Nursing Documentation 101

This module is intended to support the continuing education of Alberta's Licensed Practical Nurses.

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Module 1
Introduction to Nursing Documentation 101

Purpose

Most health providers know that accurate documentation (also known as charting, recording and reporting) is an important component of their professional and legal responsibilities. Nursing organizations have standards of practice (or practice guidelines) and specific competencies that address quality documentation, not just "good" charting.

The *purpose* of this Nursing Documentation course is to provide the knowledge and practical skills needed to ensure that accurate documentation takes place in our health care systems. The documentation must not only meet professional and employer standards, but it must also be acceptable to our legal system.

The Need

The College of Licensed Practical Nurses of Alberta (CLPNA) has a number of good reasons for developing this course.

- First of all, documentation was among the most frequently requested training from their members.

- Secondly, although most care providers believe that they do an adequate job of documenting, research and independent audits show that most documentation fails to meet professional and legal standards.

- College committees and practice consultants agree that the deficiencies in documentation are a significant issue.

- Discussions with health care employers, and even care providers themselves, echo similar concerns regarding inadequate and inappropriate documentation.

- Finally, in many cases, nursing documentation has not met the criteria required by the legal system and has resulted in lost lawsuits.

Course Content

This Nursing Documentation consists of seven modules. These are:

1. *Module 1* – An introduction and overview of the course.

2. *Module 2* – Importance of accurate documentation. Topics include such things as documentation in health care, and the purpose, perceptions, challenges and reasons for accurate documentation.

3. *Module 3* – Essential elements of documentation. The topics include common deficiencies, approved formats and terms, the nursing process, strategies, and progress notes and documenting adverse events.

4. *Module 4* – Legal issues in documentation. Some of the topics discussed include legal terms, what documents can be requested in a lawsuit, what lawyers are looking for, and how to reduce your liability and legal risks.

5. *Module 5* – Apply your documentation knowledge. Topics include differentiating between accurate and inaccurate documentation, and documenting in different situations and applications.

6. *Module 6* – Electronic documentation. Since technology is becoming increasing prevalent in electronic health records, this module will give us an overview of how electronic documentation works, advantages and disadvantages, some tips on what to do and not to do, and use of mobile devices at work.

7. *Module 7* – Additional exercises and resources.

Learning Components

The course is available on the Internet at *http://www.CLPNA.com*. It provides for many different components for learning, including:

- Narrated video presentations
- Podcasts
- Print handouts and notes
- Module quizzes
- Learning games
- Reflective exercises
- Practice exercises
- Final examination

Strategies of Effective Learning

Here are some suggestions for getting the most from this documentation course.

1. Use the online video player controls smartly. You can pause a slide, replay it, or use the menu to go directly to another slide. The player features give you total control over the pace and direction of your learning! Take the short tutorial to familiarize yourself with the player controls.

2. Our second suggestion is that BEFORE you view a video, print out the handout for that Module. The handout provides you with a copy of the slides and our narration. This makes it easier for you to follow along. Remember you can pause the presentation if you want to review what we said, or to make notes.

3. There is a lot of information in this course. Do not try to do the course all at one sitting. We learn better, and remember more, if we pace ourselves. Being online, this course and its components are available at all times and at any location where there is an Internet connection. Learn at your own convenience and comfortable pace.

4. Be sure to do the quizzes, games and interactive activities we have included in this course. They are fun, engaging and will help you learn better.

5. Finally, unless you are a documentation expert, you will need to continue your learning. There will always be room for improving your documentation. So we strongly recommend that you periodically return to repeat parts of this course. Review will be especially useful in those areas where you are having problems or feel you could do better.

Module 2
The Importance of Accurate Documentation

Specific Learning Outcomes

After successful completion of this module, you will be able to:

- Describe documentation in the context of health care

- Name the organizations and individuals who may have access to client health records

- Review the purpose of documentation

- Discuss care provider perceptions of documentation

- Identify challenges health care providers experience in completing accurate documentation

- Discuss societal factors that demand accurate documentation

- Explain the link between documentation and standards of practice

- Describe the role of an employing facility or agency's documentation policies and procedures

Introduction

Documentation is one of the main communication tools that both regulated and unregulated health care providers use to exchange client information. According to Ashurst (2000), client records thirty years ago in hospital wards were limited to a series of classic statements that stated simple facts: "Good day, no visitors today, good night, slept well, appears stable and tolerated procedure well". This type of documentation is now widely viewed as ineffective and inappropriate. Furthermore, there was no evidence of ongoing assessments and re-evaluation of client condition and risks.

