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| http://ce.nurse.com/Courseimages/CourseImages/60076_4_web.gifDocument It Right: A Nurse's Guide to Charting60076 :: 5.20 Hours  |

**Authors:**

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**Objectives**

This course has been approved for 4 hours by the Commission on Case Manager Certification for 2008, 2009, 1/15/10 through 12/31/10, 2011, 2012, and 2013.

The purpose of this documentation continuing education program is to provide nurses with information needed to document patient care effectively and appropriately. After studying the information presented here, you will be able to:

* Explain the multiple purposes of documentation and documentation fundamentals
* Compare and contrast documentation formats
* Compare and contrast the focus of documentation in acute, long-term and home healthcare settings
* Describe documentation strategies for challenging situations
* Explain how to meet legal and professional nursing standards when documenting
* Discuss the effect of technology on nursing documentation
* Describe ways to save time when documenting

**Introduction**

From the earliest beginnings of the nursing profession, nurses have carefully recorded their observations of patients and their interventions to help patients recover from illness and achieve optimal health. In the beginnings of the profession, the primary purpose of nurses’ notes was to verify that physician orders were completed. Today, professional nurses are vital partners with other healthcare professionals and nursing documentation is an essential part of comprehensive patient care. Although documentation has always been an important part of nursing practice, today’s increasingly complex healthcare environment, litigious society and the diversity of settings in which patients receive care require that nurses pay more attention to documentation. The computerized patient record has become standard practice, and the days of repetitive task-oriented narrative notes will soon be part of nursing history. Your patient care documentation will need to be brief, accurate, and focused on your patient’s status and progress toward specific clinical outcomes.

Many people depend on your patient care documentation. Your nursing colleagues and other healthcare team members make clinical decisions based on your charting. Representatives of regulatory and accrediting agencies look to your charting to make critical decisions about reimbursement, licensing and accreditation. Although documentation formats have evolved dramatically from simple handwritten notes to sophisticated nursing information systems, the purpose of documentation remains constant: to provide a written record of the care a patient receives and the patient’s response to nursing care and medical interventions in a clear, concise and accurate manner. From protecting your patient to safeguarding your nursing license, to know documentation principles and to apply them in daily practice are musts for every nurse.

**Chapter 1: Documentation Fundamentals**

After studying the information presented here, you will be able to:

* Name eight areas that nursing documentation affects
* Discuss the basic components of a medical record
* Describe the relationship between the nursing process and documentation
* Describe documentation practices that improve the quality of documentation and provide legal protection for nurses

**Why Documentation Is Important**

Nineteenth century British nurse Florence Nightingale is regarded as the founder of nursing documentation. In her book “Notes on Nursing,” she stressed the importance of gathering patient information in a clear, concise and organized manner.1 As nursing achieved professional status, nurses’ observations about patient care and written details of interventions gained increasing relevance and credibility. In the 1970s, nurses began to create their own vocabulary for documentation based on nursing diagnoses.

Although nurses sometimes view documentation as a time-consuming process that takes precious time from direct patient care, documentation is one of the most critical skills they perform.1 In fact, appropriate and effective documentation is at the core of nursing practice.

Nurses need to continually improve patient care documentation. One study described the problems caregivers have locating pertinent information because of a huge volume of routine notes.2 ([Level B](http://ce.nurse.com/ebp.aspx)) This study also emphasized that nursing records need more clarity and need to be more pertinent about specific nursing information.2

Effective documentation is strongly linked to providing patients with safe and effective care.3 Accurate, detailed charting shows the extent and quality of care that you provide, the outcome of that care and the treatment and education that the patient still needs.4-6 Keep in mind that what you chart today may be read in the future by many people, including other team members who care for the patient; accreditation, certification and licensing organizations; performance improvement committee members; the Centers for Medicare & Medicaid Services; and private insurance company reviewers. Lawyers or a judge may also review your charting if your patient’s medical record is part of a legal action.5,6 In today’s complex healthcare environment, where care takes place in a variety of hospital and community settings, effective documentation is more important than ever.7

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| **Why Document It Right?** Documentation affects:* Accreditation and licensing
* Coordination of care
* Legal protection
* Peer review
* Performance improvement
* Quality of care
* Reimbursement

**Source:** Guido GW. *Legal and Ethical Issues in Nursing.* 4th ed. Upper Saddle River, NJ: Pearson Prentice Hall; 2006:172. |

Effective documentation provides a picture of the care a patient receives, his or her response to care and any need for further treatment.1 To provide a record of the quality of care a patient receives, you must describe the care you gave and provide evidence that it was necessary. You should also document the patient’s response to care and any changes needed in the nursing plan of care. To assess the quality of your charting, ask yourself: If I were the next nurse responsible for this patient’s care, would these notes allow me to make good nursing decisions?4

**Coordination of care:** One of the most important objectives for documentation is to communicate the patient’s status and progress or lack of progress to other healthcare professionals.8 To plan effective interventions and evaluate a patient’s progress, team members need all pertinent information about a patient’s care. Accurate nursing documentation is an important factor in care coordination because it helps other team members provide more effective care.1

**Accreditation and licensing:** Organizations such as The Joint Commission certify that healthcare organizations meet standards to provide healthcare. Through the accreditation process, healthcare organizations validate their eligibility for government reimbursement and demonstrate to their consumers that they provide quality care. To assess whether a facility should receive accreditation, Joint Commission reviewers determine how the organization is structured and how it functions. This determination may include patient and staff interviews, along with a review of medical records, to determine whether the organization meets the accreditation standards. Nurses must document care based on Joint Commission core measures and evidence-based findings.9 Most accrediting organizations require that each patient’s clinical record contain an assessment, a plan of care, medical orders, progress notes and a discharge summary.1 Some states also require all healthcare facilities, including home healthcare facilities, to be licensed. Licensure reviews include an assessment of the quality and appropriateness of patient care as demonstrated through a review of documentation.1

**Performance improvement activities:** Federal and state regulations and Joint Commission standards mandate performance improvement activities. Members of performance improvement committees monitor and evaluate patient care and seek ways to improve patient care. Committee members develop indicators of quality care to assess the structure, processes and outcomes of patient care. The medical record can be used to measure quality indicators and to plan corrective action when necessary.7

**Peer review:** Federally mandated quality improvement organizations, or QIOs, rely on the patient’s medical record to evaluate the quality of care in healthcare facilities. Reviewers evaluate samples of a facility’s patient records to determine whether certain processes are in place, such as those that minimize the need for unscheduled returns to the OR or ensure adequate and appropriate discharge planning. QIOs operate under the auspices of the Centers for Medicare and Medicare Services.7

**Requirements for reimbursement:** The federal government uses a prospective payment system based on diagnosis related groups (DRGs) to allocate reimbursement for patients covered under the national Medicare program.10 For a healthcare facility to receive payment, the patient’s medical record must contain the correct DRG codes and must demonstrate that the patient received care in the appropriate setting. Many insurance companies also base their payments on a prospective payment system; they look at medical records to determine the appropriate reimbursement for services provided. In some settings, such as home health, nursing documentation directly affects the amount of reimbursement. Your documentation is key to reimbursement when it verifies and justifies your actions to provide care.7 Nurses should be knowledgeable about hospital-acquired conditions as defined by the [Centers for Medicare & Medicaid Services](http://www.cms.hhs.gov/).

These conditions, e.g., catheter-associated urinary infection, pressure ulcers, blood incompatibility and deep vein thrombosis following hip or knee replacement, are examples of events which affect a healthcare organization’s reimbursement.9 Nursing documentation can make a significant difference in these situations. For example, documenting that a patient has symptoms of a urinary tract infection when admitted and immediately having a urinalysis ordered may qualify for reimbursement as opposed to responding to symptoms that occur several days later.9

**Legal protection:** Good documentation should protect you, your patient, other caregivers and the healthcare facility where care is provided. Admissible in court as a legal document, the medical record demonstrates the type of care a patient receives.1 Medical records are often used as evidence in disability, personal injury, mental competency and malpractice cases.1,5 Remember that what you document — or don’t document — can mean the difference between whether a court case is won or lost for you and your employer. Effective ways to protect yourself and your employer legally are to make sure you document your adherence to professional standards of nursing care following your employer’s documentation policies and procedures and document carefully in high-risk situations.7

**Research and continuing education:** Researchers who study certain types of patient care phenomena also examine nursing documentation. For example, clinical records can provide data for a study to look at outcomes of nursing interventions and complications associated with a specific intervention or to assess the effects of patient teaching on compliance.4

**Clinical Record Components**

Although each healthcare organization has its own clinical record system, a patient’s medical record contains some generic forms that are used throughout the healthcare industry. The table below shows the components that comprise a typical patient record for an acute hospital stay.

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| **Components of a Hospital Medical Record*** Face sheet — contains information that identifies the patient, including name, birth date, marital status, address, telephone number, Social Security number, religion, closest relative, food or drug allergies, admitting diagnosis, any assigned diagnosis related groups and name of attending physician
* Medical history and physical examination record: a form completed by the patient’s physician; contains details of the initial medical assessment and a synopsis of medical background information
* Initial nurses’ assessment form: contains details of the initial admission nursing assessment
* Physicians’ order sheets: contains chronological orders from physicians
* Problem list and/or nursing diagnosis list: for facilities that use a problem-oriented medical record system; lists actual and potential patient problems by number
* Nursing care plan: outlines the nursing plan of care; usually kept with the basic medical record; sometimes kept at the nurse’s station until discharge. (The Joint Commission now requires that the hospital plan of care be permanently integrated into the clinical record by written or electronic means.2)
* Graphic sheet: a type of flowchart that shows comparative chronological recordings of basic patient parameters, such as temperature, pulse, respiratory rate, blood pressure, pulse oximetry, weight and intake and output. (Other flow sheets may document skin care, blood glucose levels and neurological assessments. To show that an assessment or an activity has been completed, the nurse dates and initials or checks the appropriate column.)
* Medication administration record: records each medication a patient receives, including the dosage, route, site and date of administration, and identifies the nurse who administers the medication. It also may include documentation of the effectiveness of as needed medications.
* Progress notes: describes patient assessments, nursing interventions and patient response to interventions that are not documented as part of flow charts. (Progress notes are used for variance reporting or to detail information that influences patient outcomes.)
* Physicians’ progress notes: a written record of physician observations, treatment data and patient response to treatment
* Diagnostic findings: contain diagnostic data from the medical laboratory, radiology and other diagnostic testing sources
* Healthcare team records: contain observations and interventions from ancillary departments, such as physical therapy, occupational therapy, speech therapy, dietary and psychology. (The Joint Commission now requires evidence of multidisciplinary planning. This is usually evidenced by a multidisciplinary planning sheet that often takes the place of health team progress notes.)
* Consultation sheets: reports of evaluations made by physicians and other healthcare providers asked for opinions and treatment recommendations
* Patient and family teaching record: a section or form detailing health teaching activities involving the patient, his or her family, or other patient caregivers
* Discharge summary: Completed by the attending physician, this document contains a brief review of the patient’s hospital stay and plans for care after discharge, including dietary and medication instructions, follow-up medical appointments and referrals

