation:

1. Centers on the patient. Documentation reflects the patient's concerns, responses, and perspective and does not simply list nursing tasks accomplished.
2. Reflects the actual work of nurses. 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. 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. Does not duplicate information to be found in other parts of the record. Does not list tasks.
7. Fulfills legal requirements.

Flow Sheet and Checklist Formats to Document Standards of Care

When you first arrive on a patient care unit that is new to you, ask to be oriented to the flow sheets in use.

Avoid flow sheet hazards:

- Be sure to document patient response when relevant if the flow sheet does not provide space.
- Comply with the procedure for filing flow sheets in the medical record.

Your organization may use forms to document nursing care plans or plans-of-care. Use the forms as directed by policy and assure that you individualize such documents. If your organization does not use forms for this purpose, document and update plans-of-care according to organizational P&P.

Flow sheets and electronic checklist formats may not provide sufficient evidence of complete follow-up on changes in patient condition. Assure that you supplement these records with your actions in response to assessment findings and the patient's response to interventions.

Charting by Exception (CBE)

Charting by exception implies that all standards have been met with a normal or expected response unless otherwise documented. Well-defined guidelines and standards of care must be in place.

If your organization uses CBE, review the pertinent policies, standards, and guidelines carefully. If you have concerns about the use of CBE or possible ambiguity of the guidelines, consult with your direct supervisor.

When in doubt about whether an observation should be documented, err on the side of caution and document. Inadequate observation is among the leading causes of lawsuits against nurses (Helm, 2003). Reliance on checklists can lead to a false sense of security, be certain to document changes in patient condition, notification of provider, and follow-up monitoring.

Preprinted Provider Order Forms

- Use only organization-approved forms which display a form number. Forms created by providers, drug companies, medical supply or equipment companies, or other nurses have no place in patient records. Forms used for documenting observations, care, and responses become a permanent part of the patient's record.
- Assure that all orders conform to organizational policy, such as use of only organization-approved abbreviations.
- Inspect the form to assure that it has been completed according to policy. Assure that any exclusions are properly indicated.
- Verify that orders correspond to medications and doses available. Use of generic medication names is recommended.
- Assure that the form and any copies of a no-carbon-required (NCR) form are legible. Illegible copies that serve as orders for pharmacy are particularly dangerous.
- If you identify conflicts with organizational policy or unclear orders, clarify with your manager or the provider.

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.

FACT Criteria

FACT criteria give you an outline to critique and improve your documentation.

F = Factual

A = Accurate

C = Complete

T = Timely

"Delivering appropriate care can also become litigious when actions are undocumented, casually or inaccurately described, completely unintelligible, or rely heavily on the use of in-house acronyms or abbreviations instead of an individual nurse's own words" (Plawecki & Plawecki, 2007, p. 3).

More info:
Unless your facility has standardized definitions for terms, use specific descriptors when there is any chance of misunderstanding a term.

For example, rather than "Pt is obtunded," "Patient aroused by gently shaking her arm and repeatedly calling her name; responds with one-word answers; follows simple commands; disoriented to time and place" (Huntley, 2008, p. 63).

F = 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.
  - That you notified the patient's provider, and the provider's response.

  Example: Hydromorphone (Dilaudid®) 1 mg IVP was ordered and you gave 0.5 mg.
    - Document according to policy on the medication administration record (MAR).
    - In your notes state "Hydromorphone 0.5 mg IVP, Dr. Fred Styles notified, no new orders."
    - State your assessment of the patient and the patient's pain status.
    - 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.

Think About It: How to Avoid Value Judgments

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

- "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.”

A = Accurate

- Be precise. Quantify whenever possible.
- Be sure to make clear who gave the care.
  - Example: You document a patient’s statement to a caregiver who is not authorized to write progress notes.
    - Accurately state what occurred: “Morning care given by Dave Brent, CNA who stated that patient complained of soreness of the mouth during oral care.”
    - Then be sure to document your own follow-up assessment, interventions if any, and the patient’s response.
    - Delegating documentation is not only risky – it is illegal.
- If countersigning with a student or another nurse, review carefully the content of the documentation. Similarly, if you take responsibility for double-checking a colleague’s mathematical calculations, be certain that you perform the calculation yourself.

More Info

Not Documented, Not Done

A post-operative patient died after experiencing a pulmonary embolism. The patient’s wife had called the RN because her husband was “breathing heavy.”

The RN reassured the woman, assessed the patient, and called the MD. But the RN documented NO assessments.

She did not document her contact with the MD until she wrote her progress note ON THE FOLLOWING DAY. She claimed it was her practice to make handwritten notes during the shift and enter them on the computer-based documentation system on the following day.

The MD received her call within 45 minutes of the spike in respiratory rate, left immediately for the hospital and communicated with the hospital while en route. He called a code when he arrived in the patient’s room.

The nurse’s documentation did not support that she complied with standards of care. The jury returned a verdict of wrongful death against the nurse (Legal Eagle Eye, 2008).

C = Complete

Be sure to include:

- Condition change.
- Patient responses, especially unusual, undesired or ineffective response.
- Your 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 per policy for items that do not apply to your patient. DO NOT LEAVE BLANKS.
- Blanks are hazardous in progress notes because they permit entries above your signature. Others may make entries in such blanks by mistake, or to purposely falsify records. Completely fill each line. When you begin a new page, be sure there are no blanks at the bottom of the previous page.