To be clear, documentation (sometimes called reporting, charting or recording) can be described as any electronic or written information or data about client interactions or care events that meet both legal and professional standards (College of Registered Nurses of British Columbia, 2012). Meeting legal standards refers to how your documentation would be examined by the legal process or the court system. Your College (regulatory or licensing body) may also judge your documentation to see if it meets their standards, competencies and expected behaviors that a prudent care provider would have. Your employing facility or agency may also examine your documentation to see if it meets their policies and procedures.

Charting or documentation audits across all health disciplines show serious deficiencies in documentation. A recent study found that most documentation efforts fail to meet legal and professional standards when examined (Paans, Sermus, Nieweg, & van der Schanns, 2010). This is in sharp contrast to the many care providers who believe that their charting is "good" or "adequate".

College committees and practice consultants also agree that deficiencies in documentation are a significant issue. Anecdotal remarks from employing agencies and facilities and care providers themselves have reiterated similar concerns regarding inadequate and inappropriate charting.

The Health Care Environment

A large research report with its main partner, Health Canada (Blake & Norton, 2004), compared world-wide practices on patient safety and errors in health care. It concluded that the risk for injury or death for a client in health care services was greater than extreme sports such as bungee jumping or skydiving. The World Health Organization (WHO) (2013) also indicated that client safety is a serious global health issue. Their data was gathered from Australia, United States and Western Europe and suggests that eight to twelve percent of persons admitted to hospital incur adverse events. Because you work in a high risk environment, you must make it your practice to communicate effectively and document all necessary details for safe client outcomes.

Who's Looking

It is helpful for care providers to know who may be viewing and examining client documentation. This is why it is necessary that you and other care providers strive for excellence in documentation so reviewers have complete and accurate information on client care and events.

Anyone on the health care team who provides services or care for a client has authority to view the client record or document; however there may be limited access for some care providers to specific portions of electronic charts. This depends on the electronic permissions allowed for a particular health discipline. Prudent care providers are aware that anyone who provides care or who has an interest in client safety may examine or scrutinize their documentation at any time.

These organizations, agencies, facilities or individuals include the following:

1. *Accreditation bodies* – These have great interest in patient safety and may consult client records for safety concerns.

2. *Certifying and licensing organizations or Colleges*, such as CLPNA, may examine your documentation as part of their regulatory role. Investigations and reports often cite inadequate or inappropriate documentation.

3. *Performance improvement monitors* – Your employing facility or agency considers your documentation in client records to monitor budgets and facility risk.

4. *Colleague reviewers* – Other care providers examine client documents so they can detect important client changes and administer the best possible care for a client.

5. *Coroners or medical examiners* will preview charts as they are looking for facts leading up to a sudden or unexpected death.

6. *Insurance companies* may want client details to see what happened before they pay out claims if there is an injury or death.

7. *Lawyers or attorneys, judges* and other members of the legal team examine client records so they can reconstruct events to see if there is a case for a potential lawsuit.

8. The *client and/or his family or legal designate* have rights to see what is written about them. The employing agency or facility owns the chart; however the client owns the information that is written about him or her.

As you can see, there are many individuals or organizations that may request details on client care. Does your documentation contain the necessary client information?

Methods of Communication

Client information is obtained and released through various methods. Methods that share client data consist of verbal or face to face, reports, notes, telephone, facsimile (fax), and electronic means such as e-mail and electronic health records (EHRs). Traditionally, care providers do well with oral communication; however written communication or documentation has not been given the attention it deserves according to some researchers who study the topic of documentation (Jeffries, Johnson & Griffiths, 2010). Regardless of the method of documentation, it requires timely and constant attention to detail to disperse relevant client information.