**Source:** Adapted from *Complete Guide to Documentation.* Springhouse, PA: Lippincott Williams & Wilkins; 2008. |

**New Ways to Plan Care**

Because The Joint Commission has concluded that the traditional care plan does not necessarily affect patient outcomes, a formal written plan of care is no longer required; however, the nurse must develop a plan of care. Several new types of tools for care plans are available, including standardized plans of care, clinical pathways and patient-outcome time lines.10 Standardized plans of care are concise plans that correspond with a DRG or other descriptors of a patient’s healthcare status. Clinical pathways — also known as critical pathways, care maps or care tracks — integrate the principles of case management into documentation. Clinical pathways incorporate multidisciplinary diagnoses and interventions, including nursing and medical interventions, and key events that must occur for the patient to be discharged by a specific date.1 A clinical pathway is usually organized by categories based on the patient’s diagnosis; it projects his or her expected length of stay, specifies daily care guidelines and forecasts expected outcomes. For example, the clinical pathway for a patient who is one-day postoperative after a colon resection would focus on nasogastric tube maintenance, intake and output, vital signs, pain management, urinary catheter care, incentive spirometry, use of antiembolism stockings and ankle exercises, ambulation, IV site care, wound care, mouth care, safety measures and bed positioning. The nurse records whether the patient’s progress follows that outlined in the clinical pathway when he or she documents “no variance” from the standard or documents reasons for a variance if one occurs. A patient-outcome time line is another recent documentation tool that allows all members of the healthcare team to note essential diagnostic tests, interventions, patient outcomes and other parameters to attain the average length of stay for each DRG. For example, the patient-outcome timeline for the patient with a colon resection might predict that the patient be out of bed and sit in a chair the day after surgery and walk in the hallway by the third or fourth postoperative day. The time line also lists key interventions to achieve the expected outcomes that monitor the patient’s progress during each shift.10

**Nursing Process and Documentation**

Whatever charting format you use, your documentation must reflect the nursing process.1,7 The nursing process is a scientific approach that systematically organizes nursing activities to provide the highest quality of care.1 The five-step nursing process ensures compliance with care requirements mandated in both acute and long-term care settings. The importance of the nursing process to provide and document care is also evident throughout The Joint Commission standards. The table below displays the five steps of the nursing process and shows related documentation tools in italics.

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| **Nursing Process and Related Documentation Tools** The steps in nursing process and related document tools in italics:* Step 1: Assessment — a summary of data from the patient’s history, physical examination and diagnostic test results (*initial assessment form, flow sheets, screening tools) (Assessment must occur continually throughout the patient’s stay*.)
* Step 2: Nursing diagnosis — clinical judgments based on assessment data (*nursing plan of care, patient care guidelines, clinical pathway, progress notes, problem list*)
* Step 3: Planning—care priorities, goals with outcome criteria and target dates, description of interventions (*plan of care,* *progress notes, flow sheets*)
* Step 4: Intervention — description of interventions as they are implemented (*progress notes, clinical pathway, graphic records*)
* Step 5: Evaluation *—* outcomes assessment of plan (*progress* *notes, outcome tool*)

**Source:** Adapted from *Complete Guide to Documentation.* 2nd ed. Springhouse, PA: Lippincott Williams & Wilkins; 2008. |

The first part of the nursing process, assessment, starts when you meet the patient and continues throughout your relationship as you obtain information about his or her changing condition.1,7,10 The initial step of the nursing process includes the collection and analysis of relevant information from the patient and other sources as a basis for planning care. The Joint Commission requires healthcare facilities to perform an initial patient assessment specific to their patient population.7,10 Document patient assessments as often as your facility requires, and more often when you observe a change in the patient’s condition. The Joint Commission standards require that each patient’s initial assessment address the patient’s physical, psychological and social status. Physical factors include relevant physical findings from the initial physical assessment.

Psychological factors include the patient’s concerns about his or her healthcare status. Social status factors may include family structure and the patient’s role in the family, in addition to the patient’s occupation, income level and socioeconomic factors as they relate to his or her illness. Other important areas for assessment include the patient’s nutritional status, functional status, learning needs and discharge planning needs.9 The Joint Commission also requires healthcare facilities to establish policies on the frequency of patient reassessment. You should reassess your patients and document your findings at least as often as required by your facility’s policies.1,7

To move to the second step of the nursing process, nursing diagnosis, you must evaluate the patient’s assessment data; look for actual or potential health problems. A nursing diagnosis has three components: the human response or problem, related factors and signs and symptoms. The human response or problem refers to an actual or potential problem that nursing care can affect positively. Related factors are phenomena that may precede, contribute to or be associated with the human response. Signs and symptoms, also referred to as defining characteristics, support the nursing diagnosis.

After you formulate a nursing diagnosis, you need to plan relevant expected outcomes, or goals that your patient should be able to reach as a result of nursing interventions. An outcome can include either an expected improvement in the patient’s functional abilities, such as an increase in walking endurance, or the stabilization or resolution of a problem, such as a decrease in acute pain to an acceptable level of tolerance.

An effective plan of care is the basis for effective and meaningful documentation.3 The plan includes patient problems identified during assessment; realistic, measurable expected outcomes with dates of expected resolution; and nursing interventions that will help the patient and family achieve desired outcomes.

Evaluation, the final step in the nursing process, documents the effectiveness of treatment interventions and proposes changes in the plan of care if necessary.

**Discharge Instructions**

Hospitals discharge patients earlier than they did in the past. As a result, the patient, his or her family, or other caregivers often perform healthcare activities in the home that nurses have traditionally done before patients leave the hospital. These activities may include wound-healing assessments, dressing changes, emptying of drainage bags, tube feedings and medication administration. Patients and home caregivers may also have to ensure an appropriate diet and activity level and learn how to operate specialized medical equipment.1

To fulfill these responsibilities, the patient and home caregiver must receive adequate instruction. If a patient doesn’t receive appropriate teaching, you may be liable for any injuries caused by inappropriate or inadequate instructions. Many hospitals distribute printed instructions that describe treatments and other home care procedures. Indicate in your documentation which materials were provided and to whom.6,9,10 Some facilities combine discharge summaries and patient instructions in one form. The table below shows information that should be in discharge instructions.

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| **Discharge Instruction Documentation Essentials** * The date and time of discharge
* Family members or caregivers present for teaching
* Treatments to be administered after discharge, such as dressing changes or use of medical equipment
* Signs and symptoms to report to the physician who will follow the patient after discharge
* Patient, family or caregiver to understand instructions or be able to give a return demonstration of procedures
* Whether a patient or caregiver requires further instruction
* The name and telephone number of the physician who will follow the patient after discharge
* The date, time and location of follow-up appointments
* Details of instructions given to the patient, including medications, weighing themselves, activity and diet (include any written instructions given to patient)

**Source:** *Chart Smart: The A to Z Guide to Better Nursing Documentation.* Springhouse, PA: Springhouse Corp; 2006. |

**Documentation Guidelines**

**Document accurately and objectively.** Record only what you see, hear, touch or smell. When you record a patient’s statement, chart the exact words in quotes whenever possible. For example, write, “I am not taking that medication” if a patient, after your discussion with him or her about the importance of therapy, refuses medication 9 Document only data you witness or data from a reliable source, such as the patient or another nurse. When you include information reported by someone else, name your source.1,5 Chart exact measurements and distances. For example, charting that a patient can walk to one end of the hallway and back won’t be meaningful for a home health nurse trying to evaluate a patient’s endurance. Instead, chart the actual distance in feet or yards. When documenting quantities, avoid generalizations, such as “a small emesis” or “voided a large amount.” Exact measurements in size or amount may be critical. Be sure to be precise about what you observe. For example, writing, “Patient’s incision appears to be healing” is much less specific than “Wound on abdomen measures 12 cm x 6 cm. Pink wound edges approximated granulation tissue at wound edges. All sutures intact, with no drainage noted.” When you describe a patient’s pain intensity, describe it on a standardized numerical pain scale, such as “Patient reports pain as 8/10, with score of 10 being worst ever” rather than “Patient reports severe pain.”9 Avoid terms that don’t give an accurate picture, such as “voided qs,” “ate well” or “bowel sounds normal.” Effective charting should read, “Voided 400 ml clear yellow urine in urinal,” “ate 80% of dinner meal” and “abdomen flat and flaccid; rumbling noises heard on auscultation.”

**Get the facts about a situation before charting and don’t make assumptions about an event.**5,8 For example, don’t chart that a patient pulled out his IV line unless you or another staff member saw him do it. Instead, document your findings: “Found patient’s IV line and venipuncture device untaped and hanging free. Arm board and bed linens covered with blood.”7,9 Avoid terms that are ambiguous or subjective. For example, charting that a patient “requests pain medication periodically” doesn’t communicate much. Instead, describe the time intervals between requests for pain medication specifically. Don’t use vague terms, such as “seems” or “appears.” These terms may imply that you aren’t certain about your observations.1,7 Avoid subjective references to a patient’s behavior, such as “Patient seems frustrated” or “Appears anxious.” Instead, paint a picture of the behavior: “I just don’t think I will ever be able to give myself insulin” or “Patient has used her call light five times in the last two hours to ask about results of lab tests.” Rather than charting a vague statement such as “Patient reports good relief from pain medication,” provide clearer detail by charting “Patient states incisional pain is decreasing; describes pain now as 2 on a standard 1-to-10 scale.”

**Document clearly and thoroughly.** Avoid using long or complex words when short simple words will be more effective. Don’t be afraid to use the pronoun “I,” as in “I contacted Dr. Bryant at 1115 and reported the following facts…”1 Be sure to chart all relevant information about a patient’s care. In court, you’ll find it difficult to prove you provided an aspect of patient care if you haven’t documented it. For optimum legal protection, describe in detail actual or potential problems, nursing actions you took to resolve them, and the patient’s response to your actions. Chart specific information about implementing safety precautions and attempts to contact the patient’s physician

**Note times carefully.** Be specific when you record the exact times of observations and events, particularly any changes in the patient’s condition or significant events and nursing actions.1,7,10

**Don’t use block charting that covers a wide range of time, such as “7 a.m. to 3 p.m.”** This time range sounds vague and implies inattention to the patient.1,7,10 Try to document pertinent information as soon as possible after an event. That way, you won’t be as likely to forget important details, and your charting will be more accurate. In addition, if you become involved in litigation, you’ll find it easier to defend your actions because prompt charting leaves no question about when an event occurred. If you can’t document at once, note the time when you do chart — explain the delay, such as “no access to patient’s chart temporarily,” and note the time the event occurred. Record the exact time something happens: If a patient has an emesis at 1:15 p.m., chart that time, not “approximately 1 p.m.” — noting the precise time of a significant event or complaint and your response to it may be crucial, especially in a court of law.1

**Avoid assigning blame or calling attention to errors.** Staff conflicts about patient care are legitimate but don’t belong in a medical record. For example, when you question a physician’s decisions or criticize a colleague’s performance or care given by others, it reflects poorly on all members of the team. In a court of law, accusations in the chart can be used to show that the patient received incompetent or substandard care.5 Report any criticism in the chart of your care by another nurse to your supervisor. Don’t respond to criticism in the chart, and don’t alter the chart in any way. If you question another nurse’s care, objectively report your findings in an incident report. Without blame, describe what you assessed or witnessed, your interventions to protect the patient, and the names of your supervisor and the physician and the times you notified them.6

**Avoid using terms associated with errors, such as “accidentally,” “by mistake,” “somehow,” “miscalculated” and “unintentionally.”1** These words can be interpreted as admissions of errors in patient care. Instead, document the facts: “Patient given 10 mg morphine sulfate IM for incisional pain at 0830. Dr. Green notified at 0845. No orders received.”9 Don’t chart that a piece of equipment isn’t available. Instead, document a clear picture of the facts: “Blood transfusion via a regular pump on the recommendation of the laboratory (or physician order)” — then, fill out an incident report that states no blood warmers were available, what you did and why.11 Don’t write, “No blood warmers available” in the patient’s medical record.

