PLEISS CASEY SITAR & ROSS
— Attorneys at Law —

DOCUMENTATION FOR LICENSED NURSES

Introduction

Documentation for licensed nurses in our Center is an important aspect of providing care to our residents. Medical records are not only used as an important communication tool for the healthcare team but they are also used by the licensing agency, insurance companies, attorneys and families to assess the care that is provided to your patients. Documentation that is accurate and complete is a key to demonstrating the care provided to our patients.

Learning Objectives

1. Discuss the purposes of documentation.
2. List 3 charting tips to assure documentation is accurate and correct.
3. List 3 legal aspects of charting.
4. Describe the licensed nurse's role in CNA charting.
5. Explain the importance of using proper spelling and grammar when documenting.

ELEMENTS OF EFFECTIVE CHARTING

1. Write legibly. Print if necessary.

2. Use full sentences and accurate spelling.

3. Chart the date and time you wrote your entry. Include the year and designate the time with a.m. or p.m.

4. Accurately document events **at the time they occur**. Avoid block charting such as 0700 to 1500.

5. If you are documenting a late entry, chart the time you are making the entry and "late entry for _____" to designate the time of the events or observations documented.

6. Document plans for continued follow-up and additional communication with physicians, family, etc.

7. Document telephone calls thoroughly and the action taken as a result of the call.

Charting Resident History/Condition

Document data that has been gathered including relevant elements of the resident's history or risky health habits.

Maintain objectivity in your charting and avoid diagnosing a condition in your charting.

Document what you see, hear, and smell, especially those things that indicate changes in health status.

Document Education and Referrals

Document the education provided and the patient/family's response.

Incorporate direct "quotations" and non-verbal responses from the patient, family or visitor.

Document referrals to community resources.

Documenting Interventions

Document the actions taken in response to the resident's status or change in condition.

Document the individuals notified about concerns and issues (physician, family member, pharmacist, psychologist, etc.)

Document all telephone calls and be specific.

If you fax information (lab results, radiology reports, etc.), document the time, date and contents of the faxes not retained in the medical record.

Communication logs are not part of the medical record. Be certain that important information communicated about the resident's condition or interventions & response are also reflected in the medical record.

Chart Outcomes

Document the resident's response to the intervention, including unexpected responses. This shows that you were following up on a concern and demonstrates how the resident responded to your intervention.

Example:
If you document that the client is in pain (i.e., 11:00 a.m., Resident complains of left knee pain 7/10, dull and throbbing, facial grimacing and moaning with movement.) Record the medication and the repositioning you provided and then the response (Tylenol #3, i tab, provided at 11:05 a.m. per order. 12:00 Resident reports left knee pain is improved, dull ache 2/10, with medication and repositioning with pillow between legs on right side.)

Documenting Telephone Calls

For a physician's call document the date and time of the call. If the call is about a change of condition, document what information was provided to the physician. Ask the physician if there is any additional information he/she requires and when/if they would like an update.

If the physician gives an order, in the physician's order section of the chart, write the physician's name and "t/o" to indicate a telephone order was given. Write the order word for word.

If you are noting and transcribing an order, document that you have noted/transcribed it according to policy and sign your name and credentials.

If a family member calls, chart the date and time of the call, caller's name, caller's request or complaint, advice you gave and follow-up requested.

When Completing Forms, Notes and Other Records:

Record your full name, credentials and job title in the appropriate section on forms. Your signature must be in cursive. Take the time to sign your name legibly.

DOCUMENTATION TIPS

1. Chart in the **RIGHT** chart.

2. Write neatly and **LEGIBLY** with blue or black ink.

3. Provide **ALL** significant details.

4. Chart **ALL** changes of conditions, interventions and response.

5. If checking boxes on a form, make certain they are **ACCURATE**.

6. Sign and date **EVERY** entry.

7. Use proper spelling, grammar and appropriate medical phrases but avoid diagnosing.

8. Use only **AUTHORIZED** abbreviations.

9. Make certain patient's name is on **EVERY** page.

10. Correct an error by drawing a single line through the error and chart your initials (No erasing, blacking out or white out.)

11. Do **NOT** document "Incident Report Completed".

12. **AVOID** tattling and finger pointing.

13. Review CNA charting for accuracy and completeness each shift.

More Charting Tips

Chart the time and route of PRN medication administration and the patient's response.

Chart precautions or preventive measures used, such as bed rails, alarms, WanderGuard in place, turning and repositioning, bed surface, floating heels or heel protectors, call light within reach, frequent toileting, etc.

Document the resident's refusals for interventions including treatment, medication, therapy, splinting, eating, toileting, repositioning, etc. Report refusals to the physician and supervisor.

When performing a procedure, document what procedure was performed, when, who, how, how well the resident tolerated it and the outcome.

Chart as soon as possible after giving care.

If you don't give a medication as ordered, circle the time and document the reason for the omission.