How often a method of documentation is utilized, depends on several factors: complexity of client needs, acuity of client condition, and employing agency or facility policies and procedures. Regardless of a client's condition or needs, client care information becomes part of the permanent client record. Evidence shows that accurate documentation improves clinical outcomes, processes of care and professional practice (CRNBC, 2012).

Purposes of Documentation

Documentation by health care providers has several purposes. You probably know many of these. Let's take time to review:

- *Communicating and providing continuity of care* – If another health care provider had to step in and care for the client on a moment's notice, does your documentation provide the necessary information for easy transfer of care to the second care provider?

- *Accountability* – Care providers are responsible and accountable for their own practice and documentation is part of that accountability. Did you know that your standards of practice and competencies are linked both indirectly and directly to your documentation?

- *Legal implications* – Was the care provided competent and safe, did it meet acceptable standards, and was it timely and consistent with the employing agency or facility's policies? Is the care you provided and documented consistent with your College's standards and competencies? A chart or client record is one of the main documents of evidence.

- *Provides quality improvement and risk management* – Accurate documentation provides a way to measure and improve health services and client outcomes. Your documentation is used to manage risks in a health care setting and is investigated if adverse events occur.

- *Facilitates evidence informed practice* – Accurate documentation can be an important source of data for improving client outcomes and practice. Many medical studies and client care research projects gather data from your documentation. Your client notes or

progress notes may be reviewed to find out what worked well in a client's care and what did not. Your documentation is also a learning tool for health discipline students who are learning to become safe and conscientious care providers. Textbooks and future data bases for health care depend on your documentation. Your documentation can also provide information for the protection of client rights (Cheevakasemsook, Francis, Chapman & Davies, 2006).

Now that you are familiar with the many purposes of documentation, what is your attitude towards improving your documentation?

Perceptions of Documentation

Health care providers have varying perceptions of documentation. Many say that this skill takes years to become proficient at. You may have learned documentation on the job by copying what other care providers have written about the client. This method perpetuates deficiencies and is a dangerous practice. You may have learned the basics of accurate documentation in formal education, but were not proficient when you started your career as a health care provider. During your practicum, you may have adopted inappropriate documentation practices from other care providers.

Some documentation frameworks or systems do not accurately reflect the type of care that a specific individual requires nor do they work well in a particular health care setting. This may make it difficult for you to document in a clear, concise, comprehensive and timely manner.

From another viewpoint, documentation may not be as glamorous or popular as other aspects of care provider activities. In some health care settings, tasks usually take priority to documentation and little time is devoted to it.

Health care providers who are most successful with documentation are those who view documentation as an integral part of the nursing process. Can you recall the nursing process? Are you able to reflect on each step and how it corresponds with accurate documentation?

Challenges of Documentation

What are the challenges to complete *clear* (facts only), *concise* (not wordy), *comprehensive* (includes all the necessary details) and timely documentation? Research studies on documentation and care providers report many reasons for challenges.

1. *Time factors* – Wilkinson and Treas (2011), health education experts, explain that a nurse may spend between fifteen and twenty five percent of his or her working day documenting. Another study by Blair and Smith (2012) concluded that nurses working in acute care may spend between twenty five and fifty percent of their time documenting. Because you work in an extremely demanding health care environment, care interactions and professional skills may take priority to documentation. You may find it extremely difficult to document client care *contemporaneously* (at the time of occurrence or shortly thereafter) when you are multi-tasking. You may leave your documentation for less busy times, usually at the end of your shift or work day. Although a large amount of research

has been done on nursing documentation, current research does not address how to make documentation less time consuming (Cheevakasemsook, Chapman, Francis & Davies, 2006).

2. *Fatigue* – Warren and Creech-Tart (2008) discussed that care provider fatigue contributes to deficiencies in documentation. Since some care providers work long hours and have demanding client assignments, they may not have clear thinking processes required for documentation. You may think about what needs to be documented, but often do not write it down. This is especially challenging for you to do when a client has numerous health problems and requires immediate attention. Being too busy in a health care setting is not an excuse for poor documentation.