**Fill out forms correctly, write in ink, and sign each entry.** The Joint Commission and Centers for Medicare & Medicaid Services require that each entry include the date, time and the caregiver’s signature. Don’t leave blank spaces in the progress notes or on flow sheets — a blank space may imply omission of a potentially important task, such as the completion of a procedure or a full patient assessment

**Blank spaces in progress notes also allow others to add information to your notes.1,7** Because the medical record is a permanent document, use black or blue ink when you fill it out or print it from a computer.10

**Use standard abbreviations.** Use only abbreviations approved by your facility. Healthcare organizations develop approved abbreviation lists based on input from patient safety resources, such as the Institute for Safe Medication Practices and The Joint Commission.

**For drug names, use generic rather than trade names and spell out drug names.** To avoid misinterpretation, write abbreviations out. New patient safety goals from The Joint Commission address these issues.

**Write legibly and spell correctly.** A person who reviews a chart with sloppy writing and poor grammar and spelling may conclude that the care given was unprofessional.1 Be sure to write neatly and use correct grammar and spelling. It is helpful to keep a dictionary in charting areas for staff reference and to post a list of commonly misspelled words, especially common terms and medications on your unit.10 Illegible handwriting frustrates other healthcare professionals; they may waste valuable time to decipher it. A patient may even be injured if other caregivers can’t read vital information.

**Correct errors and omissions.** When you make a charting error or omission, correct it as soon as possible following your facility policy. Never erase, cover, write over or make an entry unreadable.1,5,7

If the chart is reviewed in a legal action, the patient’s attorney will look for any evidence that may imply the patient’s chart is inaccurate. Erasures, correction fluid or heavy black ink to make an entry unreadable are red flags.10

**Cosign correctly.** Review and follow carefully the policy at your facility for countersigning chart entries, for example with a nursing student or technician. Although countersigning doesn’t indicate that you personally performed a procedure, it does imply that you reviewed the entry and approved the care given.6

**Use caution when you countersign a subordinate’s chart entries.** Review each entry and make sure it clearly identifies who did any procedure or provided care. Validate observations made. If you develop a practice of automatically countersigning without reviewing an entry or if you overlook a problem that the entry raises, you could be liable for any patient injury that results.

**Don’t document care given by someone else.5** Unless stated otherwise in the chart, any person who reads notes with your signature assumes that they are a firsthand account of observations made and care provided. If in your facility, unlicensed assistive personnel, including nursing assistants and technicians, are prohibited from making formal charting entries, your documentation must reflect that you assessed the patient and evaluated the care you assigned to a subordinate.1

**Follow correct procedures for late documentation.** You may need to make a late entry to a patient’s chart when the patient’s chart is unavailable, or when you need to add important information after you have already finished documenting. To avoid any implication that you’ve altered a medical record, be sure to follow your facility’s policies and procedures when you make a late entry. Often, the policy is to add your entry to the line in the progress notes available and write “late entry” to indicate that the entry is out of chronological sequence. Then, record the time and date of the late entry and, in the body of the entry, record the time and date of the care.

Documenting the care you provide for patients is one of your most critical responsibilities. In addition to communicating vital information about patients to other nurses and healthcare professionals, documentation validates the crucial importance of nursing care.12 In some situations, nurses may feel that spending time charting interferes with patient care.3 At other times, nurses may view documentation as burdensome task that must be completed before a shift ends.13 Some observers report that even when there is adequate time for documentation, nurses may not value its importance in relation to hands-on nursing activities. Reports in the nursing literature suggest several barriers to effective documentation, including nurses’ apathy about documentation, time needed to document effectively and nurses’ writing skills.13 Nurses should be encouraged to consider documentation as a vital part of patient care and must be involved in designing effective strategies to improve the quality and efficiency of patient care documentation.

**Review Questions**

1. The primary purpose of nursing documentation is to obtain reimbursement for patient care services.
True false

2. The medical record may be used in court to demonstrate the type of care a patient received.
True false

3. Clinical pathways integrate the principles of case management into documentation.
True False

4. Joint Commission standards require multidisciplinary care planning.
True False

5. You have no legal responsibility when you countersign charting entries made by another person.
True False

**Answers to Chapter Review Questions**

1. False

2. True

3. True

4. True

5. False

**Chapter 2: Different Formats, Different Settings**

After studying the information presented here, you will be able to:

* Describe the basic processes in the narrative, problem-oriented, focus; PIE (problem, intervention, evaluation); CBE (charting by exception); FACT (flow sheets, assessment, concise progress notes, treatment); and core charting formats
* Describe five components of problem-oriented charting
* Name four regulatory bodies that influence documentation in long-term care
* State four documentation criteria that a patient must meet to receive reimbursement for home health services
* Discuss two ways in which documenting patient care in a long-term care facility differs from documenting in an acute care setting

The type of facility and the setting in which you work will determine the different documentation formats you may encounter. Each documentation system has its strengths and limitations. The Joint Commission standards that emphasize outcomes of care and state and federal regulations should drive the selection of a documentation system. The goal is to implement a system that demonstrates the essence of nursing care, supports an interdisciplinary approach and focuses on patient outcomes.1-3 Follow your facility’s and your state nurse practice act’s requirements for documentation.

**Documentation Formats**

**Narrative or source-oriented charting:** The traditional method of documentation in acute care is known as source-oriented or narrative charting. In organizations that have not yet converted to electronic medical records, narrative charting may be used. For this type of charting, members of each discipline — the sources — chart patient information in separate sections of the medical record. Narrative charting is a straightforward,1,2,4 chronological account of the patient’s status, nursing interventions and the patient’s response to interventions. Narrative charting is usually written on progress notes and supplemented with various types of flow sheets.2,4 Although narrative charting is simple, it is time-consuming, it may contain numerous duplications, and it often results in an unorganized record that makes it difficult to determine a patient’s progress quickly.2 It may also make it difficult for team members to obtain a clear and comprehensive report of the patient’s care and may cause communication barriers. Collaboration is easier when team members who use narrative charting document on the same progress notes.2 Focus charting and PIE (problem, intervention, evaluation) charting, which will be discussed later in this section, have evolved from traditional narrative documentation.

**Problem-oriented charting:** Problem-oriented charting was introduced as an alternative to the traditional source-oriented or narrative charting format.1 Many healthcare facilities have converted in whole or part to problem-oriented charting to document patient care.

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| **Components of Problem-Oriented Charting** * Patient database
* Patient problem list
* Initial plan for each identified problem
* Progress notes
* Discharge summary

**Source:** *Chart Smart: The A to Z Guide to Nursing Documentation.* Springhouse, PA: Springhouse Corp; 2006. |

The patient database contains subjective and objective data about the patient from all disciplines as part of the initial assessment. The database includes information such as the reason for admission and the patient’s medical history, allergies, medications, physical and psychosocial assessment findings, self-care abilities, learning needs and discharge planning issues.1,3,5 The problem list is a numbered list of health problems written in chronological order as each problem is identified.1,2,5 Problems are referred to by number in progress notes. The problem list, which serves as an index for the medical record, is placed at the front of the record, where members of all disciplines can see it quickly. Problem names may include medical diagnoses, such as “congestive heart failure,” and nursing diagnoses, such as “activity intolerance.” When a problem is resolved, the time and date are noted, and further documentation on the problem ceases.

The initial plan of care is based on the patient problems identified during the first assessment. The plan for each problem includes care goals or outcomes, treatment plans and patient education plans.5 Involve the patient and significant others in the planning process. Progress notes, written in a format called SOAP,1-3 monitor changes in the patient’s condition and response to treatment. Components of problem-oriented documentation are:

* **S**: Subjective information
* **O**: Objective information
* **A**: Assessment
* **P**: Plan

“S” is the subjective information the patient provides, such as why he or she seeks care or statements of symptoms or concerns. Subjective data can also come from family or significant others. The “O” is for objective information, such as observable signs and symptoms, vital signs or the results of laboratory tests or other diagnostic information. “A” is for assessment. Under the assessment heading, document your conclusions, formulated as patient problems or nursing diagnoses, based on both subjective and objective data. “P” stands for plan, the interventions you intend to use to resolve the problem, including short-term and long-term goals.6 Policies indicate charting frequency, e.g., progress notes may be written for each problem every 24 hours or when the patient’s condition changes.

Some facilities use a SOAPIE or SOAPIER format to add the categories interventions, evaluation, and revisions. “I” details the interventions to resolve the problem. “E” focuses on your evaluation of the patient’s response to interventions. “R” is for revisions to the plan based on an evaluation of the effectiveness of the treatment plan.4 The discharge summary addresses each problem on the list and notes whether the problem was resolved. Document plans for any unresolved problems after discharge in the discharge summary, along with pertinent communications with other healthcare providers, such as home health agencies.

