



COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

Nursing Documentation 101

Module 5: Applying Knowledge – Part I

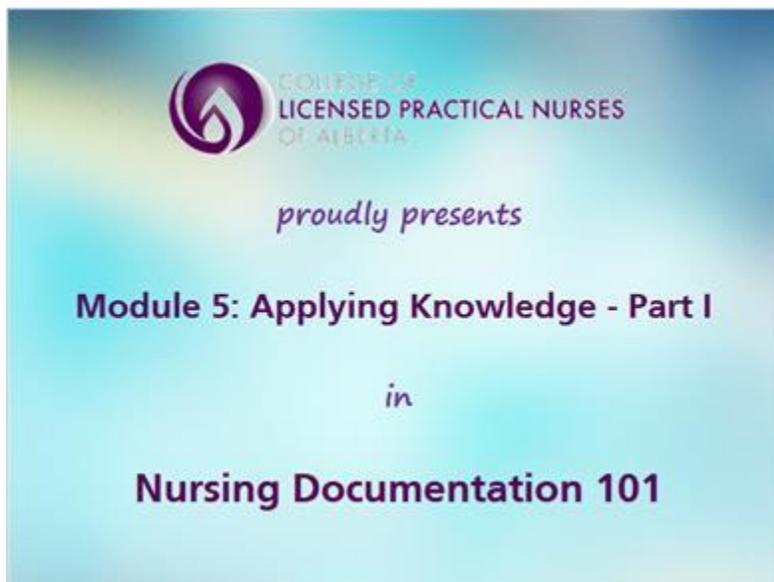
Handout

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Module 5 – Applying Documentation Knowledge – Part I

1. Introduction

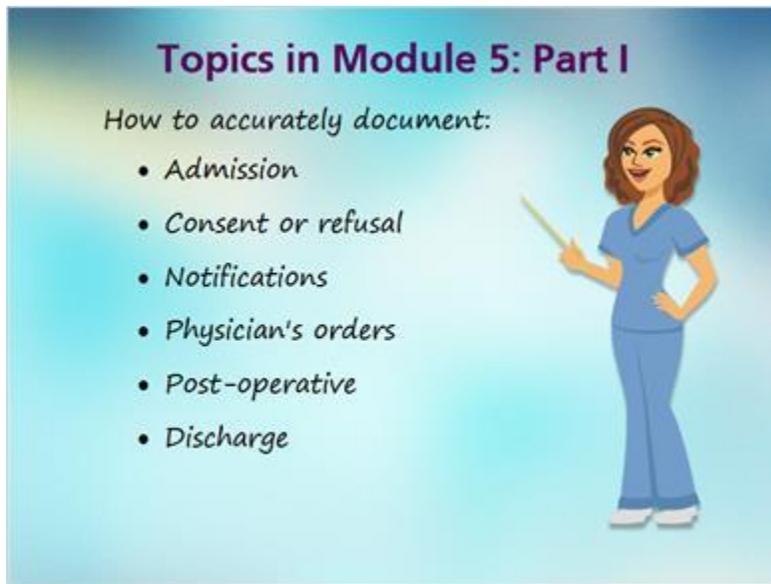
1.1 Welcome



Narration

No narration, only music.

1.2 Topics



Narration

JILL: Hi ... I'm Jill and with me is Mark. Welcome to Part I of Module 5 – Applying documentation knowledge and principles in practice.

MARK: So is this where we learn how to apply what we have learned so far?