3. *False beliefs* – With technology becoming more common in the health services industry, many care providers have a false belief that computers will do their "thinking" required for documentation. Some care providers may lack writing or keyboarding skills to complete clear, concise and comprehensive entries. Whether electronic documentation is used or not every care provider should strive for accurate documentation, not just "good" charting.

4. *Employer support* – Some care providers have suggested that employing facilities and agencies take a more active and supportive role in assisting employees to become more proficient in documentation. Does your employer have up-to-date and clear policies and procedures? Do you know your employer policies and procedures on documentation? Does your employer provide education and training?

5. *Societal factors* –There are societal factors that create added pressures for care providers. With increased media and consumer health awareness, there is an intense demand for safe, quality care with client involvement. The public expects care providers to be flawless in delivery of care, even when there are increased numbers of clients, particularly the frail elderly who have complex and chronic medical conditions that require intensified time for care.

6. *Costs and budgets* – With an increased emphasis on outcomes and cost containment, documentation has become one of the main mechanisms for gathering data. Funding for health care services, including client care and staffing, is *corroborated* (checked against) with documentation. If documentation does not accurately express the high care needs of a client, then funding is withdrawn or diverted to other areas in the health care system.

Have you experienced many of these documentation challenges in your practice? How have you dealt with these challenges?

Although accurate documentation has its many challenges, this does not mean that they cannot be overcome or minimized. Your College in its professional role provides documentation support by way of standards, practice statements, continuing education and practice consultants. Do you know your competencies, standards of practice and practice statements? You need to be aware of these when documenting.

Standards of Documentation

Health care provider organizations have standards for documentation that generally encompass similar characteristics. The College of Nurses of Ontario (CNO) (2002) has these standards for documentation. Let's briefly review these:

1. *Client focused* – Your documentation should be about the client and this includes the extension of his family or someone who is legally named if there is no family.

2. *Relevant* – Do you chart events that are relevant to a particular client's care and progress? Do you document the most important details?

3. *Confidential* – You and other care providers are bound by law to respect client confidentiality. Do you carry charts or records around with you? Do you leave paper-based charts open for others to view or do you leave the computer screen exposed and visible by others? Do you have organizational policies and are you aware of legislation on client confidentiality? Have you completed "jurisprudence" education?

4. *Clear, concise, and comprehensive* – These are the 3Cs of accurate documentation. Is your hand writing clear and legible? How does your grammar and expressions of client care enable others to understand what have you written?

5. *Permanent and retrievable* – You need to remember that client notes become a permanent and retrievable health record. These could be retrieved several months or years later by a lawyer for examination. Will you be able to recall what you did or did not do for a specific client with the passing of time? Think of it this way – you could be caring for five clients who have at least ten interventions! Will you be able to remember fifty care events that you performed on your shift in a couple of years?

6. *Accurate* – One of the most common deficiencies in documentation is accuracy of missing details. Lack of significant detail is also the most highly criticized in the legal process. Do you know how to find the balance between significant details and wordiness?

7. *Chronological and timely* – It is important to document in order of occurrence and chart contemporaneously (as soon as possible after the event or care). This can be extremely demanding for a health care provider who is caring for several clients with complex and multiple health issues. Do you endeavor to document as soon as possible after a care event?

8. *Record of care* – Documentation must include assessments, perhaps planning, implementation or interventions and evaluation or results of client events or ones that involve their families). Once again, think of the nursing process. Do you mentally rehearse the nursing process when you document? This is an excellent way to keep focused on your documentation and improve your accuracy.

Your College offers support and continuing education in documentation. Besides College practice standards, you need to be aware of federal and provincial laws affecting documentation. These laws are amended from time to time; therefore it is important that you stay current.

Your Employer's Role

Employing agency or facility policies and procedures assist care providers to document accurately. Care providers should be familiar with these – what they are and where they are located. Do you know your employing facility or agency's documentation policies and procedures and their location? Are you able to provide feedback on documentation practices to your employer?

Generally, employing facility or agency policies and procedures should address method(s) of documentation, forms used, who is able to document, approved abbreviations, how the date will be consistently written, and what type of designation and signature is required for client entries. An employer may also provide a visual map or algorithm to show you how documentation is to be completed. If you work for more than one employer, you must know the policies and procedures of each employer, as they may differ. Are you able to participate in employer health record audits or documentation committees? These may be excellent learning opportunities.