The major advantage of the POMR (problem-oriented medical record) system is better communication among healthcare team members. Any team member can readily find the patient’s problems at the front of the record, obtain a status report from a single progress note and easily find specific information in well-organized progress notes.1,4

Some disadvantages exist to the POMR system because of its emphasis on documenting problems chronologically rather than in their order of priority. POMR also isn’t suited for settings with rapid patient turnover.6

**Focus charting:** Focus charting, an adaptation to narrative charting, lists pertinent patient information (or the focus of concern) by key words in a column on a progress sheet.1-3 The key words may be a sign or symptom, such as pain or dyspnea; a nursing diagnosis, such as potential for skin breakdown or ineffective airway clearance; a behavior; a condition; a significant event; or an acute change in the patient’s condition. In the next column, notes are organized by data, action and response or DAR framework. “D” refers to the data gathered from the patient assessment; “A” refers to the actions you take based on assessment data, and “R” describes the patient’s response. Routine nursing tasks and assessment data can be documented on flow sheets and checklists.2,4

**PIE charting:** The PIE system organizes information by patient problems.4-6 This system requires the completion of a daily assessment flow sheet and progress notes. Integration of the care plan into the nurses’ progress notes eliminates the need for a separate care plan and provides a record with a nursing rather than a medical focus.3-5 Data are collected from the initial nursing assessment to formulate relevant nursing diagnoses. For PIE charting, each documentation entry is divided into three components: the problem, written as a nursing diagnosis (P); interventions (I), states the nursing actions to resolve the problem; and evaluation (E), determines the success of the nursing interventions. A variation of this format, APIE, includes an assessment component, labeled “A.” PIE charting is a logical and easy-to-use format; however, to find all the nursing actions performed for each problem you must read documentation from several shifts.1,2

When you document a problem, label it as “P” and assign the problem a number, such as P No. 1 in the progress notes. The next step is to document the nursing interventions taken to address each problem or the nursing diagnosis. Label each entry as “I” followed by “P” and the problem number, such as IP No. 1. To document your evaluation of the patient’s response to treatment, use the letter “E,” followed by “P,” and the problem number, such as EP No. 1.1,2

**Charting by exception:** The charting by exception (CBE) format differs significantly from traditional systems as documentation is limited to only significant or abnormal findings in the narrative portion of the record.1,4 To use CBE documentation effectively, you must know and adhere to established guidelines for nursing assessments and interventions and follow written standards of practice. You document only significant findings or exceptions to certain norms that are based on clearly defined standards of practice and predetermined criteria for nursing assessments and interventions. Explanations for deviations from the norm are noted on progress notes. To supplement these notes, there are specially designed flow sheets for physical assessments and interventions documentation. Because the CBE system streamlines documentation, it saves time, a major advantage.2 It is also easy to find issues that affect patient outcomes with the CBE system.

The CBE format involves the types of forms below:5

* A nursing diagnosis-based standardized care plan. For each nursing diagnosis identified, the nurse uses a standardized plan of care for that nursing diagnosis and personalizes the care in the blank spaces provided.
* Nursing care flow sheets to document assessments and interventions. These flow sheets, usually designed in a hospital or home-care setting to cover 24 hours, compare findings with normal parameters and with previous nurses’ notes to determine whether the patient’s condition has changed. If there is no change, the nurse checks the box and adds his or her initials. If findings aren’t within normal limits or don’t match the previous assessment, the nurse places an asterisk in the box and charts assessment findings about the abnormality or change in a comments section or some other designated area such as progress notes.
* A graphic record to document trends in vital signs, weight, intake and output, and activity level. As with the nursing care flow sheet, use check marks and initials to indicate expected findings and asterisks to indicate abnormal findings. Then chart a description of the abnormality or deviation.
* A patient teaching record. This record tracks and documents patient and family teaching and outcomes of teaching.
* A patient discharge note to document discharge planning. A typical discharge form includes sections to document patient instructions, appointments for follow-up care, medication and diet instructions, signs and symptoms to report, level of activity and patient education.
* Progress notes to document revisions to the plan of care. These notes document interventions that don’t lend themselves to any of the flow sheets.

Because minimizing documentation may increase legal risk, well-designed flow sheets are crucial in a CBE system. However, you may need to supplement your CBE documentation with progress notes.5,6 For example, in a situation in which CBE doesn’t provide a clear, accurate description of a patient’s condition, you’ll need to write it in a narrative note. As it may be several years before a lawsuit is filed, CBE makes it difficult for nurses to demonstrate they provided appropriate care, especially when patients develop complications. Although CBE saves charting time, legal experts advise hospitals to develop their CBE systems carefully and to establish quality-control measures to ensure the systems are used appropriately.7

**FACT charting:** The FACT (flow sheets, assessment, concise progress notes, treatment) documentation system incorporates many CBE principles; the nurse documents only exceptions to what is normally expected or significant patient information.2,5 The FACT system contains flow sheets, assessments with baseline parameters and concise progress notes that document the patient’s condition and response to treatment.2,5

**Core charting:** Core charting focuses on the core of documentation: the nursing process. Core charting consists of a database, a care plan, flow sheets, progress notes and a discharge summary. The database is used as the initial assessment and focuses on the patient’s body systems and ability to perform activities of daily living. The care plan includes a summary of the patient’s problems and relevant nursing diagnoses. Flow sheets chart the patient’s activities and responses to nursing interventions, patient teaching and diagnostic procedures.4,5 A DAR (data, action and response) format is used for documenting in the progress notes.

**Documentation in Different Settings**

**Acute care documentation:** In an acute or critical care setting, nurses record assessment findings, nursing interventions, patient responses and patient outcomes.1,2,8 Much of critical care documentation is entered on flow sheets accompanied by commentary and critical data, such as an ECG strip.1,2 The nursing admission assessment form contains physiologic, psychosocial and cultural information, and describes subjective and objective data about the patient’s healthcare status and actual and potential problems. The admission assessment form also provides information about the patient’s ability to comply with therapy, his or her expectations for treatment and family relationships and dynamics — psychosocial information needed to plan effective nursing care.1,2

Progress notes describe patient problems and needs, nursing observations, nursing reassessment and interventions, patient responses to interventions and progress to meet expected outcomes.1,2,8

Graphic forms are used for around-the-clock assessments. These forms track various changes in quantitative data, such as vital signs, weight, intake and output. Flow sheets provide an easy-to-read description of changes in a patient’s condition. A clinical pathway is often used in acute care to outline the standard of care and specify expected activities related to the patient’s diagnosis.1,2 Patient and family teaching forms provide evidence that the healthcare team has implemented a teaching plan and evaluated the effectiveness of the plan. These are often preprinted forms for a specific diagnosis that can be customized for each patient’s unique situation. Discharge summary and patient instruction forms document assessment of a patient’s continuing care needs and referral for care. Many healthcare facilities combine discharge summaries and patient instructions in one form.

**Long-term care documentation:** Although documenting in acute care and long-term care settings is similar, documenting in long-term care settings differs in two important ways.8 First, documentation isn’t done as often as in acute care because changes in patients’ conditions are not expected to occur frequently, and patients stay longer, often for weeks or months. Second, long-term care facilities are highly regulated by state and federal agencies, and strict documentation standards are required;2 a comprehensive view of the patient’s needs is documented on forms that are often lengthy and complex.2,8

State laws and Medicare’s conditions of participation determine to a large extent what to record in long-term care. The Centers for Medicare & Medicaid Services ensures compliance for government-paid services under the Medicare/Medicaid program. Medicare provides limited reimbursement for services provided in long-term care facilities, except for services that require skilled care, such as IV therapy, parenteral nutrition, respiratory care, mechanical ventilation and physical, occupational and speech therapy.6,8 To reimburse long-term care facilities for these services, Medicare guidelines require that documentation clearly show that the patient requires care by professional or technical staff members. When patients don’t improve or aren’t expected to benefit from skilled intervention, they become ineligible for Medicare coverage.8 Nursing documentation is vital to provide such evidence.

Not all patients in long-term care facilities are elderly. Patients under 65 who need skilled care must pay for care themselves, rely on their health insurance or if they are eligible, may receive reimbursement through the federal Medicaid program. To receive Medicaid reimbursement, documentation must reflect Medicaid standards.5,6

For Medicare or Medicaid patients, the Omnibus Budget Reconciliation Act requires the completion of a comprehensive assessment known as a “minimum data set for resident assessment and care screening,” or MDS, within a specific time of the patient’s admission to a long-term care facility.6 The MDS must be also be reviewed and repeated at specified time frames.6

The current MDS 3.0 is an updated reporting system that involves a resident interview with individuals who can at least partially participate in the interview. Family members can also act as the resident’s proxy when appropriate.9 This requirement is intended to stimulate more participation of residents in their care choices.9

The [American Association of Nurse Assessment Coordinators](http://www.aanac.org/) is a valuable organizational resource for nurses in long-term care. The organization offers education, advocacy and networking opportunities, including online education about long-term care documentation and other issues.

The quality of nursing documentation in long-term care is critical for reimbursement.2,8 Patient records must clearly reflect the level of care the patient receives. For example, if you provide care for a patient with a pressure ulcer, Medicare requires documentation that describes daily activity; skin condition; turning and positioning measures; the ulcer’s size, site and degree of healing; the patient’s nutritional status; and any other relevant factors.5

**Documentation in Home Care**

The increasing aging of the U.S. population and the availability of sophisticated home care equipment are among the factors that have spurred significant growth in home healthcare services.2 As with acute and long-term care, state and federal law and agencies regulate home healthcare agencies.8 Nursing services provided in a patient’s home range from caretaking and help with basic ADLs to highly complex and advanced interventions, such as IV therapy via central and peripheral lines, mechanical ventilation and chemotherapy. In no other healthcare setting is the nurse as responsible to ensure reimbursement as in home health.10 The ability to receive appropriate reimbursement for services depends on the nurse’s documentation skills. For this reason, home healthcare organizations have a highly structured documentation system. Medicare’s conditions of participation strongly influence the documentation required. The table below outlines criteria for a patient to receive Medicare reimbursement for home healthcare services.

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| --- |
| **Criteria for Medicare Reimbursementfor Home Healthcare** * Patient must be confined to the home.
* Patient must need skilled services on an intermittent basis.
* Care must be reasonable and medically necessary.
* Patient must be under a physician’s care.

**Source:** *Complete Guide to Documentation.* Springhouse, PA: Lippincott Williams & Wilkins; 2008. |

To increase efficiency and to meet licensing, accreditation and reimbursement requirements, most home healthcare agencies use visit sheets and physical discomfort forms for each patient rather than narrative notes.8 Home health documentation includes any referral for home care services, Medicare and Medicaid forms, patient assessments including the Outcome and Assessment Information Set B (OASIS-B), a plan of care, medical update, progress notes, nursing summaries, patient or caregiver teaching, recertification, a discharge summary and referral to community resources.10 The OASIS-B is critical to reimbursement.

One study examined the quality of home care nurses’ documentation using electronic patient records.11 ([Level B](http://ce.nurse.com/ebp.aspx)) Although the current emphasis is to include patient participation, this study pointed out the need for nurses to more effectively address and document patient communication.11

**Review Questions**

1. Narrative charting makes following a patient’s progress easy.
True false

2. The statement “I think my father is hard of hearing” is an example of a subjective statement in a problem-oriented documentation format.
True false

3. A major advantage of problem-oriented documentation is increased communication among healthcare team members about common issues.
True False

4. Joint Commission standards require that a patient’s initial assessment address the patient’s physical and psychological status.
True False

5. To minimize legal risks when using a charting-by-exception format, you should supplement charting with progress notes when necessary.
True False

**Answers to Chapter Review Questions**

1. False

2. True

3. True

4. True

5. True

**Chapter 3: How to Document in Challenging Situations**

After studying the information presented here, you will be able:

* Explain how to document a patient’s refusal of treatment or decision to leave against medical advice
* Discuss documentation requirements for a patient advance directive
* State how to report understaffing or negligent practice by a colleague
* Identify the registered nurse’s responsibility when documenting care given by an unlicensed staff member

Because of their legal significance, certain patient care situations present unique documentation challenges. This chapter describes generally acceptable nursing practice for how to document in challenging situations. Readers should also consult their state nurse practice acts and policies and procedures of the healthcare agencies that employ them. In all instances, you should understand and follow the requirements of your state’s nurse practice act and your organization’s documentation policies.