T = 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.
- Computer entries are automatically date-and-time stamped; if your entry refers to earlier events, note the time to which you are referring.
- Resist the temptation to leave documentation until the end of the shift.
  - You may forget key pieces of information when rushing.
  - Managing a number of patients may cause you to forget details.
  - If your documentation is reviewed for legal reasons and you have not documented completely, you will have to rely on your memory of events.
  - Charting as your shift progresses will help keep your documentation at the end of the shift to a more manageable load.
  - 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 will not know of important observations you have made and may not seek you out to ask.
- NEVER document in advance. This practice is illegal falsification of the record, contributes to errors and confusion, and threatens patient safety.
- Computerized documentation and some automatic medication dispensing machines create a time-stamped record. Assure that your practice and documentation are consistent with the documentation trail you are creating.
- Some organizations use clinical pathways or protocols that specify timelines. Assure that your documentation reflects the time element whenever pertinent.

Dangers of Charting in Advance

Certain situations may tempt nurses to chart in advance:

- Flow sheets used in conjunction with charting-by-exception documentation systems.
- Protocols that mandate frequent assessment and documentation, such as neuro checks and patients in restraints.
- The sponge count in the OR. One of the most dangerous charting practices in the OR is the notation, “sponge count done and correct” before the operation is over and the sponge count has, indeed, been done. This practice carries with it many liabilities. Most obviously, it raises the issue of whether the count was ever done.

- Medication administration records. Some nurses have the dangerous habit of charting medications in advance. This practice places the patient at risk because it misrepresents the current medication profile of medications the patient has on board. If for whatever reason a medication is not given after a nurse has charted it as given, the nurse has falsified the 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 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.

Did you know?

"Time Heals Nothing, it Merely Rearranges our Memory"- Gary Numan

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. *Litigation that will call upon your documentation often does not arrive in court for at least …*

TWO YEARS AFTER THE EVENT!!!

Late Entries

When the medical record is unavailable or when you remember further information to document, you will need to make a late entry. Document the time of your entry. Within the body of your note indicate the time of the occurrence to which you are referring.

However, entering pertinent information is better done late than never. Shorter lengths of stay on inpatient units may increase the likelihood of the need for late entries. 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.

Beware of Directives to "Update" a Medical Record

A patient fractured her femur in a fall at a skilled nursing facility (SNF) and 16 days later died in a hospital. A SNF 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, and
- 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.

The jury awarded the patient’s family $9,000,000. Freeman, et al. v. Cresthaven Nursing Residence, et al (cited in Helm, 2003).

In another case a family received an award of $1.75 million. Their adolescent daughter died following surgery to correct scoliosis. The surgery concluded without complication, but in the PACU, the patient was found unresponsive. Nurses were accused of failing to check vital signs every 15 minutes. The medical record contained 2 different pages of nursing notes which differed in form and substance (Lippincott, Williams, & Wilkins, 2008, p.18).

Risky Words

Words to avoid in documentation:

- Accidentally
- Apparently
- Appears
- Assume
- Confusing
- Could be
- May be
- Miscalculated
- Mistake
- Names of others (roommates)
- Somehow
- Unintentionally

Use of these words can reflect negatively on your nursing care.

Handwriting

Providers’ illegible handwriting is a common joke. But nurses too must exercise vigilance to keep handwriting legible.

- Does your handwritten “r” look like an “s”?
- Does your handwritten “k” look like “ls”?

Clear communication is threatened not only by messy handwriting or handwriting in which all letters look alike, but also by neat, pleasant styles that create ambiguous letters.

The six groups of letters and four groups of numbers listed below can be difficult to distinguish from one another.

Letter Groups	Number Groups
a, c, e, o	2, 7, 8
b, d, f, h, i k, l, t	0, 4, 9
g, j, q, p, y	1, 7
m, n, r, s	3, 8
u, v, r	
e, i	

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.

Correcting a Documentation Error

The most widely accepted procedure for correcting errors has been to draw a single line through error and note "mistaken entry," "error," or the error notation that is required by your organization, followed by the date and your initials. Since your signature follows the original entry, your initials are sufficient unless organizational policy requires otherwise.

HOWEVER, consult your organization's policy regarding correction of errors. Some organizations have discontinued and prohibited the use of the terms "error" or "mistake" because of the possible interpretation that an error occurred in patient care and not simply in making a documentation entry.

Never erase an entry or use correction fluid, liquid paper, or "white out." If you need to replace several words, you may need to add an addendum sheet and follow the procedure for late entries.

Electronic records have specific methods for correcting errors. Assure that you know the proper procedure for the system that you are using.

Rewriting Whole Pages of Nursing Documentation

A patient sued his physician, the hospital, and nurses because he required extensive emergency surgery. He endured a difficult recovery to remedy a condition that could have been resolved if it were diagnosed sooner.

During the discovery process, the physician denied knowing about the patient's complaints of headache and nausea. These complaints were not documented. The physician also claimed he had not received telephone notification of changes in the patient's condition.

During her deposition, the nurse said that on the day in question she thought her charting was messy. She had rewritten several pages of notes for the time during which the patient's condition worsened, and had forgotten to copy the section regarding the patient's complaints and her call to the physician.

The lawyer for the nurse's insurance company had no choice but to offer a large cash settlement to the plaintiff. All claims against the physician were dropped.

If you must recopy, leave the original records in place. A messy chart may protect you more than any neatly rewritten charting.

Documentation and the Law

Documentation provides legal evidence of care rendered. Certain allegations and laws have specific implications:

- Malpractice
    - Malpractice suits against nurses have increased in number during the past decade. Between 2000 and 2009, 2 in every 100 malpractice payments resulted from claims against nurses (Reising, 2012)
    - Although most cases are settled without trial (Lippincott, Williams, & Wilkins, 2008), documentation is carefully examined when determining the amount of a settlement
    - Failure to document is among the six common categories of malpractice claims against nurses (Reising, 2012)
- Defamation: Slander and Libel
- Health Insurance Portability and Accountability Act (HIPAA)

Elements of Malpractice (Professional Negligence)

Duty

This involves the duty of care owed to a patient when an individual engages in an activity in which that individual is under a legal duty to act as a reasonable and prudent person would act (Guido, 2006).