Consequences of Inaccurate Documentation

There are consequences of inappropriate or inadequate documentation. A care provider could face loss of employment or suspension from his or her College. No doubt, there would be personal stress, possible loss of income and perhaps legal expenses. An employing agency or facility could face a lawsuit and negative publicity. Since you are a care provider, one of the most serious situations could involve a severe injury or death of a client because your documentation was inadequate or inaccurate.

By striving for improvement and accuracy in documentation, you will be fulfilling your professional and legal requirements. You will also be fulfilling your responsibilities to provide safe and competent care for your clients.

Reflective Questions – Take away thoughts

Before proceeding to the next module, please complete the following documentation attitude checklist:

- Do I understand my legal and professional role in accurate documentation?

- Am I able to identify the purposes of accurate documentation?

- What is my perception of striving for accuracy in documentation?

- Do I recognize documentation challenges and am I able to minimize or overcome these?

- Am I able to explain the College and employer role in accurate documentation?

- How does accurate documentation correspond with the nursing process?

- Do I provide input to employing facility or agency and my College on documentation issues?

- Do I regularly review employing facility and agency's policies and procedures, College competencies, practice statements, standards of practice, and laws that relate to accurate documentation?

- Do I attend in-services or take courses to improve my documentation skills?

- Do I know the consequences of inadequate or inappropriate documentation?

- Am I a champion for accurate documentation, not just "good" charting?

- Do I assist nursing students or colleagues to improve their documentation skills?

Key Points

- Documentation is the main communication tool for the exchange of client information.

- Many organizations and individuals have access to client health records.

- Documentation has several legal and professional purposes, other than exchange of client information.

- Care providers have both negative and positive perceptions of documentation.

- Health care providers experience several challenges in completing accurate documentation.

- North American society expects care to be flawless, safe and competent and your documentation should reflect this.

- Understand the links of documentation to the nursing process and standards of practice.

- Employing facility or agency's documentation policies and procedures protect and assist you to complete accurate documentation.

By completing this module, you now understand why documentation is an important aspect of client focused care. You are now ready to proceed to the next module. It will discuss the essential elements of accurate documentation.

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Module 3
Essential Elements of Accurate Documentation

In the previous module, you learned about the importance of accurate documentation for health care providers. You also learned that many care providers have a false belief that their documentation meets both legal and professional standards and that all health disciplines have challenges with accurate documentation. In this module, you will take a closer look at the essential elements of accurate documentation.

Specific Learning Outcomes

Upon completion of this module, you will be able to:

- Describe common deficiencies in nursing documentation

- Clarify the role of approved abbreviations, spelling, grammar and correct terminology for accurate documentation

- Formulate the link between documentation methods and the nursing process

- Review basic documentation principles

- Discuss the role of progress notes in documentation methods

- Apply accurate documentation principles to adverse events

- Explain how individuals or situations may contribute to adverse events

Clear, concise and comprehensive language is the goal for written, verbal and electronic communication. Because a team of care providers require access to current client data, updates or changes in a client's condition need to be completed in a timely and competent manner. Your interventions, according to the care plan, should always be client-focused and your documentation should reflect this.

Documentation Deficiencies

Many care providers are quickly able to point out documentation deficiencies. Now, take a few minutes to reflect on what you have experienced in your workplace. Think about your practice or experience as a care provider and your situations with documentation.

- Were all the necessary details in your client's record so that you could go ahead and provide safe and competent care?

- Did you have to waste time and try to figure out what information was missing?

- Did you have to locate the first care provider, if available, to obtain more detail on the client's care?

- If paper-based recording, was the handwriting legible?

- Was there an unrecognizable abbreviation in the progress notes?

- Did you have to ask another care provider to explain to you what the notes stated on a client's condition?

The following information discusses common deficiencies that care providers have commented on:

- *Illegible writing* – One of the most common complaints in written documentation is that of illegible or messy handwriting. It is preferable to print your client notes if you have challenges with legible handwriting. If you write your clients' information, ask your colleagues if they can easily read your hand writing.