**Refusal of Treatment or Failure to Follow Restrictions**

Any mentally competent adult can legally refuse treatment if fully informed about his or her medical condition and the likely consequences of refusal.1-4 If a competent person refuses treatment, the only way he or she can receive treatment is by a court order that overrules the patient’s decision. When a patient refuses any type of prescribed treatment, such as a prescribed diet, talk to the patient to try to determine why he or she is refusing and explain why it is important to continue therapy and the risks of refusal.1 For example, a patient may find a medication adverse effects distressing; in many situations, such adverse effects can be decreased by other strategies.

If the patient still refuses, notify his or her physician. Chart the date and time and the patient’s own words in quotes that detail his or her reasons for treatment refusal in the progress notes.2-5 Document that you didn’t administer a prescribed treatment because of the patient’s refusal, and if your facility has a refusal of treatment release form, ask the patient to sign it. If the patient refuses to sign the form, chart the refusal to sign in the progress notes.2,3,5 Your facility’s policy may direct you to ask the patient’s spouse or next of kin to also sign a refusal-of-treatment form.2,3,5,6 If your facility doesn’t have a form, document refusal of treatment and fill out an incident report.

**Against Medical Advice**

The ultimate form of treatment refusal is a patient’s decision to leave a healthcare facility against medical advice, or AMA.3,7 Although a competent adult patient can choose to leave a healthcare facility at any time, the law requires clear evidence that the patient is functionally competent to make the choice. In most situations, an AMA form serves as a legal document that protects you, the physician and the healthcare facility from problems that may occur because of the patient’s unadvised discharge. An AMA form should clearly indicate that the patient understands that he or she is leaving the facility against medical advice, that the patient has been advised of the risks and that the patient knows that he or she has the right to return.2,4,6 Indicate the results of any standardized tools used in assessment, including mental status. If a patient refuses to sign the AMA form, use the patient’s exact words to document the refusal to sign in the progress notes. The table below shows important details to document when a patient leaves AMA.

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| --- |
| **What to Document When a Patient LeavesAgainst Medical Advice** * Patient’s reason for leaving AMA
* Names of designated emergency contacts, usually relatives or significant others notified of the patient’s decision, including dates and times these people were notified
* Explanation of the risks or consequences of the AMA discharge, including name of person who provided this information to patient
* Instructions about alternative sources of follow-up care given to the patient
* List of those accompanying the patient at discharge and instructions given to them
* Patient’s destination after discharge
* Notification of the patient’s physician of AMA discharge

**Source:** *Charting Made Incredibly Easy.* 2nd ed. Philadelphia, PA: Lippincott, Williams & Wilkins; 2002:250. *Mastering Documentation.* 2nd ed. Springhouse, PA: Springhouse Corp.; 1999:321. |

Be sure to chart any statements or actions that reflect the patient’s mental status at the time he or she decides to leave AMA. These written observations may help protect you, the physician and the healthcare facility against a future charge of negligence.2 Keep in mind that although a patient leaves AMA, his or her rights to discharge planning and knowledge about follow-up care are the same as those of a patient who has been discharged on medical advice. Your facility may require an incident report as well as the AMA form and documentation of the AMA discharge in the progress notes.2,4,6

**Incident Reports**

In healthcare, an incident is an event inconsistent with the facility’s ordinary routine regardless of whether someone is injured.7,8 In most healthcare facilities, any injury to a patient requires an incident report. Patient complaints, medication or treatment errors and injuries to employees and visitors also require incident reports. The primary purpose of an incident report is to inform the healthcare agency’s administrators of the incident to help prevent similar incidents in the future. An incident report also alerts administration and the facility’s insurance carrier to the possibility of a liability claim and the need for further investigation.2 As a nurse, you have a duty to report any incident about which you have firsthand knowledge. An incident report is not part of the patient’s permanent medical record and should not be a disciplinary tool for you.3 However, if you don’t report an incident, you may be subject to disciplinary action and increase your risk of personal liability, especially if your failure to report an incident relates to a patient injury.4

|  |
| --- |
| **What to Document in an Incident Report** * The exact time and place of the incident
* The names of the people involved and any witnesses
* Factual information about what happened and the consequences to the person involved
* Actions to protect the person involved, e.g., notifying the patient’s physician, helping a patient back to bed

**Source:** *Chart Smart: The A to Z Guide to Better Nursing Documentation.* Springhouse, PA: Springhouse Corp.; 2008.  |

When you file an incident report, provide objective details about the incident, avoid hearsay and assumptions, and don’t admit to liability.2 Describe exactly what you saw and heard, including your actions to provide care at the scene, such as help in returning the patient to bed. Don’t use a patient incident report to blame colleagues or administrators or to complain about staffing issues. For example, don’t write a statement such as “Assigning this patient to a more experienced nurse would have prevented this incident” or “The side rails were left down as usual by the night shift.”

Don’t document the incident report in the patient’s record as this action destroys the confidential status of the report and may render the incident report open to discovery by the patient’s attorney.7 Include in the incident report and progress note any statements made by the patient or family about their roles in the incident. For example, if the patient says he was reminded not to leave his bed, document, “Patient stated: ‘The nurse reminded me not to get up without help, but I decided to go on my own.’”

Documentation for this type of information helps a defense attorney demonstrate that the patient may be fully or partially at fault in the situation. If a jury finds that the patient had some culpability, damages could be reduced or eliminated. If an injury occurs to one of your patients in another department, the staff members in that department who have firsthand knowledge about the details of the incident have the responsibility of reporting the incident. Regardless of who reports incidents, send all incident reports promptly to the person in your facility whose responsibility it is to review them.

**Advance Directives**

An advance directive (AD) is a legal document that is a guideline for the application of life-sustaining medical care for a patient incapable of indicating his or her own wishes.2,7,9 An advance directive becomes active only if the conditions under which the patient defines activation occur, such as a permanent unconscious state or a terminal condition. The basic principle for advance directive planning is that an adult has a right to decide what happens to his or her body. An advance directive is the written expression of that right and is enforceable in a court of law.3,10 Advance directives include living wills, documents that instruct a physician to withhold life-sustaining treatment and durable powers of attorney for healthcare documents that name another person to act on the patient’s behalf in the event that the patient can’t act for himself or herself.

Because laws vary from state to state, find out how your state’s laws apply to your practice. If the patient has an advance directive, place a copy of it in the patient’s chart and make sure the physician is aware of the contents. Document that the patient has an advance directive and include the name, address and telephone number of the healthcare decision-maker surrogate or durable power of attorney.3,7,9,10 If the patient doesn’t have an advance directive, document that the patient was given written information about his or her rights under the law to execute an advance directive.5 This documentation is usually part of the admission assessment process and is a requirement of The Joint Commission.

In most states, the advance directive is a legal document that patients formulate while they are of sound mind to specify their wishes should they become incapacitated and unable to make their own decisions. Ideally, patients discuss their feelings and desires with their family members, and family members agree to honor patients’ desires.3,9,10,11 ([Level B](http://ce.nurse.com/ebp.aspx)) But sometimes the family doesn’t agree with a patient’s treatment preferences. If this occurs, the legality of the advance directive supersedes family rights. You can encourage family members to discuss their feelings with the patient and the patient’s physician, or you may refer them for counseling. If family members contest the advance directive, document any conversation you have with them, and record their exact words in quotes. Also notify the patient’s physician and your nursing supervisor and document their notification and the date and time they were contacted.7,10

For a variety of reasons, many patients wait until their hospitalization to consider executing an advance directive or to make significant legal decisions.7,9,12 In most states, medical record documentation of a competent patient’s spoken wishes is as valid as a written advance directive.3,9,10 If a patient wants to execute an advance directive during his or her hospital stay, you aren’t required, or even allowed in some states, to sign as a witness. Ideally, advance directives undergo an annual review and updates occur as necessary. The patient may revoke the advance directive at any time orally or in writing. Make sure you follow your facility’s guidelines about how to handle the revocation of an advance directive, including how to document that the patient wishes to revoke an existing advance directive.3,4

**Difficult Patients**

Document carefully when you care for patients who seem unhappy with their care or who threaten to sue you or your agency.6 You can often recognize difficult patients by their angry behavior, consistent complaints and lack of response to friendly remarks. Communicate with a difficult patient even if he or she does not respond. Offer to talk to the patient about why he or she is upset. However, don’t argue with the patient or try to convince the patient that a situation didn’t happen the way he or she thinks it did. Use the patient’s own words in quotes to document the patient’s concerns, e.g., “No one comes when I put on my call light — I have to wait hours.” Record the specific care you give to the patient in direct response to his or her complaints, e.g., “Reassured patient that staff will watch for his call light and respond as quickly as possible.”

Record behavior, but don’t label the patient “difficult.” If a legal situation occurs, this label can be evidence of prejudice against the patient on the part of the caregiver. If the patient threatens to sue you or the hospital, document the threat and notify your nursing supervisor or your facility’s legal department.7 Continue to care for the patient; do not allow a threat of legal action to change your practice.

**How to Document Understaffing**

Understaffing occurs when a facility’s administration fails to provide enough professionally trained personnel to meet the needs of specific patient populations.7 To determine whether your unit has too few nurses or too few specially trained nurses may be difficult. The few guidelines that exist vary from state to state and are generally limited to specialty care units. The Joint Commission sets no specific nurse-patient ratios, but states generally that an organization should provide an adequate number of qualified staff.

If you believe that you or nurses on your unit do not have enough staff to provide safe patient care, notify your manager or nursing supervisor at once. Be specific about the unmet patient needs and the type and number of staff members you need. If the nursing supervisor can’t or won’t provide more staff, go up the chain of command.7 If the situation remains unresolved, provide patient care to the best of your ability and take notes about how understaffing affects your ability to meet patient needs during your shift. Record the name of the nursing supervisor you notified about understaffing, the time of the conversation, exactly what you reported and the supervisor’s response. Include the names of other administrators you notified, the times they were notified and their responses. Don’t leave your unit to go home or fail to provide care, because you could be charged with patient abandonment.7 Do not document the staffing issue in the patient’s medical record.

After your shift, use your notes to write an incident report or memo to your director of nursing. Document what happened, what you did to correct the situation, whom you called and when, and their responses. Keep a copy of the memo and send the original to the chief nurse executive. A written report does not guarantee to absolve you from liability if a patient injury occurs during your shift. You may still be liable, especially if you could have foreseen and prevented the injury. But a written report may provide you with a defense if the alleged negligence involves something you should have done but couldn’t because of lack of staffing.3,7 Many organizations have staffing variances that become part of performance improvement efforts in the area of staffing ratios. Some organizations have a “protest of assignment” form that serves the same purpose as an incident report or written memo.3

**How to Document Negligent or Unsafe Practice**

The nurse practice act in each state emphasizes the obligation of nurses to protect patients from harm. A part of that obligation is to report unsafe or negligent practice by a colleague.3,7 A nurse who reports a negligent colleague is legally protected by the doctrine of qualified privilege — a provision that protects a nurse who reports negligent practice from charges of libel (written defamation of character) or slander (oral defamation of character) to serve as a patient advocate.3,7 Consult your facility’s policies for how to make these reports.