Breach of Duty

This occurs when a nurse's care falls below the acceptable standard of care owed to the patient. The deviation can occur by an act of omission or commission.

Patient Injury
This involves injury to the patient resulted from a breach of duty.

Causation (proximate cause)
This area is more difficult for the plaintiff attorney to prove. Causation builds upon cause-in-fact and foreseeability. In cause-in-fact (also known as the “but-for” test), the plaintiff must show that the nurse’s breach in the standard of care actually resulted in the plaintiff’s injury and that these injuries were reasonably foreseeable.

All 4 elements must be present to substantiate malpractice (Reising, 2012).

Did you know?

State Laws Vary

Laws often differ from state to state regarding certain elements of documentation. Always follow your organization's policy and procedure. Particularly when you move from one state to another, be aware that differences you observe in documentation may be the result of differences in state law, and not simply a matter of preference on the part of the person who is documenting.

Documentation Takes the Stand

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

Evidence of Malpractice

Evidence presented in malpractice cases frequently focuses on documentation of:

- Timely vital signs
- Reporting of changes in patient condition
- Medications given
- Patient response to medication, treatments and interventions
- Discharge teaching

Lippincott, Williams & Wilkins, 2008

Beware of relying upon written or electronic checkboxes to document the full provision of patient care. Document all information that indicates a change in patient status and response to treatment.

A patient was discharged after a laparoscopy during which the patient sustained damage to a ureter. The RN documented that the patient had significant pain at the time of discharge. The surgeon failed to read the nurse’s progress note and was unaware of the problem. The court ruled that it was beneath the standard of care for the surgeon to have failed to read the nurse’s notes (Legal Eagle Eye, 2007b).

Malpractice Insurance

Some organizations and employers discourage nurses from carrying their own malpractice insurance. They advise that the employers' insurance will cover the nurse and that carrying individual insurance may invite individual suits since more sources are available to pay damages.

Although employers do accept responsibility for their employees, as a professional you are also accountable for your own actions and judgment. Professional organizations can assist you in obtaining affordable malpractice insurance. Many nurses believe that the investment is worthwhile.

Documentation as a Witness

"From a legal standpoint, documented care is as important as actual care. "Courts assume that care was not done if it was not documented...Failure to document implies failure to provide care" (Lippincott, Williams, and Wilkins, 2008).

- Does your documentation tell an accurate story about your patients' care and their responses during your care?
- Is your documentation factual, accurate, complete, and timely?
- Does it provide a snapshot of each of your patients during the day?

Attorneys search medical records to find evidence to defend against negligence claims. Unfortunately, attorneys often discover omissions, alterations, contradictions, inconsistencies, incomplete notes, and untimely notes, which damage the defense considerably.

Even when staff members provided adequate care, lack of adequate documentation often leads to out-of-court settlements or court decisions in favor of the plaintiff.

Example:

An elderly resident of a skilled nursing facility who suffered from Alzheimer's disease fell and was injured. The facility practiced a no restraint policy and had a sound fall prevention program in place which included hourly rounding by nursing assistants. Although the staff had followed the protocol, they had failed to document their compliance. The patient's family received an award of $500,000 (Legal Eagle Eye, 2007d).

Sound documentation testifies as a star witness for the defense. But, poor documentation appears as a star witness for the plaintiff.

Defendant

The person against whom a lawsuit is filed. For example, the hospital, provider, or nurse.

Plaintiff

The person, corporation, or other legal entity that initiates a lawsuit. Examples include the patient or patient family members.

Documentation as a Hostile Witness

In a 2009 case, a $300,000 settlement was paid to the family of a deceased patient who developed Stage IV pressure ulcers during her first 2 months in a nursing home. Despite the standard of care per policy that patients were to be regularly turned and repositioned, there was NO documentation to indicate that these measures were accomplished. The medical record did however document the

deteriorating condition of the patient's skin (Legal Eagle Eye, 2010).

In a 2011 case, a medical-surgical nurse, who lacked ICU orientation and training specific to respiratory assessment, was caring for a post-surgical patient in the ICU. The patient aspirated and ultimately suffered a respiratory arrest and died. When the patient became short of breath, the nurse encouraged the use of the incentive spirometer, but per documentation took no other actions despite a pulmonologist's orders for a nebulizer treatment, NPO except for ice chips, and arterial blood gases if the respiratory rate increased or decreased, if oxygen saturation decreased, or if there was a change in mental status. Documentation offered no evidence of the nurse's monitoring of the patient. The jury found the nurse negligent (Legal Eagle Eye, 2011c).

Slander and Libel

Written and spoken words that damage the reputation of a person can be a cause for legal action.

The term defamation encompasses:

Libel
Written words that could damage someone's reputation

Slander
Spoken words that could damage someone's reputation

A claim of defamation may be made when such information is shared in circumstances in which it is irrelevant, or is shared with malicious intent.

The truth of the information constitutes an absolute defense, unless the information is shared with malicious motives.

Defamation

5 requirements for a successful claim of defamation:

1. Language that would adversely affect one's reputation
2. Defamation about or concerning a living person
3. Publication to a third party or to several persons, but not necessarily to the world at large
4. Damage to the person's reputation as seen by adverse, derogatory, or unpleasant opinions against the person defamed
5. Fault on the part of the defendant in writing or telling another the defamatory language

Nurses may be at risk for charges of defamation for statements vocalized or written about co-workers, other health team members, organizational employees, and employers as well as patients.

Nurses are granted qualified immunity in situations in which disclosing information protects or furthers the public or private interests recognized by law. For example, law requires the report of:

- Suspected abuse or neglect of a child or an elderly person
- Gunshot wounds (GSW)
- Certain communicable diseases

Most states grant immunity from liability for good faith report of suspected abuse.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA protects consumers' health insurance coverage after job changes and sets standards for use of protected health information (PHI) by insurance companies and other involved third parties. Since April 2003, healthcare organizations must comply with HIPAA provisions.