- *Signature* – When your client notes are completed, your signature should be in a written format and not printed. This means that you sign your name and print your designation as per your employing agency or facility's policies and procedures. A cursive signature is much more difficult to reproduce or falsify than a printed signature.

- *Failing to record pertinent health or medication information* – Remember that past health related experiences or medications prescribed assist the health care team to make the best possible choices for a quick and speedy recovery if that is possible.

- *Failing to record nursing actions* – Documenting what you do for and with your client is very important. Although most health providers are diligent and competent in client care activities, the legal system views undocumented care as "not done".

- *Failing to record medications given* – This can have drastic consequences, as a client could inadvertently receive another dose of medication which may be injurious or life threatening.

- *Failing to document a discontinued medication or treatment* – A client could continue to receive a medication or treatment that is damaging or injurious.

- *Recording on the incorrect health record* – This happens frequently and may not be discovered until the next shift. In the meantime, a client could receive incorrect or no care. A chart or patient record that has recording of another client's care raises suspicion in the legal system. The competency of the caregiver who has charted on the incorrect patient is then in question.

- *Failing to record medication reactions* – If a client has a serious allergic reaction to a medication and is given it again, this could cause serious injury or even death. All reactions, no matter how minor, should be documented.

- *Not providing adequate detail of changes in the client's condition* – You must work on finding a balance between excessive wordiness and necessary client details. Missing details have often been cited in lawsuits and this reflects on inadequate or incorrect care.

- *Transcribing orders incorrectly or transcribing inaccurate orders* – Special precautions must be taken with telephone orders. Numbers and doses must be repeated back to the health professional issuing client orders. This repetition may need to be done more than once in the interests of client safety. For example, stating "one, seven" instead of "seventeen" over the phone is best practice. If the prescribing health professional uses words you are not familiar with, it is your responsibility to ask for repetition and clarification or have another care provider listen to the orders.

- *Incomplete records* – If pages or specific forms of a client record are missing, this raises suspicion in the legal system and may give evidence of poor care. Removing pages from a client's record is an illegal activity.

Spelling and Grammar – Who Cares

All care providers need to ask themselves if spelling and grammar are important in documentation? You should take the position that spelling and grammar are very important when completing client notes. Let's discuss why.

Misspelled words and poor grammar creates an undesirable impression. Lawyers and jurors or other witnesses who read client records view spelling mistakes and grammatical errors negatively. They think or believe that the care provider who wrote the notes was uneducated and careless. Therefore, you must use care and attention to make sure that your documentation has correct grammar and spelling. It may be helpful to have a quick reference page at the documentation desk or carry a small personal notebook with correct spellings for commonly used terms. You may ask an experienced colleague to give you feedback on your client notes.

There have been many amusing examples of documentation. I am sure you have read some in your practice. For example, "fecal heart tones" heard instead of "fetal heart tones, "vaginal packing out, and doctor in". Another humorous example stated "may shower with nurse".

Although these examples are funny and entertaining, they can be most embarrassing for the author or care provider. They also create an undesirable impression and question your credibility. How can you improve? You need to pay attention to what and how you write so that you express yourself in a clear, concise and comprehensive manner. You should strive for consistent and appropriate writing tense and express facts in an unbiased manner. Other strategies you may find helpful for improvement in spelling and grammar are:

- Refer to a standard and a current medical dictionary at the charting desk or documentation area

- Post a list of commonly misspelled or confusing words, especially ones linked to medications

- If using spell check or electronic charting, make it a habit to double check the context, as these systems are not foolproof. For example, the spell check system does not know the difference between "anal" and "oral".

Can you think of any other documenting tips or strategies that meet legal and College standards that you were taught or have learned in practice? Could you share these with your colleagues or students?

Abbreviations

In the past decade, there has been much discussion and controversy with correct and appropriate abbreviations. Have you spent extra time trying to find out what an abbreviation meant in a client's notes? Has there been a delay in your client care so that client safety was compromised? Are you using prohibited abbreviations or terms?