Most healthcare facilities require an incident report for cases of suspected negligent or unsafe practice. You should also report the incident to your supervisor. To describe negligent practice in an incident report, use objective wording and describe only the specific incident and behavior. Include statements from witnesses, the names and titles of people you interviewed about the incident, and the names of people you notified, e.g., your supervisor and the patient’s physician. Describe your actions to prevent further injury to the patient. Don’t record that you filed an incident report in the patient’s chart, but do document your interventions to minimize harm to the patient.3,7

**Physician Orders**

Mistakes in patient care and an increase in nursing liability can occur when there are errors in the interpretation and documentation of physician orders.2,4,5 Double-check all written physician orders and clarify them if necessary. Preprinted orders must be personalized for each patient’s need.2 Telephone and verbal orders may constitute a majority of all medical orders in many organizations as nurses respond to changes in patients’ conditions that require medical interventions when a physician or credentialed physician assistant or nurse practitioner may not be inhouse.

The Joint Commission, in conjunction with its emphasis to improve patient safety, has recommended practices for telephone orders. Because orders by telephone are usually implemented quickly, the ordering physician doesn’t have the opportunity to intervene if an order is misunderstood. When you accept a telephone or verbal order, have the patient’s medical record available to record the order as it is spoken. Nurses should read the order as they have written it to the physician and have the physician acknowledge the accuracy of the order that has been read back to him or her. This is a new Joint Commission requirement. It is unsafe to restate verbally the physician order and record the order later in the medical record.10

Make sure the physician countersigns the telephone or verbal order within time limits set by your facility. Without this countersignature, you may be liable for practicing medicine without a license.3 In most cases, do-not-resuscitate orders shouldn’t be taken verbally.5

**Unlicensed Assistive Personnel**

The American Nurses Association defines unlicensed assistive personnel as people trained to function in an assistive role to registered nurses to provide patient care activities.2,3,7 The nurse supervises and delegates tasks to the UAP. Delegate only care tasks that UAPs are competent to perform and are within their scope of practice and job description. It is the nurse’s responsibility to assess the patient, evaluate the care and ensure that accurate documentation is in the patient’s medical record.

Your documentation responsibilities depend on your facility’s policies. If your facility doesn’t allow UAPs to document, you must evaluate what care was provided and document your findings. If UAPs may document their care, you will need to countersign their documentation. Your countersignature indicates that documentation in the medical record describes care that the UAP had the authority and competency to perform and that you agree with the UAP’s documentation.3,7 If your facility’s policy says UAPs must provide care in your presence, don’t countersign unless you witness care as it is provided.3,7

**Review Questions**

1. Documenting the mental status of a patient who decides to leave against medical advice is not appropriate.
True false

2. You may be subject to disciplinary action if you don’t report an incident about which you have firsthand knowledge.
True false

3. After you report an incident, document the incident report in the patient’s medical record.
True False

**Answers to Chapter Review Questions**

1. False

2. True

3. False

**Chapter 4: Will Your Documentation Stand Up in Court?**

After studying the information presented here, you will be able:

* Explain the value of documentation that is legally credible
* Discuss laws and standards that govern nursing documentation
* Recognize legal basics for appropriate documentation
* Discuss strategies to document changes in a patient’s condition

It’s likely that one of your nursing colleagues will become involved in a professional liability lawsuit or you will know another nurse who is sued.1 If you are asked to testify in a legal action, you may need to recall details that occurred months or years ago. Without an accurate and legible medical record, you may be unable to defend yourself against allegations of improper care.2,3 Effective documentation can be your best defense if you’re named in a lawsuit and may even support its dismissal.4 Three recent legal decisions emphasize the vital importance of nursing documentation.5-7

In one case, the court found for the parents of a 1-month-old infant whose IV infusion had infiltrated, causing a permanent muscle injury. In this case, there was more than a two-hour gap in the nursing progress notes from one entry to the next. The court found that the site should have been checked every 30 minutes. The nurse claimed that the site had been checked, but written proof of regular assessment was missing.5 In another case, a patient sued, claiming that OR staff incorrectly placed a blood pressure cuff on the same arm where he had a peripherally inserted central venous catheter. This suit was dismissed based on the circulating nurse’s documentation that the blood pressure cuff had been placed on the arm without the catheter. The circulating nurse was the only OR team member who had documented which arm was used for blood pressure measurement.6 In another court case, a jury returned a defense verdict for a hospital based on complete and accurate nursing assessment of a patient’s fall risk and steps taken to prevent a fall.7

The table below lists examples of recent court decisions from the [Legal Eagle Newsletter for the Nursing Profession](http://www.nursinglawcom/) in which nursing documentation was vital in deciding whether a nurse or organization was responsible for a patient’s injury or death.

|  |
| --- |
| **Recent Court Decisions Involving Nursing Documentation** * PEG feeding, aspiration: nurse’s late-entry progress note fails to persuade the jury (December 2010)
* Postsurgical care – changes in neurological status not reported (August 2010)
* Cardiac care – nurse failed to report status, held partially to blame for patient’s death (July 2010)
* Labor and delivery: critical evidence missing from chart, court validates right to sue (May 2010)
* Falsification of records – nurse did not perform assessment herself; nurse’s firing upheld (May 2010)
* Neurosurgical patient’s status changed – nurse failed to access chain of command (April 2010)
* Labor and delivery – nurse did not report monitor tracings to physician (March 2010)
* Skin care – two sets of medical records; jury awards damages (March 2011)
* Labor and delivery – good nursing documentation; no negligence found (April 2011)
 |

**Legally Credible Documentation**

Most malpractice lawsuits that involve nurses are civil cases that try to prove that a nurse’s negligent care resulted in injury to a patient. The law defines “negligence” as failure to provide a patient with the standard of care that a reasonably prudent nurse would exercise under the same or similar circumstances.1,8 To prove that a nurse was negligent, the patient’s attorney must prove these four elements:

* The nurse had a duty to provide care to the patient and to follow an acceptable standard of care.
* The nurse failed to adhere to the standard of care.
* The nurse’s failure to adhere to the standard of care caused the patient’s injuries.
* The patient suffered damages as a result of the nurse’s negligent actions.1,3,8

If you face an allegation of negligence or improper conduct, your documentation can make or break your case. Your contention that your care was appropriate is significantly weakened if you didn’t document or if your documentation doesn’t clearly show that you met the standard of care. Without black-and-white evidence as written in the medical record, you must rely on your ability as a witness to convince a judge or jury that you gave appropriate care despite your failure to document it.1

Charting errors and omissions are a significant source of liability risk for nurses. During a trial, the patient’s attorney will use documentation to try to prove that the standard of care wasn’t met. An accurate medical record is worth its weight in gold because appropriate documentation provides evidence that you met the standard of care.2

**Laws and Standards**

The U.S. legal system helps nurses demonstrate appropriate nursing care through their documentation.9 Standards developed by state laws, the nursing profession and accrediting organizations, such as The Joint Commission, determine the type of nursing information that needs to be in the medical record.3

Each state has a nurse practice act that authorizes a person to practice as a registered nurse if the applicant meets specific criteria. Laws or administrative rules in each state further outline documentation issues, such as handling of records, falsification of records and confidentiality.10 Regardless of your work setting or specialty, you must document care based on the requirements of your state’s nurse practice act. For information on your state’s nurse practice act, contact the National Council of State Boards of Nursing.

|  |
| --- |
| **Sources of Documentation Standards** * The Joint Commission
* National professional standards
* Specialty nursing organizations
* States nurse practice act and administrative codes or rules
* The facility that employs you
* Code of ethics
 |

In addition to the laws that govern documentation, you must adhere to professional standards, such the American Nurses Association standards.10 If you practice in a nursing specialty area, you must be familiar and demonstrate compliance with the documentation standards for your specialty organization. The Joint Commission publishes widely accepted professional and documentation standards. Although The Joint Commission doesn’t require a particular documentation format, it does require each health facility to adopt a format that conforms to its standards.3 The ANA and Joint Commission standards are much more stringent than state laws. The ANA standards of nursing practice require that you base your documentation on the nursing process, that it should be continuous and that it should be accessible to all members of the healthcare team.3 Because the ANA standards reflect a national practice consensus, they carry a great deal of weight in court.3

You must also follow the documentation policies of the facility that employs you. Most facilities develop internal documentation policies and procedures based on state law, professional nursing standards and Joint Commission requirements. For example, your facility’s documentation policies should identify how often you should document, which staff members are responsible for charting in each part of a patient’s record, as well as the acceptable charting techniques and procedures.2 If your facility’s standards are less strict than those of your state’s nurse practice act, you must adhere to the higher standard.9 Allegations that harm was caused related to a medication error is one of the most common causes of negligence claims against nurses.8 Because of this, know and follow your organization’s medication administration policies; this is even more important when high-risk medications are involved.8

**Legal Basics**

There are certain legal basics that form a foundation for effective documentation. The adage “if it wasn’t documented, it wasn’t done” is as valuable today as it was when you learned it in nursing school.

Organize your documentation by the nursing process — assessment, planning, nursing diagnosis, interventions and evaluation. Your charting should leave no question in a future reader’s mind that you continually assessed your patient’s condition, provided appropriate care and supervised others in providing aspects of care and carefully monitored his or her progress. To ensure legal credibility, make sure your charting is timely, accurate, truthful and appropriate. Timely documentation means documenting care as soon as possible. Although charting intervals will vary by healthcare settings, regular charting entries demonstrate that you checked your patient’s condition frequently.3,11,12 Don’t wait until the end of your shift to document; you may not recall important details or eliminate potentially important information.

Accurate documentation means that you document the facts about patient care. Chart only what you see, hear, smell or feel. Document only the care that you give or, depending on your facility’s policy, document only the care that an unlicensed assistive staff member gives and that you observed or evaluated. Write specific, accurate descriptions. For example, charting “Bright red blood 18 cm in diameter on bed linens” is much more specific than charting “bed soaked with blood.”7 Don’t use meaningless expressions such as “patient had a good night” or “appears” or “seems” or “quantity “sufficient.”

Truthful documentation avoids assumptions and documents only what you actually observe. Appropriate documentation refers to statements you consider acceptable for public scrutiny.4 Follow your facility’s documentation policies on issues such as late entries, legible charting, record confidentiality, blank lines, approved abbreviations, cosigning and patient refusal of treatment. Document any safety precautions you implement, such as to raise side rails. Keep comments about other staff members, allegations of inadequate care or references to staffing problems out of the patient’s medical record.