Include important information remembered later as a "late entry", noting the date and time of the late entry.

If information on a pre-printed form does not apply to your client, write NA for "not applicable" rather than leaving it blank.

Chart often enough to tell the story.

When continuing a note over 2 pages, sign the bottom of the first page and at the top of the next page write the date, time and "continued from previous page." Make certain all pages have the resident's name.

NEVER alter a resident's record. Do not squeeze information in at a later date. Do a proper "late entry." Do note date an entry so it appears it was written at an earlier time. Do not add inaccurate information. Do not re-write records or destroy records.

DO NOT use shorthand or abbreviations that are not approved.

DO NOT use vague descriptions such as "drainage on sheet" or "large amount".

DO NOT give excuses such as "medications unavailable so not given".

DO NOT chart what someone else said, heard, felt or smelled unless the information is critical and then, use quotations and give credit to the individual who experienced it.

DO NOT CHART OPINIONS or SPECULATION.

DO NOT use language that suggests a negative attitude towards the resident, family or another health care worker.

NEVER chart ahead of time.

DO NOT record staffing problems or conflicts.

NEVER chart care that was not done.

Fill in the lines or spaces. Do not leave extra lines without drawing a single line to prevent charting by someone else.

DO NOT write in the margins.

DO NOT chart words associated with errors like "accidentally", unintentionally", "miscalculated," "by mistake".

DO NOT put other resident's name in the charting of this resident. Use initials or room and bed number.

Licensed Nurse and CNA Documentation

Only nurses can document the nursing process and outcomes.

CNAs chart on flow charts and check-off lists. Licensed nurse's input and oversight of that documentation is essential as you are a "team" providing care and each team member has specific knowledge that affects the other team members.

It is challenging for nursing assistants to make certain that each and every box is completed so it is important that you review these forms as well.

Things to pay attention to in CNA flow sheets:

1. Is the resident voiding sufficiently?
2. When was the last BM?
3. Has hygiene been attended to?
4. Is the patient eating?
5. Is the patient being turned and repositioned?

It is important to note when a patient has refused care. This should be immediately reported by the CNA to the charge nurse and included in your narrative note.

If blanks appear in the CNA flow sheets, then it appears as if the care was not offered or provided. Because CNAs report to licensed nurses, it is the duty of the licensed nurse to review the for accurate and timely documentation.

The RN Supervisor is responsible also for documenting the interventions he/she delivers and assisting the charge nurse as necessary with the completion of records.

Samples of Inaccurate Documentation

The following are true examples of spelling errors noted on nursing flow sheets:

MD order: Walk resident in *hell*.
Resident lying on *eggshell* mattress.
Resident observed to be *seeping* quietly.
Foley draining *fowl* smelling urine.
Treatment provided to right *hell.*

The following are true examples of errors in grammar and incorrect use of words noted on nursing flow sheets:

MD order: “May shower with nurse”
“Resident has no rigor or chills, but husband states she was hot in bed last night"
“Large BM up walking in the hall”
“Resident had a cabbage done”
“The pelvic exam was done on the floor”
“Skin – Somewhat pale but present”

Our goal is 100% accurate nursing Documentation that is TIMELY, ACCURATE, AND COMPLETE.

Post-Test

1. All of the following **basic** information should be included in chart entries **except**:

a. ○ the date

b. ○ the time

c. ○ your name and title

d. ○ the resident's admission date

2. Which of the following is a false statement:

a. ○ You should document that an incident or accident report was completed.

b. ○ Do not use "white out" or erase if you make a mistake.

c. ○ Reasons care was not given should be documented.

d. ○ Documenting ahead of time is not allowed.

3. If the CNA fails to chart in the box on the flow sheet next to the word "Breakfast" then it may be presumed that:

a. ○ The resident was not given breakfast.

b. ○ The resident only ate 50% of his breakfast.

c. ○ The resident received breakfast but ate nothing.

d. ○ The resident refused breakfast.

4. Neither the CNA nor the licensed nurse should document when a resident refuses care

a. ○ True

b. ○ False, both should document refusals.

c. ○ False, only licensed nurses document refusals.

d. ○ False, only CNAs document refusals.

5. When you later remember important information to be charted you should:

a. ○ consider it unimportant since you did not remember it earlier.

b. ○ go back and write what you forgot in the margin of the page where you already documented.

c. ○ document it tomorrow using the notation "late entry" along with the date and time you are writing it.

d. ○ call your place of employment and ask someone else to document it for you since you aren't there to do it yourself.

6. Falsifying information in the medical record is a against the law.

a. ○ True

b. ○ False

7. When a nurse takes a verbal order over the phone he/she should document that he/she read the order back to the doctor to check that the order was communicated correctly.

a. ○ True

b. ○ False

8. To save time when she is extremely busy, a nursing assistant should be encouraged to document care on everyone before she provides care to anyone.

a. ○ True

b. ○ False