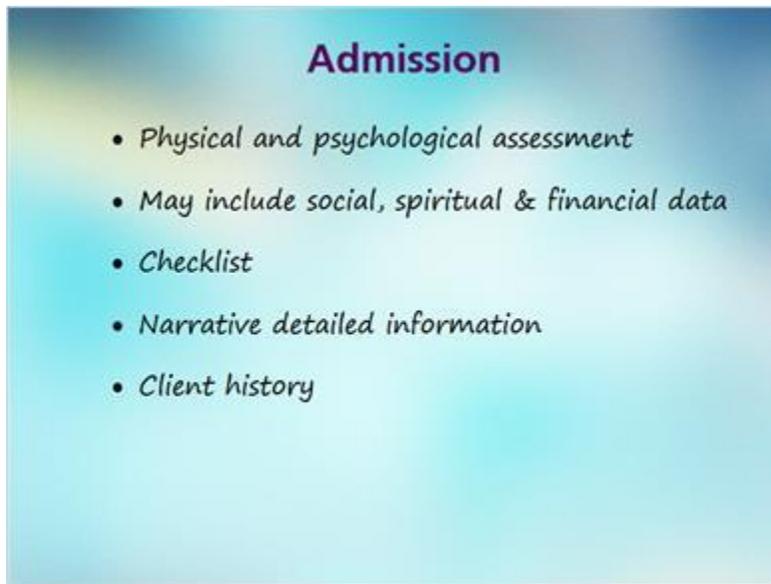
JILL: That's right. In this module, we will learn how to apply documentation knowledge and principles to many common nursing situations. This module shows us how to improve our documentation, regardless of the healthcare setting we work in.

MARK: Looking at the topics for this lesson, it looks like we will focusing on how to accurately document ... admission ... consent or refusal ... notifications ... physician orders ... post-operative care and discharge.

JILL: There are probably hundreds of documentation situations that we encounter in our practice. We will look at the more common ones.

We need to make a disclaimer before we continue. Your employer's policies and procedures take precedence over the examples and protocols we discuss in this course. Our goal is to make your documentation more accurate within the framework of those policies and procedures.

1.3 Admission



Narration

JILL: Let's start at the beginning. A client is admitted to healthcare services. Mark, care to do this one?

MARK: Sure ... admission sounds like a logical place to start. The admission form is a very important part of the client record. It includes physical and psychological assessments and may also include social, spiritual and financial information. If an admission form is part of the client's record, it is best to state if the form was partially or fully completed in the progress notes.

The admission form may be a checklist and it usually has narrative areas. Sometimes the form has fill-in-the-blanks and closed and opened-ended questions. Close-ended questions are the ones with a "yes" or "no" answer while open-ended questions are ones where a client gives you a verbal answer. Since open-ended questions may have bias or interpretation challenges, remember to use exact quotes from the client, even if the client uses slang. On check lists, it is best practice to use your initials, not check marks or "x's".

If there is no admission form, you will have write up the client's admission information in a narrative or story-telling manner.

A client history is a very valuable tool for both the physician and care providers because it includes a client's past medical, psychological and social history. It often includes previous care provider interventions – what worked well and not so well for the client.

1.4 Admission Strategies



Narration

JILL: Let's now look at some specific strategies to improve your documentation at admission. Let's do this one together. I will start.

You do not want to duplicate in the progress or client notes what is already on the admission form. The more times the same information is repeated and copied, the greater likelihood of mistakes or errors. Also, this is not efficient use of your valuable time. You should make a notation on the admission form to "see progress notes" if there is significant or extra information about the client that is important to his care that is not addressed in the admission form.

MARK: Remember to include notes on the emotional status of a client – he or she may have very real fears of being in care.

JILL: Most facilities or agencies require that the admission process be completed within a specified time. Sometimes more than one care provider is involved. When two or more care providers are involved in a client's admission, you must follow your agency's policies and procedures. You may need to initial or sign parts of the admission form. You will then need to make a notation in the client's progress notes.

MARK: Sometimes a client is too ill to answer your questions. You may need to ask family or significant others for information. This is especially important when obtaining data from a small child, someone who cannot speak or who has cognitive impairment. You need to document who provided the client's information and their relationship to the client.

JILL: A care provider should always complete vital signs when receiving a client into care, as the previous care provider may not have done so on discharge from his or her care unit. Also, it is important to assess and document the client's pain level.

1.5 Admission Example

Admission Example

24/06/2014	1430	Received via stretcher at 1400 from ER. Daughter, Emily Robinson present. Report received from J. Milligan, LPN. BP 140/90, P 84, R24. Temp 38.5 C (T). O2 Sats 94% on room air. See admission form for partial completion.----- C. Williams, LPN
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Click NEXT to continue

Narration

MARK: On this slide we have an example of how an admission should be documented. Remember to click NEXT to continue.