Patient confidentiality is another vital legal basic. Nurses have always had a major role to maintain confidentiality and protect the privacy of a patient’s medical record. With the passage of the Health Insurance Portability and Accountability Act of 1996, this role is even more important. The goal of [HIPAA](http://ce.nurse.com/ce.nurse.com/ce513) is to provide safeguards against the inappropriate use of protected health information, including all medical records and identifiable health information in any form — paper, electronic or transmitted orally9-12 It is a requirement that employers give nurses training on HIPAA policies and procedures for their facilities.

Some information, such as mental health records and information about infectious diseases and substance abuse, is further regulated by state law.12 To protect patient confidentiality, do not discuss patient issues in public areas, close and secure patient medical records when not in use and dispose of unneeded identifiable patient information properly. (See Chapter 5 for suggestions on how to avoid technology-related violations of patient confidentiality.)

Once litigation has begun, do not add information to a patient’s medical record. Handwriting experts can determine when entries were made. If you suspect that another healthcare professional has made illegal changes to a patient’s chart, notify your nursing supervisor. And do not change your notes if a colleague requests you to do so.2

Evidence of tampering with a patient’s chart is not only illegal, but can cause the medical record to be inadmissible as evidence in court.2 The table below shows examples of illegal tampering or alterations to the medical record.

|  |
| --- |
| **Illegal Tampering With Medical Records** * Adding to another person’s note
* Adding to previous notes and not indicating that the note is a late entry
* Destroying the patient’s chart
* Documenting inaccuracies deliberately
* Omitting significant facts
* Writing an inaccurate date or time

**Source:** *Mosby’s Surefire Documentation: How, What, and When Nurses Need to Document.* 2nd ed. St. Louis, MO: Mosby Elsevier; 2006:332. |

You may also be subject to charges of falsification of records and fraud if you document care that hasn’t been provided, which may be an issue with electronic record defaults. Charting medication administration, dressing changes or other treatments in advance all constitute falsification of records.10 The only component of the nursing process that can be documented before it is done is the plan of care. All other observations and activities must be charted only after you assess or evaluate the patient or perform an intervention.10 When you write your initials on a medication record, your initials indicate that you gave medication to the patient, not just removed it from the drawer. If you initial the record before you give the patient medication, you expose yourself to legal risk.

With barcode medication administration, the nurse scans the patient’s wristband and the drug at the bedside before giving it to the patient. The nurse should not in the record if the patient then refuses the medication.

If your facility uses a charting by exception format, take extra precautions. In a CBE system, only exceptions to expected observations are charted. Because the minimal documentation in a CBE system is risky, use well-designed flow sheets. If the CBE documentation doesn’t give a clear, accurate description of the patient’s condition, write it in a narrative note. If you’re asked to testify several years later, you’ll be able to reconstruct an accurate picture of your patient’s condition from the narrative note.9,13

Certain types of charting actually increase your legal risk, such as a failure to describe clearly situations that are out of the ordinary.13 Another documentation practice that increases risk is the expression of a negative view or animosity toward a patient. To describe a patient’s behavior as “uncooperative,” “difficult,” “noncompliant” or “manipulative” or to refer to the patient in a sarcastic manner are excellent ways to alert the patient’s attorneys that a nurse did not respect or value the patient.8,11 Although a negative label for a patient may reflect a nurse’s frustration, consider its effect in a chart projected on a screen in a courtroom.4 Describe a patient’s behavior factually and impartially.

**Critical Incidents**

Critical incidents are often the basis for legal actions against nurses and hospitals. In many instances, the precipitating event that results in a lawsuit is poor communication and documentation.14 Good documentation is especially important to mount an effective defense against an allegation of negligence or malpractice. In one case, based on the timelines and quality of nursing documentation, a court found that neither the hospital nor nurses were liable for postoperative spinal cord compression.15

Documenting care as you provide it is especially important when you’re charting in an emergency. Record what time you called the provider or the rapid response team. If possible, ask another nurse to record events as they occur during the emergency. If you don’t have a recorder, keep a running log of notes rather than rely on your memory to reconstruct events after the emergency. Make sure your documentation addresses the issues in the table below.

|  |
| --- |
| **What to Report When a Patient’s Condition Changes** * What was the patient’s condition before the emergency?
* What was the patient’s condition when the emergency began?
* When did the emergency occur?
* When was the physician notified?
* What were the interventions and when were they started?
* How did the patient respond to the interventions

**Source:** Adapted from: Nurses Service Organization. How to protect yourself from malpractice. *Nurs.* 1998;28(12):5. |

You place yourself at great legal risk when you don’t assess or monitor patients regularly or when you don’t report a significant change in condition. Situations in which nurses have been liable for failure to observe and report include when a patient’s condition undergoes a rapid change, such as after surgery or during labor; after the patient suffers an injury in the facility; and when the patient has known self-destructive tendencies.12 Accusations of failure to observe and monitor adequately can be substantially countered by accurate, detailed documentation.16

Numerous legal cases involve a nurse’s failure to notify the physician in a timely manner about changes in a patient’s condition. These cases are often extremely serious; the results were death and permanent disability.3 As a nurse, you have a duty to intervene on your patient’s behalf. Often, your intervention is to contact the physician about a change in the patient’s condition and to carry out the therapy the physician prescribes. But your legal obligation as a patient advocate goes beyond carrying out treatment. If in your professional judgment the physician’s orders place a patient in jeopardy, you must intervene on behalf of the patient and clarify the treatment plan with the physician.16

Some malpractice cases have hinged on whether the nurse was persistent enough in attempts to notify the physician or to convince him or her of the seriousness of the situation. When necessary, a nurse should contact a nursing supervisor or go up the chain of command when he or she questions an inappropriate physician order. A nurse who fails to continue to question inappropriate orders can be liable for failure to intervene because the intervention was below what is expected of a nurse as a patient advocate.16

It is vital to communicate any significant change in a patient’s condition.14 When communicating with a patient’s healthcare provider, plan and organize data in a clear and logical manner that helps paint a clear picture of the patient situation.17 The SBAR technique, developed at Kaiser Permanente of Colorado, is an example of how to organize communication about a patient’s changing status or request for a change in therapy.18 The acronym SBAR stands for situation, what’s the problem; background, pertinent to current situation; assessment; and recommendation, the action requested. The SBAR framework helps nurses develop a clear picture of a patient’s changing condition or needs. The [Institute for Healthcare Improvement](http://www.ihi.org/) provides more detailed information about the SBAR communication technique.

Your communication may be with an on-call physician or other provider instead of the patient’s primary physician. Because this provider may not be familiar with the patient, you must summarize the patient’s background clearly before you describe the problem.11 The table below outlines a way to organize data before you contact the physician. With this information as situation and background, you can apply the “A” (assessment) and “R” (recommendations) of the SBAR strategy to advocate on behalf of the patient.

|  |
| --- |
| **How to Organize Your Reporting Data** * Patient’s history — present illness and/or surgery, medications, significant comorbidities
* Assessment —
	+ Complete set of vital signs
	+ Change in level of consciousness
	+ Changes in perfusion as indicated by skin color, oxygen saturation, and urine output
	+ Pain out of proportion to the diagnosis or procedure
	+ Unusual behavior: irritability, hallucinations, agitation, sense of impending doom
	+ Change in a wound or drainage status
	+ Relevant diagnostic test results

**Source:** Carelock J, Innerarity S. Critical incidents: effective communication and documentation. *Crit Care Nurs Q.* 2001;23(4):60. |

When you call the physician, don’t apologize and don’t make him or her fill in the blanks or guess what you really mean.14 Some nurse experts report that there is evidence that nurses continue to use indirect communication and defer to physicians to avoid conflict.15 Be clear about why you’ve called rather than give the physician a list of findings for him or her to interpret.14

Document each time you place a call, even if you don’t talk to the physician.3 Document the name of the person you spoke to, not just “spoke with Dr.” or “spoke with resident.” When you talk to the physician, chart the details of your message and the physician’s response.3 If you believe the physician’s response is inappropriate, add documentation as a legal safeguard.14 Note specifically the details you reported, the time you called, the time that new orders or no orders were received, and the actions you take.2 If you don’t note the time you called, allegations could be made later that you failed to obtain timely medical treatment for the patient.

Always note in the chart the specific change in the patient’s condition or diagnostic test result that prompted your call to the physician. If you’re reporting a crucial lab result, such as a high glucose level but don’t receive an order for intervention, verify with the physician that he or she doesn’t want to give an order. Your charting should note: “Dr. Green notified of blood glucose of 220 mg. No orders received.”

Reducing your legal risk is important in today’s healthcare climate, in which patients are sicker and more likely to have poor outcomes. Documentation that reflects the nursing process — including competent assessment, frequent observation, timely and accurate reporting, and the use of the chain of command if necessary — will often protect the nurse from accusations of negligence, even when there is a poor outcome.14 A patient’s medical record and what’s documented in it is the single most important tool available to a nurse facing a charge of negligence.14 Legally credible documentation provides an accurate written record of the care your patient received and evidence that you met an acceptable standard of care. It tells anyone who reads it that you did all you were expected to do.4

When you are familiar with your state’s nurse practice act, follow professional standards for documentation, and adhere to your facility’s policies and procedures, you can provide your patient quality nursing care while you protect yourself and your employer from legal action.

**Review Questions**

1. Your memory is as valuable as your documentation when you testify in a legal action.
True False

2. Regardless of your work setting or specialty, you must document based on the requirements of your state’s nurse practice act.
True False

3. The American Nurses Association and Joint Commission standards are less strict than state law.
True False

4. When you save time to chart at the end of your shift, it will allow you to document care more accurately.
True False

5. The law interprets nursing observations and interventions that are not documented as not done.
True False

**Answers to Chapter Review Questions**

1. False

2. True

3. False

4. False

5. True

**Chapter 5: Technology and Time**

After studying the information presented here, you will be able:

* Discuss advantages and disadvantages of a computerized documentation system
* Describe how computerized documentation affects home healthcare
* Discuss the relationship between computerized documentation systems and the nursing process
* Explain the goal of the Nursing Minimum Data Set
* Identify strategies to protect patient confidentiality when you use a computerized documentation system
* Describe ways to save time when you document

In today’s healthcare environment, technology plays a significant role in documentation. Healthcare organizations increasingly use computerized documentation systems to improve documentation efficiency and effectivness.1 In the past few years, computerized patient records have developed from basic documentation systems to complex, integrated electronic records.2

Nurses are on the cutting edge of documentation technology, with some making nursing informatics their area of expertise. In 1992, the American Nurses Association recognized nursing informatics as a nursing specialty.3

Nurses who are interested in nursing informatics can contact the [American Nursing Informatics Association](http://www.ania.org/). This organization publishes the journal CIN: Computers Informatics Nursing, which provides information and research on informatics applications for nursing.