There are published lists of prohibited abbreviations and terms that should not be used, as they have been found to jeopardize client safety (Brunetti, Hicks & Santell, 2007). Your employing agency or facility has policies and procedures with approved abbreviations and terms and ones that should not be used. It is best practice to spell out the word when you are in doubt! This is especially essential if you receive physician orders over the telephone.

To decrease medication errors, pharmacies are labeling medications with full spelling of doses and directions. Physicians are also required to spell out doses and directions for medications. Be careful of the location of the decimal point and zeros in hand written orders. You must keep in mind client safety at all times, as outcomes can be drastic and irreversible when incorrect or inappropriate symbols, abbreviations or terms are used. Rather than just focusing on medication orders, it is prudent for a care provider to adopt a consistent systems approach! This means that you use approved abbreviations or terms in all types of communications, not just medication orders.

The following are some inappropriate examples of abbreviations that were located in client records. Although they are amusing, they may contribute to unsafe client outcomes:

- FOF – found on floor
- FOB – fell out of bed
- FLK – funny looking kid
- D/C- discharged or discontinued?
- LOC – loss of consciousness or level of consciousness?

Can you think of other unacceptable abbreviations that may have jeopardized client safety?

The Nursing Process

There is another important strategy that care providers use as a guide or framework to ensure accurate documentation. Are you able to guess what that guide may be? It is the nursing process!

The care services you provide directly link to the nursing process. Nearly all documentation systems use the nursing process, whether overtly or covertly as a guide when documenting client details. Although the *charting by exception* (CBE) method of documentation may be used by your employing agency or facility, the care provider still has to critically think about the nursing process to determine if her client has "abnormal" findings or "exceptions" to normal findings. If you are working in a health care setting where there is no formal system of documentation, you can always depend on the nursing process as a way to guide your thinking to complete client documentation.

You have just learned that accurate documentation has the nursing process as its basic foundation. Let's now take a few minutes to review in closer detail how the nursing process applies to documentation.

Assessment – This initial step includes all your measurements and observations, including objective and subjective data. Direct quotes from the client or his family are very helpful in documentation, as this minimizes stating your opinions of the client. It is prudent to omit opinions even if you are correct in your assumptions.

One area that is often excluded from assessment details is that of not recording the emotional status of a client (Brenner & Dimitroff, 2010). This study found that from client experiences, caregivers did not include an adequate assessment of emotional status of clients and care providers did not document the emotional support they provided. Remember also to do a pain assessment if applicable to your client, as pain may often be a warning sign of a significant change in a client's recovery.

Nursing diagnosis – These are the client's health problems as it relates to the standard care required for each of a client's particular health problem. It differs from medical diagnosis. Nursing diagnoses may get burdensome if a client has numerous health issues and several corresponding interventions for each health problem on the care plan. However, you should keep these in mind as you document.

Planning – This is a thinking step of the nursing process about the interventions you will perform for each of a client's health problems. It is about what you did in priority sequence for the client. You do not normally chart or document this step, but you could make brief paper notes.

Implementation – This is your appropriate interventions or what you did and the care events you performed. Once again, it is prudent to document in the appropriate place in the client's record all that you did for the client, because in the legal system, undocumented care means that it was not done. This may be done on special forms, checklists or client progress notes.

Evaluation or outcomes – This is the client's response to your interventions and includes an unexpected response if that is what happens. When documenting outcomes, this proves that you followed up a concern and demonstrates how the client responded to your intervention.

Now let's review this information.

For Review

Review the following documentation example from an acute care setting, using the nursing process. Although the nursing diagnosis and planning steps are not specifically stated, let us assume that the care provider has already reviewed these for this client.

1100 – Pt. states he has "throbbing pain in his right knee at 8/10" as per employer pain scale. Facial grimacing and moaning with movement in bed. Reports he "feels like crying because the pain is so bad". Requests analgesic. --------------------- A. Smith, LPN

1110 – Analgesic, Tylenol #3 given as per patient request (See MAR). Pillow placed between knees while in side lying position. ------------------------- A. Smith, LPN

1200 – Reports "right knee pain has decreased to 3/10", but states there is a "dull ache still present". Requests side rails down and pillow support for right knee. Will continue to monitor. -- A. Smith, LPN

In this example, it is not necessary, but acceptable, to use "patient" or "pt." in the progress or client notes. This is because the patient's correct identifying information is on both sides of the progress notes page.