1.6 Consent



Narration

JILL: Next, we will discuss obtaining client consent for a treatment or procedure. Mark?

MARK: Consent may be expressed verbally or in writing. Consent may also be implied by the client's actions such as a nod or permitting the healthcare provider to continue on with a treatment or procedure. Consent can be given by the client or by a designated legal decision maker.

Consent typically involves the following:

- The medical condition of the client ... the diagnosis
- Purpose and proposed nature of the treatment or procedure
- Risks and benefits

JILL: The documentation for consent should include ... the agreement to the treatment or procedure ... the refusal of the treatment or procedure ... and the withdrawal of consent that was previously given.

Although a consent form is used for more major treatments and procedures, documentation regarding the consent discussion is highly recommended. There should be no abbreviations used on the consent form.

MARK: What happens if a client refuses the treatment or procedure?

JILL: If a client refuses treatment or care, this must be documented in the client's health record. You also need to document the reasons for refusal, if known. Your discussion should include outcomes of the client not receiving the care or treatments. This discussion should be done in a non-threatening and non-coercive way.

MARK: That is all good information about consents and refusals. What's next?

1.7 Notifications



Narration

JILL: The next situation is professional notifications. Most care providers must notify a physician or healthcare professional of changes in a client's condition, laboratory or test results and client or family concerns.

When you are documenting a notification, your documentation must include the 5 W's – what, when, where, why and who and how. The **WHAT** is the client problem or issue ... the **WHEN** is the correct date and time ... the **WHERE** is your location or unit ... the **WHY** is the details as to why you called ... the **WHO** is the physician's or care practitioner's name ... and the **HOW** is method of communications, that is was it by phone, fax, or e-mail?

1.8 Physician Example

Notification Example #1

Physician example

24/06/2014	2215	Dr. D. Spence notified by telephone at 2200 to report 100 ml increase of serous drainage from right chest tube. Dr. Spence's order was to observe drainage for one hour and report back to him.---- -----C. Williams, LPN
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Click NEXT to continue

Narration

MARK: On this slide is an example of documenting a physician notification.

1.9 Inaccurate Example

Notification Example #2

Inaccurate physician example

24/06/2014	2215	<i>Client's physician telephoned X3 of client's deteriorating condition. No responses from physician. Supervisor notified and chain of command activated as per hospital policy.-----C. Williams, LPN</i>
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Click NEXT to continue

Narration

JILL: This is an example of notifying a physician of a change in client's condition. This documentation is inappropriate as it crosses professional boundaries and has several deficiencies.

1.10 Accurate Example

Notification Example #3

Accurate physician example

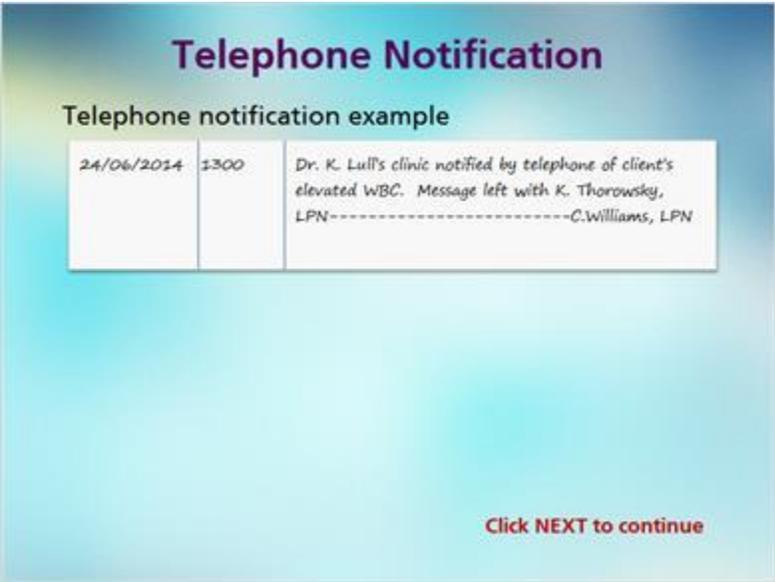
24/06/2014	2130	Dr. D. Spence telephoned of client's elevated temperature of 39.5 C (t).-----C.Williams, LPN
24/06/2014	2145	Dr. D. Spence telephoned of client's elevated temperature of 39.5 C (t).-----C.Williams, LPN
24/06/2014	2200	Message sent to Dr. D. Spence's pager of client's elevated temperature of 39.6 C (t).-C.Williams, LPN
24/06/2014	2215	Supervisor, M. Jones, RN notified of client's elevated temperature of 39.7 C (t) and attempted physician contacts. Supervisor states she will contact physician by ER cell phone. Chain of command activated as per hospital policy. -----C. Williams, LPN