Experts in nursing informatics believe that all nurses should be informed users of electronic record systems and should understand the importance of standard documentation language and nursing classifications systems as well as the basic operation of the systems in everyday clinical practice.2 A recent study emphasized the need to establish a baseline of informatics competencies for the nursing workforce as vital for expanding into an electronic healthcare delivery era.4

**Advantages and Disadvantages**

As with other technological advances, computers have both advantages and disadvantages. Here are some advantages of computerized documentation systems.1,5,6 The systems:

* Store and retrieve information quickly, simply and reliably
* Update information consistently and efficiently
* Link sources of patient information
* Use standardized terminology
* Promote communication among healthcare team members
* Facilitate transmission of request slips and patient information between departments
* Protect patient confidentiality
* Provide legible and grammatically correct documentation
* Contain valuable data on patient populations

The advantages of using electronic documentation over handwritten notes include accurate and timely charting, easier access to patient information and more efficient and legible patient information.7 Disadvantages include reliance on electricity and electrical outlets, limited numbers of terminals and staff’s lack of familiarity and confidence with computer technology.7

A large server can store information for all the departments in a healthcare facility. Personal computers or terminals at workstations allow staff members to access patient information and to contribute to the medical record. Some hospitals add terminals at patients’ bedsides, which makes access even easier.

At a bedside computer terminal, the nurse can document as soon as he or she makes an assessment or provides care. When the nurse no longer needs to write patient data on a worksheet and later transfer the information to the patient’s chart, he or she saves valuable nursing time.5

Depending on the software, the nurse can use a keyboard, a light pen, a touch-sensitive screen, a mouse or his or her voice to enter information in the patient’s chart. Most systems provide a selection of words or phrases that the nurse can choose to personalize documentation for each patient in a standardized format.5

Voice-activated systems are used in departments that have a high volume of structured or routine reports, such as the OR. These software programs use a specialized knowledge base, including nursing terms and phrases together with automated speech recognition technology.6 An automated speech recognition system requires little or no keyboard use and allows the user to record nursing notes into a telephone handset. The system displays the text on the computer screen. These systems increase reporting speed and reduce nursing paperwork.6

Real-time clinical and operational report writing and Internet-based self-scheduling are other computer applications are options with some systems.8

Computerized systems can speed up documentation. When the patient’s medical record is on the screen, the nurse selects the function. For example, the nurse can enter new data on a plan of care, read or update progress notes or compare a sequence of vital signs. To the extent possible, automated documentation systems should be less time-consuming than comparable manual systems.3 One study showed that using an electronic documentation system reduced the amount of time nurses spent documenting by 12%, allowing them more time for direct patient care.9 ([Level B](http://ce.nurse.com/ebp.aspx))

Computerized documentation systems have features that help protect patient confidentiality.5,10 To gain access to a medical record, a healthcare team member must enter an identification code, which may require updating at regular intervals. The codes may even specify the type of access to information that a particular team member has. For example, a code for a dietitian may allow him or her to see diet orders, the patient’s history and laboratory values, but not physical therapy information or the results of diagnostic tests that do not affect nutritional status.11 Remember that any documentation in the patient’s automated record is a permanent part of the record, so it is vital that you follow your organization’s documentation policies.

The ability of computerized documentation technology to speed up and streamline paperwork has had a major effect in home healthcare. Computer notebooks and portable devices that contain both hardware and software continue to grow in popularity in home healthcare settings; these devices facilitate documentation for routine services.1,5 Computerized documentation also increases charting uniformity and thoroughness and promotes timely updates that speed up reimbursement. With a portable computer, a home healthcare nurse can document data and fill out forms during the home visit.1,5

Computerized systems also have disadvantages.1 Some systems:

* May scramble patient information if used improperly
* Can interfere with a patient’s right to confidentiality if security measures aren’t followed
* May break down, which causes important information to be temporarily unavailable
* May be expensive
* Can restrict the accuracy of information if the computer restricts vocabulary or phrasing
* Can increase documentation time if too few terminals are available

The move to a computerized information system must be done carefully. Overly complex care plans with long lists of real and potential problems can actually increase documentation time. Nursing documentation software often requires purchasing organizations to customize the software based on their goals, philosophies and preferences.12 It’s easy to be dazzled by a computer system’s capacity to catalog huge databases and to process unlimited numbers of routines.12 But it’s best to keep the system as simple as possible. Experts also advise healthcare facilities to undertake automation slowly and to bring online one discipline or unit at a time.12

**Nursing Process and Nursing Language**

Computerized nursing information systems can increase efficiency and accuracy in all phases of the nursing process and can help nurses meet documentation standards established by the ANA and The Joint Commission.5 Computerized documentation systems can help nurses collect, transmit and organize patient information; suggest nursing diagnoses based on assessment data; and provide standardized nursing interventions for plans of care.

**Assessment:** After you enter the patient’s initial admission and assessment data, the computer’s software program may prompt you for additional information. In some systems, if an assessment value entry is outside the normal or acceptable range, the computer flags the entry to make sure you are aware of it.5 Computerized systems can also interact and prompt you with questions or suggestions about information as you enter it in the system.11

**Nursing diagnosis:** Computerized systems can help you formulate appropriate nursing diagnoses. Computerized systems often list nursing diagnoses associated with specific signs and symptoms and suggest possible nursing diagnoses based on assessment data. Although the computer program can provide you with proposed diagnoses, you are still responsible for using good clinical judgment to evaluate whether the proposed nursing diagnosis is relevant for a patient.5

**Planning:** To help you develop a plan of care, the computer program displays recommended expected outcomes and interventions for the selected diagnosis.5 Computers can also track outcomes for large patient populations to help you select the most appropriate patient outcomes and interventions.5

**Implementation:** You can use the computer to record interventions and patient-processing information, such as transfer and discharge instructions, and to communicate information to other departments.5 Computer-generated progress notes automatically sort and print patient data, such as medication administration and treatments, which makes charting more efficient and accurate.5

**Evaluation:** Use the computer system to evaluate care and to record your observations, the patient’s response to nursing interventions, and your evaluation statements about the patient’s progress or need for revisions in the plan or care.5

Work is under way nationally to standardize nursing language.1

The Nursing Outcomes Classification system is one national nursing standard language project. This system provides the first comprehensive method to measure nursing-sensitive patient outcomes. The NOC has major implications for nursing administrative practice and the patient care delivery system.1,5 With the ability of the NOC to compare patients’ outcomes across the country based on parameters such as age, diagnosis or healthcare setting, the nursing profession will have access to a large body of information that can greatly improve the quality of nursing care. NOC is also vital for nursing research because the system incorporates patient data-related outcomes that are not yet in medical information databases.1

Electronic health records will increasingly be used in the future. There are significant financial incentives through Medicare and Medicaid available for eligible providers and organizations meaningfully using approved healthcare technology systems.13 Although there are many challenges involved in designing and implementing an electronic health record system, there are many long-term benefits for patient care.13

**Patient Confidentialit**y

Technological innovations such as computerized documentation, fax and e-mail provide new ways of documenting patient care; these innovations also may be associated with significant confidentiality issues.7 As a result, nurses should be aware of the factors associated with electronic documentation technology in order to meet patient expectations for documentation effectiveness and confidentiality.7 You must protect the confidentiality of patient information when you use computerized documentation. To meet your obligations to protect your patient’s privacy, never share your password or computer signature with others.12 If a procedure or treatment were to harm a patient and his or her family took legal action, you could be responsible for entries charted under your password, even if another nurse entered them.13 Your credibility could also be in question because you let another nurse use your password, a violation of your agency’s policy. On some occasions, you may need to document care given by another nurse without a password, such as a temporary worker. Follow your facility’s policy and procedures for documenting in such situations. Log off the system or lock it if you’re not using your terminal and don’t leave patient information on a monitor where others can see it.

To further protect your patient’s right to confidentiality, don’t leave print versions of the patient’s medical record unattended.8 In many cases, a home healthcare agency provides nursing staff with laptop computers to streamline documentation. To protect patient confidentiality, only agency personnel should use the agency’s laptop computers.11

Transmitting patient information by fax can save valuable time; however, you must use caution to protect patient confidentiality.3 Confidentiality issues that can occur with faxes include transmitting information to the wrong person or agency or receiving information from a wrong person or facility.7 It is prudent when faxing a critical document to first run a test page to verify that you are sending the fax to the correct address.

Before you send a fax that contains confidential patient information, clearly note on the fax cover sheet that the material is confidential. Develop policies and procedures for the types of information acceptable for transmission by fax. Have fax machines in areas where only authorized users have access.4,7,8

**Save Time When You Document**

One of the most important challenges nurses face is to improve documentation quality while saving time. Traditionally, nurses have worked under the principle that charting as much data as possible will strengthen their defense against potential litigation. Today’s nurses must realize that a streamlined documentation system can provide legal protection and save time.14

Constraints on reimbursement force administrators to look closely at all aspects of nursing productivity, including the time to document care. Increasing patient acuity in acute care settings, more complex equipment and the expanding role of nurses are factors that put pressure on nurses to manage their valuable time as efficiently as possible.11

Here are some strategies to save time:11

* Before you document, check that you have the right patient medical record and all the information you need to record accurately and efficiently.
* Use the nursing process to document. The five-step nursing process not only provides a framework for quality care, but also prompts you to document in a logical format that saves time.
* Document using nursing diagnoses**.** Use standardized nursing diagnosis labels; they will help you organize and focus your documentation. Effective organization and a clear charting focus save time.
* Chart as soon as possible after you provide care. Charting at regular intervals during your shift is a great way to save time. Many events can occur between the time you provide care and the end of a shift. If you chart regularly throughout a shift, you’ll forget less information and you’ll lessen the times you have to go back and add to your charting or make a late entry. Regular documentation also helps improve your documentation quality.
* Use flow sheets and bedside charting if possible**.** Well-designed flow sheets can save a significant amount of time. Bedside charting systems allow you to document quickly at the point of care and save you time; you no longer have to find a patient’s medical record at the nurse’s station.
* Don’t repeat information. If you record data on a flow sheet, don’t repeat the information in the patient’s progress notes. Instead, use progress notes to provide relevant details about information on a flow sheet or to add data, such as a patient’s psychosocial information, that isn’t appropriate to document on a flow sheet.
* Don’t ramble on with extraneous details**.** Make sure your charting is specific and to the point.
* Sign off with initials. Sign your full name and licensure on a flow sheet only once and then use your initials for subsequent entries; the use of initials saves valuable time.
* Use fax machines. Fax machines on nursing units and in other hospital departments allow you to send and receive physician orders and patient records and to diagnose test results quickly. Using fax machines and scanners to transmit patient information saves time because you no longer need to take and document orders by telephone.

**Review Questions**

1. The advantages of computerized documentation systems generally outnumber the disadvantages.
True false

2. You are responsible to use your clinical judgment when you select a nursing diagnosis proposed by a computerized system.
True false

3. You aren’t responsible for charting entries made by another nurse with your password.
True False

4. When you save time to chart at the end of your shift, it will allow you to document care more accurately.
True False

Chapter 5

**Answers to Chapter Review Questions**

1. True

2. True

3. False

4. False

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