HIPAA provisions 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.

HIPAA violations incur civil and criminal penalties, including fines up to $25,000 per year. For intentional violations, the fine is $250,000 and 10 years in prison. Fines are levied per person/per violation and may be levied against the individual violator, the organization or its officers.

Patient's Right Under HIPAA

HIPAA guarantees patients the right to:

- Control use of their health information.
- Receive information regarding disclosure policies.
- View and request amendments to medical information. Providers may choose not to amend records as requested, but regardless of the disposition of the request, the patient is entitled to a timely response to the request.
- Limit scope of data disclosed to other healthcare providers.
- Receive an accounting of disclosures of information to anyone who is not involved in their care.

Protecting PHI

Upon admission to a healthcare organization or other setting in which the patient will receive care, the organization is required to advise the patient of its compliance with HIPAA regulations and obtain a release (consent) for disclosure to carry out treatment, payment, and healthcare operations.

This requirement is temporarily waived in emergency situations or when communication barriers exist, but compliance is required as soon as possible.

HIPAA requires healthcare organizations to address issues such as electronic signatures, the safeguarding of data integrity, confidentiality, and access to information. The primary focus of security is data integrity, ensured by backup procedures and proper control of access with passwords and encryption.

Disclosing PHI

Various regulations mandate reporting of communicable diseases including Human Immunodeficiency Virus (HIV) and Tuberculosis (TB), the reporting of abuse/neglect/domestic violence, in emergency circumstances, coroner/medical examiner cases, and as required by law.

All 50 states require reporting of child, elder, spousal, and partner abuse. States also require reporting of births, deaths, and gunshot wounds. In addition, state statutes may cover psychiatric care information, information about minors, adoptive parents, or drug and alcohol treatment.

If your position involves completing written or electronic reports to disclose PHI, know and follow the policy and procedure that applies.

HIPAA and Documentation

Know your responsibilities in protecting patient privacy:

- Protect your computer identification number and password.
- Locate computers so that screen showing PHI can't be viewed.
- Log off the computer promptly.
- Set short screen saver times on the computer.
- Close the medical record when not using it.
- Be aware that not all staff members are necessarily authorized to all portions of all medical records. Clarify these requirements before making a patient's record available to other staff members.
- Patients or others may be authorized to view certain portions of their records. Clarify the parameters before releasing information. Your organization has a policy specific to this situation.
- Immediately file any loose pages containing PHI.
- Do not leave faxes or computer printouts containing PHI unattended.
- Dispose of any unneeded information per policy.

PHI and Electronic Communication

E-mail

- Do not place the patient's name in the subject line.
- Assure that you are transmitting to the correct address.
- Include only necessary information and use e-mail only when no more secure method is available.
- Include the standard disclaimer used in the organization.
- Assure that a procedure is in place for encrypting the message.

Facsimile (fax)

- Place the machine in a secure area.
- Include the standard disclaimer used in the organization, which should include what the recipient is to do in the event that a wrong number receives the fax.
- Assure that safeguards are in place for off-hours transmissions.
- Protect faxes sent to unattended machines.

Employment Implications

- Inappropriate or incomplete documentation may lead to loss of benefits such as unemployment compensation or workmen's compensation.
- Documentation that does not comply with standards of practice and policy may result in disciplinary action.

- In addition to the patient's medical record, documents related to your employment might be used as evidence to defend against allegations. Records such as the assignment sheet, competency records, narcotics records, and other records may contain information pertinent to claims of negligence or malpractice. These records are discussed later in the course.

Licensure Implications

State Boards of Nursing govern the procedures for suspending and revoking RN licenses. When allegations of violations are investigated, documentation including medical records, narcotics control records, time sheets, and other documents may be included as evidence.

Witnesses are also summoned to hearings on licensure violations. You may be called as a witness. Since it is likely that significant time will have elapsed since the occurrence, you will be forced to rely on your documentation of the events under investigation.

More info:

Not Documented, Not Done

A State Board of Nursing required an RN to surrender her license because she could not produce documentation that she had attended Alcoholics Anonymous meetings as required (Roman & Bauer, 2007).

Specific Aspects of Care

Certain aspects of care require specific documentation in order to comply with regulations, including TJC requirements. These include:

- Critical diagnostic results
- Fall reduction
- Infection prevention
- Medications and reconciliation of medications
- Non-conforming patient behavior
- Pain assessment and management
- Patient and family role in safety
- Restraints
- Skin care
- Suicide

Critical Diagnostic Results

TJC requires healthcare organizations to:

- Create a list of critical tests and critical results and values.
- Measure, assess, and if needed, improve timeliness of reporting critical test results to the responsible caregiver.

When you receive and report critical lab results, assure that you include the time in your documentation.

Fall Reduction

Patient falls cause injury and often in the case of elderly or debilitated patients begin a downward spiral from which the patient never recovers. Falls cause quantifiable damage and monitoring to prevent falls is certainly within the duty of the nurse. Therefore, when a fall results in injury it may also result in allegations of negligence against the nurse. Falls with injury also have CMS reimbursement implications.

Complying with your organization's fall protocol is vital. But doing the right thing will not protect you from malpractice unless you document your actions.

If a patient falls, and you did not observe the actual fall, state only the facts in your entry. State only how, when, and where you found the patient, the results of your assessment, and actions that you took in response.

Sentinel event statistics show that falls are the 6th most common reported sentinel event during the years 1995–2010 (TJC, 2011c).

Did you know?
What 5 patient incidents or situations most frequently lead to malpractice claims against nurses?