Click NEXT to continue

Narration

MARK: This slide is the appropriate way to notify a physician of a change in a client's condition. This example shows you how you may document in a professional way a physician's lack of response.

1.11 Telephone Notification



Narration

JILL: This is an example of how to contact a physician in regards to a client's abnormal lab test. It is important to state who the call was made to or received from, the time and why the call was made or received. If a message was left with someone, that person should be named.

1.12 Physician Phone Order



Narration

JILL: Written physician orders are not always possible in rural settings, after clinic hours and in long term or community care when a client may require immediate treatment. Although not ideal, telephone orders should be for the client's well-being and not the care provider's convenience. They should be given directly to you and not through a third party.

You should write down the orders immediately on the physician order form while the physician is talking on the telephone. Be sure to include the date and the time. Complete the orders verbatim, or exactly as told. Be sure to double check what is being ordered – this is to minimize errors. Be sure to repeat back to the physician the orders received. It may take two to three times to be sure you have heard and documented correctly.

You would write or print the physician's name and sign your name and designation. If another care provider listened to the orders, he or she would also co-sign the orders.

1.13 Phone Order Example

Telephone Order Example

24/06/2014	1430	Digoxin 0.125 mg orally now and daily in am. Furosemide 40 mg orally now and daily starting in the am.----- VTO Dr. M. Black / C. Williams, LPN-----
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You could write out "verified telephone order" instead of VTO.

Click NEXT to continue

Narration

MARK: And here is an example of documenting a telephone order. Remember to click NEXT to continue to the next slide.

1.14 Post-Op Documentation



Narration

No narration

1.15 Post-Op Example 1

Post-Operative Care Example

24/06/2014	1400	Returned from OR Lap Chole at 1030. Tolerated procedure well. Breath sounds normal, skin pink and warm, cap refill normal. Appears to be sleeping, but arouses easily. Oriented and speech OK. PEARL; pulses palpable; denies urge to void/bladder not distended; BS normal. Dressings dry. Abdominal discomfort is 4/10 - refuses analgesic. Placed in semi-fowlers, bed in low position, and call bell handy. IV infusing well. Explained coughing and deep breathing with pillow.-----C. Williams, LPN
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How can this documentation be improved?

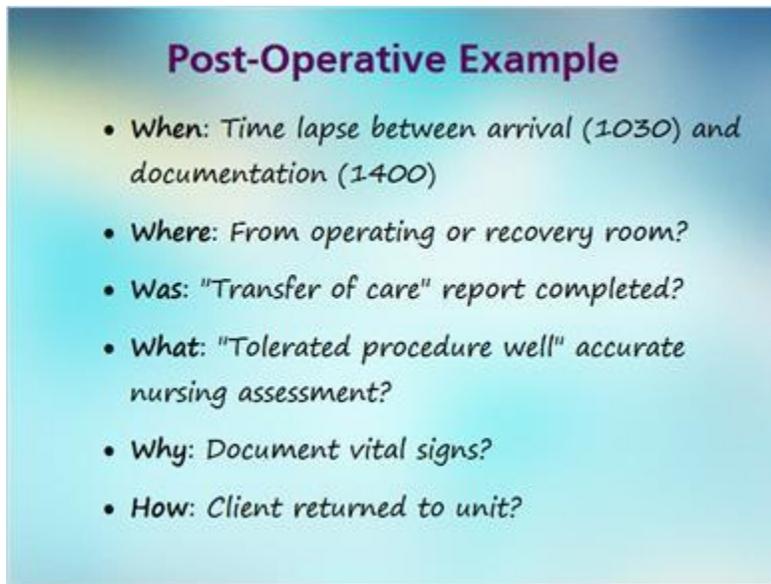
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Narration

JILL: Many care providers work on surgical units. They are caring for clients who have had anesthetics and invasive surgical procedures. A post-operative client carries higher risks for complications. Therefore, accurate and comprehensive documentation is important.