1. Patient falls
2. Pressure ulcers
3. Medication administration
4. IV therapy
5. Monitoring of physiologic status

(Reising, 2012)

Infection Prevention

TJC requirements and CMS regulations focus on infection control with particular attention to:

- Infections caused by methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (CDI), Vancomycin-resistant enterococci (VRE), and multiple drug-resistant gram negative bacteria
- Surgical-site infections
- Central line-associated bloodstream infections (CLABSI)
- Catheter-associated urinary tract infections (CAUTI)

Many facilities have implemented practice bundles intended to prevent infection. Specific forms may be in place to document compliance with these evidence-based practices.

State health department regulations also include infection prevention provisions.

Follow your organization's policies related to infection control and assure that you use the proper form to document compliance with protocols.

Medications

Follow organizational policy scrupulously regarding documentation of medications.

- Use only organization-approved symbols and codes on the MAR.
- Document patient response to medications.
- Document your patient teaching related to medications.
- Never document medications as given before you administer them. Charting medications not given is criminal as well as unprofessional (Helm, 2003).
- If for any reason, you use incorrect or unusual technique in administering a medication, document the situation, follow-up assessment, and any necessary intervention.

Nurses' 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 (more likely at breaks or mealtimes, when a second nurse may temporarily assume the patient's care)

(Austin, 2008)

Reconciliation of Medications

When a patient enters the hospital discrepancies may arise between medications previously prescribed; over-the-counter medications and nutritional supplements taken at the time of admission; and medications ordered upon admission.

TJC requires that all medications that the patient is using at the time of admission be recorded and compared with the medications ordered.

TJC also requires that the patient and family, if indicated, receive complete information about medications ordered at the time of discharge from the hospital.

Your organization has developed a procedure to comply with these requirements. Clarify and carry out your role in this important process.

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, follow organizational policy and:

- 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
- Document your compliance with any organizational policies, such as reporting possession of certain items to the security department

Documenting 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 – including patient's self-assessment of intensity of pain and pain goals.
- Initial and ongoing reassessment of pain:
    - 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.
    - The patient's pain management goals.
    - Pain management history, including effects of pain in the patient's daily life, such as upon eating, walking, and sleeping.
    - Appropriate assessment for patients who are children or who are unable to communicate verbally.
    - Pain assessment at least as frequently as other vital signs.
    - Assessment and monitoring during the post-procedure period.

Documenting Pain Management

- Date, time
- Patient behavior
- Vital signs, including pain scale rating
- Intervention: position and other non-pharmaceutical relief measures
- Pain scale rating after intervention and reassessment within thirty to sixty minutes, depending on the medication and administration route
- 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 which identifies and addresses patients' pain management needs. (for the patient at end-of-life, documentation reflecting sensitivity to comfort, including physical, psycho-social/emotional, and spiritual comfort)
- The patient's response to interventions, and modifications of the plan if needed

RN.com, 2010a

Patient and Family Role in Safety

TJC requirements call for staff to teach and encourage patients and their families to play a role in protecting the patient from harm. Teaching includes hygienic practices, safety measures and equipment, precautions, and prevention of complications.

Staff members are expected to encourage patients and their families to report any safety concerns.

Document all aspects of patient and family teaching and give special attention to this teaching in your documentation. When documenting teaching on any topic, include by title any printed materials which you give to the patient.

Restraints

Reports of patient injury and death in restraints reported to TJC, have decreased in recent years (TJC, 2011c), in part due to more careful monitoring and use of restraints as a last resort. Nevertheless, restraint-related incidents occur and have implications for legal action, accreditation, and CMS reimbursement.

Follow your organization's restraints policy scrupulously. Often the policy includes use of a specific form for documentation. Typical requirements include:

- Verification of the written order for restraint or seclusion
- Name of provider who ordered the restraints
- Reason for restraint
- Alternatives attempted
- Amount and type or restraints
- Monitoring and reassessment of the patient at prescribed intervals
- Release of restraints at prescribed intervals
- Reassessment for need to continue restraints

RN.com's 2010 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. Find out whether special forms are to be used for patients who are at risk for skin breakdown.

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.

More info:

Not Documented, Not Done

The Supreme Court of Mississippi approved a one million dollar judgment against a long term care facility related to the death of a resident who died with a 6" X 10" pressure ulcer on her coccyx. Evidence included lack of documentation of repositioning the woman and maintaining adequate nutrition (Legal Eagle Eye, 15[10], 2007e).

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.

If you have any reason to suspect that a patient may attempt suicide, report your concerns to your direct supervisor. Ask the patient whether he has a plan and the means to execute the plan. Document:

- The patient's behavior and statements that caused your concern.
- 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.

If you are not satisfied with the response of the person to whom you report your concern, follow the chain of command to achieve resolution.

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
- Reporting a change in the patient's condition, as presented earlier in this course

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 – e.g., 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, e.g., “B as in ball.”
- Obtain confirmation from the provider that the order is correct as you have read it back.
- Follow organizational policy for recording the order on the provider’s order sheet.

More info:

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 2 days after insertion, but no action was taken for another 2 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. A $1 million settlement was awarded (Legal Eagle Eye, 2011d).

Documenting Verbal Orders

- Sign and initial your notes.
- Record the order in the patient’s record as soon as reasonably possible. Note date and time and then the order verbatim. Write the prescriber’s full name and sign your name. If another nurse witnesses (that is actually hears) the order, that nurse should sign as well.
- Label the order “T.O.” for telephone order or “V.O.” for verbal order or as policy dictates. Avoid the use of “P.O.” to represent “phone order” since that designation may be confused with PO meaning “per os” or orally.
- Draw lines through any blank spaces.
- Encourage the use of fax in lieu of telephone orders to provide a written record.
- Comply with prohibitions on verbal orders, such as:
    - Most organizational policies prohibit verbal or telephone orders for do not resuscitate orders (DNR).
    - TJC standards prohibit accepting orders via voice mail.

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 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 clarification.

You may wish to discuss your concern with a colleague or your direct supervisor before contacting the provider, but it is important to clarify the order with the provider.

Do not ignore or change the order, or carry out some modified version. To do so violates your state's nurse practice act and jeopardizes your license.

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 a duty to refuse and document your refusal, rationale, and notification of your direct supervisor (Mosby, 2006).

Records that Document Your Presence and Competency

In addition to the medical record, other organizational documents may be used to present evidence of your presence, responsibilities, competencies, and compliance with policies. Such records include:

- Schedule – establishes when and where you were working at a particular time.
- Time Sheet – establishes when you were working at a particular time.
- Assignment Sheet – establishes which patients were in your care at the time and what other duties were assigned to you, such as checking the emergency cart.
- Narcotics Control Record – often is called into evidence in licensure hearings when charges of drug diversion are brought. If the record is inaccurate, it is difficult to prove your innocence. (Singh, 2007).
- Education Records – establish that you received training or education as required or as pertinent to your duties. Establishes competencies of those to whom you delegate.
- Competency Checklist – establishes your competency to perform your assigned duties. Also establishes competencies of those to whom you delegate.

Your organization may use other records that may become significant in litigation or during accreditation surveys.

Take seriously documentation on all organizational records. Assure that any entries that concern you are correct.

Don't Let a Narcotics Record Falsely Accuse You!

BEFORE YOU NEED TO KNOW, find out your organization's policy for these situations:

What documentation and action do you take when the narcotics count does not match?

- How do you document a wasted narcotic?
- How do you resolve lack of timely removal of expired narcotics and narcotics ordered for patients who are no longer on the unit?
- Who do you contact on the off-shifts to resolve any issues related to narcotics?

Use the chain-of-command to address any issues that remain unresolved.

INCOMPLETE OR INACCURATE RECORDS CAN SUGGEST THAT YOU ARE DIVERTING NARCOTICS.

Avoid any possible appearance of impropriety.

Electronic Medical Records Gain Momentum

By 2014, expectations are that nurses will be using electronic nursing documentation on patient care

units in U.S. hospitals (Kelley, et al., 2011). However, recent estimates report that only 12% of U.S. hospitals have a basic electronic health record (EHR) in place and even fewer (2%) have EHRs that include decision support elements (Blumentahl & Tavenner, 2010).

The intent of implementing EHRs is to improve safety and quality of patient care. To date, research findings have been inconsistent in validating improved quality and safety. Researchers have made few effective comparisons of electronic documentation with paper-based documentation. In addition, because of the relatively recent implementation and continuous updates of EHR systems, the learning curve among staff has an impact upon outcomes.

Electronic Medical Records: Mixed Results

Nurses who work in hospitals with basic EHRs have reported fewer incidences of poor patient safety and other negative outcomes related to quality than nurses working in hospitals that lack EHRs. 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, et al., 2011).

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). Yet researchers have found that electronic records contained evidence of patient-centered documentation (Laitinen, et al., 2010).

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,et al., 2010).

Because systems in use vary greatly among healthcare organizations and staff learning curve is certainly a factor, it is not possible to reach firm conclusions about the benefits of the EHR at this time. Nevertheless, all nurses are facing and will continue to face the need to become proficient in e-documentation.

Some healthcare organizations emphasize the benefits of point-of-care information, real-time flow of data, and have found that the combination of computerized physician/provider order entry (CPOE) with the EHR helps to prevent errors. Some organizations report that the use of e-documentation is both a patient expectation and a factor in staff satisfaction (Sutton, 2012).

By whatever method, handwritten or electronic, your documentation IS the evidence of your assessment and care of your patients.

Take full advantage of e-documentation training in your organization and identify resources for support in the use of the EHR. Ideally, nursing units designate "Super-users" among staff to serve as resources for co-workers.

Electronic Medical Record: Precautions

The defense of the nurses and physicians in a case of poor obstetrical outcome was jeopardized because entries into the computer on the night of the delivery were never printed. Staff members stated that they met all reasonable standards and documented correctly. Unfortunately, the notes for the shift were not printed. Safeguards failed to assure printing and filing also failed.

Sixty days later, defense attorneys reviewed the chart. The computer system had deleted all the key documentation. There was NOTHING to look at. Staff members had no way to confirm their memories of the event.

Find out about and comply with your responsibilities in relation to back up systems, retrieval, and printing of the information you document electronically.

Critical Clicks in E-Documentation

- Choose your own your password and protect it.
- Be sure that you are documenting on the correct patient.
- Remember to SAVE if the system you are using requires you to perform a SAVE operation.
- Assure that you receive thorough training and orientation to the e-documentation system and your role in it. Learn about wireless capability and access to resources within the system.
- Don't leave patient information in view of others. Close the record after your entry and log off (Mosby, 2006).

E-mail and Fax

E-mail

E-mail creates specific challenges to privacy, yet assists with accuracy. Receiving an order by e-mail or sending information to a provider by e-mail can enhance documentation and communication.

Before using e-mail, know your organization’s policy and how it can impact you. Find out whether e-mail is an acceptable form of communication with other team members, including providers.

Are e-mails kept? If so, for how long? Comply with procedures for documenting e-mail conversations. Protect the patient’s privacy in all e-mail communications.

Many healthcare organizations communicate important information to staff via e-mail and hold staff accountable for receiving and acting upon e-mailed communications.

Fax

Whenever possible, encourage providers to fax orders instead of giving telephone orders. The fax avoids potential misunderstanding and provides a written record of the order. Observe HIPAA regulations when working with faxes.

Special Situations

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

- Consents
- Unusual Events (Incident Reports)
- Personal Property of Patients
- 24-hour Medical Record Checks

Consents

The 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.

It is not your responsibility to explain the procedure or verify the patient's understanding. But, as a patient advocate, assure that the consent contains "clear language and plain words, understandable by the patient" (Karno, 2007, p. 18).