MARK: This is an example of a post-operative documentation. Study it carefully and see if you can locate the deficiencies.

1.16 Post-Op Improvement



Post-Operative Example

- *When: Time lapse between arrival (1030) and documentation (1400)*
- *Where: From operating or recovery room?*
- *Was: "Transfer of care" report completed?*
- *What: "Tolerated procedure well" accurate nursing assessment?*
- *Why: Document vital signs?*
- *How: Client returned to unit?*

Narration

JILL: Here are some ways that this documentation can be improved. Mark, do you want to talk about improvements shown on this slide?

MARK: Okay. The first deficiency is that the documenting time is 1400, although the client returned to the unit at 1030. This is not fulfilling the principle to document as soon as possible after the event. The legal system would view this lengthy time frame with suspicion.

The care provider may not be sure if this client was admitted to the surgical unit directly from the OR, or if the client spent some time in recovery unit.

Was there a "transfer of care" report from another care provider when received on the unit?

"Tolerated procedure well" is an unacceptable statement, as it not supported by assessment data.

When a client is received into your care, vital signs should be documented first in the progress notes.

How did the client return to the surgical unit ... ambulatory, on a stretcher or by some other means?

1.17 Post-Op Example 2

Post-Operative Example

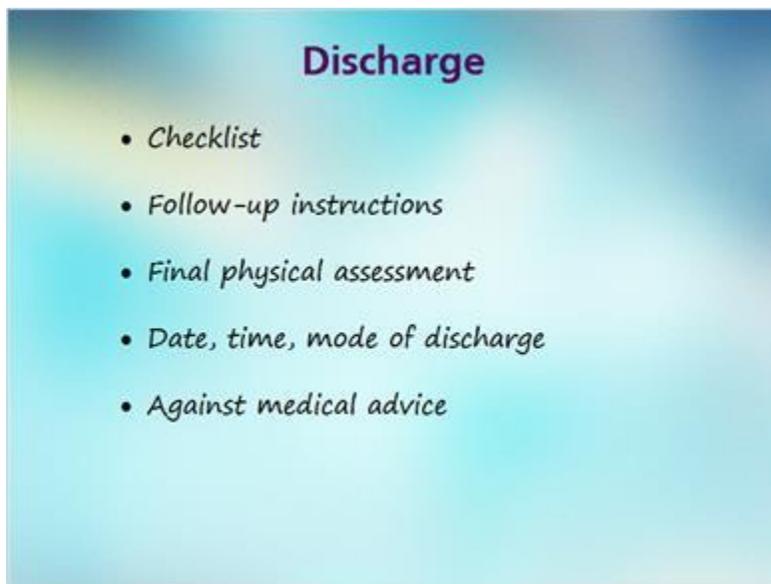
24/06/2014	1130	Returned from Recovery via stretcher at 1030 from lap chole procedure. SBAR report received from M. Jones, RN. BP 112/82, P 88 & regular, R16, 37.2 C (t). O2 Sats 95% on RA. Breath sounds clear on auscultation, skin pink & warm, cap refill less than 3 sec. Sleeping intermittently, but awakens when called. Oriented to time, person & place. Speech coherent. PEARL, denies urge to void/bladder non-distended, low pitched bowel sounds present in 4 quadrants. Abdomen slightly distended, no complaints of nausea. 4 abdominal puncture wounds covered with 4x4 gauzes -no drainage present. Pain level 5/10. Will call if pain increases. Placed in semi-Fowler's, bed in low position, call bell in reach - verbalized its use. IV of 100 ml D5/D45 NS infusing 75 ml/hr in right radial vein. (See flow sheets for VS, IV, intake/output). Reviewed deep breathing & coughing - pt. able to return demo. Will continue to monitor as per post-op policy.-----C. Williams, LPN
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Click NEXT to continue

Narration

JILL: On this slide is the improved post-operative example documentation. Study it carefully and note all the details that have been included. Once done, click the NEXT button to continue.