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 or consent form that is completed incorrectly implies no consent. Review your organization's policy regarding consents. Know the situations which commonly occur on your unit that require written patient consent.

Documenting Unusual Events

Document unusual events in the patient's medical record and on an incident report. Stick strictly to the facts. Include no assumptions about what you think probably occurred or contributed to the event. In the patient's record, do 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 an incident report or notified the risk management department.

Organizational policies may clearly define what process and wording to use in documenting an unexpected event. Identify and adhere to any such policies. If you work for a temporary staffing company, be sure to notify the appropriate personnel in your company.

Incident Reports

Some organizations use the term unusual occurrence report. The report is to alert administration to an unusual incident. Administrators then decide whether and to what extent to investigate the situation. The risk manager and the hospital's insurer use the form to assess the possibility of liability. Follow policy concerning the use of the form. Assure that you file it promptly.

In the past, incident reports were not discoverable; a patient's attorney was not entitled to receive a copy of the report. Performance improvement, quality improvement, and peer review documents are protected from discovery, but incident reports are not necessarily excluded from discovery in all states and under all circumstances.

If the patient's actions, or failure to comply with instructions, contributed to the incident, include any such details in your report of the incident. 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.

Following any unusual incident and especially if patient injury occurs, document all follow up monitoring. Document all findings and care rendered (Lippincott, Williams, & Wilkins, 2008).

Tips for Completing the Incident 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.

Personal Property of Patients

Patients' missing personal property plagues most organizations' risk managers. Encourage patients and their families to retain only necessities in the patient's room. Items frequently lost include:

- Dental appliances
- Jewelry
- Personal mementos such as photographs
- Prostheses

Complete your organization's personal property inventory form carefully and update as needed. The security department may have the capacity to provide safekeeping for valuables. If a patient alleges that an item has been lost on the unit and a reasonable search does not locate the item, document the situation and report the alleged loss promptly.

24-Hour Medical Record Checks

Your organization has a policy governing 24-hour medical record checks.
Often, the P&P requires night shift nurses to review line by line all orders that have been written in the preceding 24 hours.

Review includes assuring that each order has been:

- Transcribed
- Noted
- Carried out appropriately

Nurses frequently discover discrepancies such as:

- Orders written and not flagged
- Orders written while the patient is off the unit
- Errors resulting from misinterpretation of medication orders, particularly violations of DO NOT USE list and mistakes with Look Alike/Sound Alike medications

Your organization may require some form of report or incident report if you identify orders that are not written according to organizational guidelines.

Specialty-Specific Alerts

Some specialties have particularly critical issues related to documentation, for example:

- Ambulatory Services
- Emergency Department
- Obstetrics
- Pediatrics, Pediatric ICU, and NICU
- Perioperative Areas
- Psychiatry

Many specialty professional organizations have endorsed documentation guidelines. Consult your specialty organization’s resources, but be certain to comply with organizational policy.

Ambulatory Services

Comply with policies for documenting:

- That the patient is medically stable and understands the discharge instructions
- The patient’s signature on the discharge form and instruction sheet
- The offer of influenza and pneumococcal vaccine to patients at risk, as required by TJC

In ambulatory surgery, important documentation standards include:

- Proof of intra-operative monitoring
- Criteria for discharging patients

- Discharge instructions and follow-up phone calls

Implications for perioperative services as described in Perioperative Services section of this course also apply in ambulatory surgery.

Emergency Department

The federal statute known as the Emergency Medical Treatment and Active Labor Act (EMTALA) provides strictly defined documentation requirements regarding activities and transfer procedures. Other areas that present problems in the ED record include:

- Allergies
- Patients leaving AMA
- Arrival and departure times of patients and providers
- Assessments
- Consent for procedures
- Discharge instructions
- Times of interventions
- Medications in use by the patient and administered for treatment

- Notification of authorities
- Previous health history
- Patient identification
- Menstrual period, presence or absence
- Tetanus status
- Lost valuables
- Vital signs
- Patient's weight

All ED nurses need to be especially conscientious about communication and documentation. Familiarize yourself with ED policies and procedures and follow them faithfully.

Obstetrics

Obstetrics is such a high-risk practice setting that in recent years many providers have left the specialty due to the cost of malpractice insurance. Nurses too are subject to allegations of malpractice in this field.

Frequent allegations include:

- Inappropriate nursing judgment, including failure to notify of the provider appropriately
- Misinterpretation of electronic fetal monitor tracings
- Delays in C-sections or other patient interventions

Safe practice requires the most detailed documentation at the time when the staff is most likely to be stressed and pressured to act quickly. Document:

- On-going monitoring of the patient
- Fetal heart tones
- Interventions in response to changes in the patient's status
- Maternal and fetal responses to interventions
- Pursuit of the chain-of-command for crisis situations

Pediatrics, Pediatric Intensive Care, Neonatal Intensive Care

Know your organization's requirement for pediatric and neonatal medication orders and documentation of administering medications.

TJC recommends that the order specify the dose not the volume, and the dose calculation including data elements, such as the patient's weight, dose per unit weight, and rate of administration. Your organization should have retired the Rule of Sixes in response to a TJC requirement effective in December 2008.

TJC requires provision for schooling and time out-of-doors for long-term pediatric patients.

You may have reporting and documentation obligations if you encounter orders that do not satisfy the criteria set forth in the organization's policy.

Perioperative Services: Pre- and Intra-Operative

Each phase of the surgical process has specific documentation implications:

Pre-operative:

- Comprehensive assessment of the patient's systems
- The patient's understanding of and consent to the procedure to be performed

Intra-operative:

- "Time Out""
- Equipment checks
- Confirmation of the identification of the patient and surgical site
- Positioning of the patient
- Identification of anesthesia reactions
- Measures to prevent burns, injuries from pressure, and other injuries
- Sponge count

AORN 2012

Perioperative Services: Post-Operative

Post-operative:

- Documentation of identified post-operative risks for the patient and appropriate intervention measures
- Verification that the patient met the criteria for release from the post-anesthesia recovery room
- Immediate response to any unexpected patient events

TJC Focus on Perioperative Safety

Specific procedures and documentation requirements may include:

- Checklists
- Universal Protocol ("Time Out")
- Time Out addresses a frequent sentinel event: wrong site surgery
  - Pre-operative verification process
  - Process to mark the operative site, involving the patient
- Double-checks of paperwork
- Procedure for labeling syringes, medication cups, and basins on and off the sterile field
- Discarding unlabeled medications and solutions
- Medication reconciliation procedure and documentation
- Fire safety guidelines
- Documentation of staff members' fire safety training

Sponge Count

Inaccurate sponge count and instrument count is one of the leading causes of lawsuits against nurses. Retained foreign body is also a CMS HAC and an NQF SRE. In 2010, retained foreign body was the sentinel event most frequently reported to TJC (2011b).

- Follow your organization's procedure for documentation of counts. Remember that anything "not documented" is considered "not done" in a court of law.
- If you don't "visualize" each item in a count, ask for the count to be re-done. Your name will be on the count and you can be liable for an incorrect count.
- There may be emergencies that occur and a count cannot be done. These need to be outlined in your organization's policy and procedures and followed carefully.
- If a count is incorrect, document the count, the action steps taken, and the individuals notified. Once again, follow the policy and procedures and in your organization.
- If you discover that a sponge, needle or instrument was inadvertently left in a patient, follow the organizational guidelines and your company guidelines if you are working through a temporary staffing company.

NEVER:

- Assume that the count on an unopened package is correct. Instead, count the items in the package, and if they match the number on the container, remove and label them.
- Sign your name to a count you didn't perform.
- Change the count procedure unless you back up that change with documentation.

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Incorrect Sponge Count

Follow the policy of your organization in the case of an incorrect sponge, instrument, or needle count. If the item is not located in a thorough search, the surgeon probably will order an X-ray. Document the X-ray and results of the X-ray. Complete an incident report and notify others according to organization policy.

If the surgeon refuses to follow the policy when a count is incorrect, complete an incident report and notify the nurse in charge and the nurse manager. Document that the count was incorrect and the surgeon waived the X-ray.

Sometimes very small needles are not counted and an X-ray is not taken, because these small needles would not be seen on X-ray. Some organizations have substituted sonograms immediately before and after closure of the surgical incision. Follow your organization's policy for this situation.

More info:

Not Documented, Not Done

A lap sponge was left in the patient during a Cesarean birth. It had to be removed, and that surgery led to adhesions which led to a bowel obstruction. The jury divided fault equally among the circulating nurse, the scrub tech, and the two surgeons for an inaccurate sponge count.

Psychiatry

Describe specific patient behaviors in your documentation. Consistent documentation helps to establish a pattern of behavior. In one case, a former psychiatric patient brought a suit including complex allegations against a physician. The nurses' notes documented a pattern of the patient's belligerent, threatening behavior and as a result, the court dismissed the suit against the physician (Legal Eagle Eye, 2007e).

Many special requirements of TJC, other accrediting bodies, and state regulations apply in the behavioral health setting.

Your Documentation Takes the Witness Stand

The universal standard of care called upon in legal proceedings is what a reasonable RN of similar experience would have done in similar circumstances (Brooke, 2008). An RN who testifies as such a witness must rely upon your documentation to understand the circumstances and your actions.

Will your documentation testify that you . . .?

- Observed and monitored a patient adequately.
- 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 and/or followed a plan of care.
- Performed nursing treatments and procedures properly.

How Does Your Documentation Testify?

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.

Summary

Adhere strictly to all organizational policies and procedures regarding documentation. When documenting, assert your need to be free of distractions to the greatest extent possible.
Use FACT to strengthen your documentation and evidence, and also:

- Learn the essential policies and procedures and where to locate others
- Write legibly
- Document responses to interventions and problems
- Avoid venting frustrations in the medical record
- Follow the nursing process
- Revise the nursing care plan as appropriate
- Use the chain-of-command for resolving patient management issues
- Document continuous communication with patients and their families to assure their active involvement in care and safety

Your documentation paints a picture of your practice. “Poor documentation portrays a nurse who is inadequate, unprofessional, and incompetent” (Kilmer, 2007). 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 in high-quality patient care and safe, effective nursing practice that is legally and ethically sound.

By studying this course, you have learned:

- The goals of documentation
- The role of organizational policies and procedures in guiding documentation
- The purpose of the patient’s medical record
- Standards and principles of documentation as described by the American Nurses Association (ANA)
- Documentation implications of:
  - Centers for Medicare and Medicaid (CMS) regulations regarding Hospital-Acquired Conditions (HACs)
  - National Quality Forum (NQF) Serious Reportable Events (SREs), also known as Never Events
  - Joint Commission Requirements
- Documentation practices that validate safe, effective, and high quality patient-centered care
- Documentation practices that create legal and professional risks

You have learned:

- Key elements and examples of medical malpractice
- Characteristics of documentation that support a legal defense of nursing actions
- Actions that constitute defamation
- Documentation implications of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Employment and licensure implications of nursing documentation
- 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
- Recommended documentation practices concerning communication with the patient’s provider and provider orders, such as questioning orders and receiving verbal orders
- Examples of important nursing documentation in addition to the patient’s medical record which might establish the nurse’s competencies, presence, responsibilities, and compliance with policies and procedures
- Precautions to observe when using electronic documentation
- Crucial elements of documenting situations that require special documentation practices, including consents, unusual events, patient’s personal property, and 24-hour record checks
- Selected specialty-specific documentation issues

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