1.18 Discharge



Narration

JILL: We started this lesson talking about documenting admission of a client into healthcare services. We will now take a look at how to appropriately document the discharge of a client. Mark, do you want to begin?

MARK: Okay. Care providers may be assigned to handle discharges of clients from healthcare services. Accurate documentation is essential when a client leaves care – whether it has been a negative or positive outcome for the client. Discharge from care services begins when a physician issues an order or when care services no longer benefit the client.

Generally there is a checklist or discharge form that covers the follow-up that a client and his family will need to do. There usually are instructions on medications, physician appointments, dressing care, and warning signs of abnormal findings such as infection.

A prudent care provider will use and document several methods of communication to be sure the client and family are clear about follow-up. For example, a care provider will verbally instruct the client or his family and use written instructions or teaching materials. Be sure to evaluate if the client understands the discharge and follow-up instructions. A client may be issued a telephone number in case he or she forgets the instructions.

JILL: A care provider should complete a final physical assessment, including vital signs, in case there are different clinical findings. The date, location to, time and mode of discharge should be documented in the progress notes. It should also be noted if the client was accompanied by another person.

MARK: What happens if a client just wants to leave the hospital? I believe that it is within his legal rights to do so.

JILL: Yes Mark. It is within a client's rights to be discharged from care services. We will talk a bit more about this in a minute.

1.19 Discharge Example

Discharge Example

24/06/2014	1100	Discharged at 0930. Prescriptions and info sheets given to wife, Anne, who verbalizes correct use of medications. Anne performed dressing change to left foot using clean technique and able to state signs & symptoms of infection. Anne will make appointment with dietician for low sodium and low cholesterol diet in two days. To see Dr. R.Tooney on 02/07/2014. Written discharge instructions given. Health Link info given for concerns in the meantime. Client left facility ambulatory with wife at 1100 to his home.----- -----C. Williams, LPN
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A final assessment, including vital signs should be done.

Click NEXT to continue

Narration

MARK: On this slide that we have an example of discharge documentation. Remember to click NEXT to continue when you have finished studying it.

1.20 Discharge AMA



Narration

JILL: It is within a client's rights to be discharged from care services. This may be considered an adverse event; therefore careful attention is required for documentation. He or she signs a "responsibility release form" or "AMA"; discharge against medical advice form".

When a client signs an AMA discharge document, it does not mean that the care provider is completely released from care responsibilities.

MARK: I don't understand.

JILL: The following is a checklist of key points to do when a client is discharging himself against medical advice:

- Follow facility or agency policy exactly.
- You document the "reasons" that the client is leaving care and quote exactly.
- When the client signs the responsibility release form, you or the physician explain the risks and consequences of leaving.
- You also document who was notified, date and time, discharge teaching and materials that were given to either the client or the individual who accompanies the client and how and when the client left the premises or facility.

- You should also do a final vital signs check.

MARK: So you have to show that you did everything possible to look after the client, not just let him or her go.

1.21 AMA Example

Discharge Against Advice Example

24/06/2014	2100	<p>Dressed in clothes and packing a suitcase at 1800. Unable to dissuade client from leaving. Client states: "I'm sick and tired of all these tests. I can't take this any more so I'm going home." Dr. T. Smith notified by pager at 1830 and in to visit at 1900. Dr. discussed risks of uncontrolled hypertension. Agrees to see Dr. Smith in two days. Wife Shirley notified and visited -unable to dissuade client from leaving. Client signed AMA form. Instructions of medications, low sodium diet and Dr. appointment given to client and wife. Client unable to repeat discharge instructions but wife able. Client left facility ambulatory with wife at 2030. -----C. Williams, LPN</p>
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A vital signs check is not mandatory but best practice.

Click NEXT to continue

Narration

JILL: That is correct. On this slide is an example of the documentation of a client that discharges himself. Note that the key points are addressed.

This brings us to the end of Part I of Module 5. Mark and I will see you shortly in Part II. Goodbye for now.

1.22 The End



Narration

No narration ... music only.