It may *not* be appropriate to use the term "writer", while documenting or charting in progress notes. This is because the care provider signs the notes and obviously is the writer. If client notes that have "writer" in them are taken into the legal process, a lawyer could question who this "mystery writer" is. He may conclude that it is someone other than the care provider who signed the notes (Osgoode Law School, 2013).

Remember to sign or initial (according to employer policies and procedures) the bottom of each page when it is completed and the top of the next page when you carry forward your client notes.

Before you proceed with comparing types of documentation methods, you might find it very helpful to review basic documentation principles.

- *Document in the correct client chart or record*. Be sure you have the correct client record before you begin your documentation. You should double check this, as crossed out information and mistaken entries give a negative impression to anyone who has the authority to review the client notes. You may need to keep a small pocket note book with client specifics if you are not able to chart immediately after a client's care. For example, a care provider who has ten patients with fifteen interventions each adds up to one hundred fifty care events! Can you remember them all? These pocket notes must be destroyed after every shift, according to employing agency policies and procedures so there is no breach of client confidentiality. If these pocket notes are saved or kept in a private place, they could be demanded in court.

- *Write neatly and legibly and in ink*. Do not use white out or erase notes. You may want to check your employing facility or agency policies and procedures as to whether to use blue or black ink. Some employing agencies are now requesting dark blue pen when

documenting, as it is very difficult to tell the difference between a photocopy and the original when a black pen is used for documentation.

- *Use correct spelling and grammar*. The importance of this has already been discussed. Spell out terms rather than use incorrect ones. You should not use racist, slang or derogatory terms. For example, "He's not all there." or "She's not sure what is going on." are slang and derogatory expressions, although you may indeed be correct that the client has memory issues. If you charted that "client has memory issues", you would be making a judgment and stating your opinions even though you are correct. Also, you are not specific enough so that another care provider would know that the client has memory issues. You would need to clearly state an event or statement made by the client so that another care provider reading your notes would know that the client has memory issues. For example, you could document that the client asked you if you were her daughter from Saskatchewan, when you know the client's history states she does not have a daughter in Saskatchewan. You may document slang when it is a direct quote by a client. Remember to place a direct quote in quotation marks.

- *Document in chronological order promptly*. This makes it easier for another care provider to know what events happened in order of occurrence. Do not leave blank spaces in your notes or entries.

- *Errors or late entries are to be corrected* according to your employing agency or facility's policies and procedures. Some policies state that the care provider should not write the word "error", but rather use the words "mistaken entry". The word "error" anywhere in a client's record may be viewed with suspicion by the legal system. If you are documenting a late entry, you must give the reason why it is a late entry.

- *Sign correctly*. Include your name and designation and there should be no blank spaces after or before your name or designation.

- When reporting a change in a client's condition in the progress notes to a supervisor or physician, *identify the individual by name and designation*, unless this is contrary to your employing agency or facility's policies and procedures. Do not describe negative actions of who you made the report to, but you would state what follow-up was expected.

- *Maintain client confidentiality at all times*. Recall that in Alberta, you are legally bound by the *Health Information Act* (HIA) before you give out any client details. You must keep in mind "who needs to know and why". This includes other members of the health care team who are not involved in the care of a specific client. In the case of family or a legal guardian, you must take care that you have the client's permission to release information and any other details regarding the release of his information. If you are in doubt, be sure to always check with your supervisor or manager. Clients who are competent have the right to change their agent identified on their personal directives at any time.

- If you are using pre-printed client or hospital forms, *remember to write "not applicable"* or N/A in the areas that do not apply to your client. Do not leave these areas blank, as this may be concluded that you have not read through the form entirely or forgot to cover this section of the form. When using checklists or flow sheets, remember to initial each item. Do not use check marks or "X's".

- If you do not give a medication as prescribed, and there is not a reason why or space to check off on the Medication Administration Record (MAR), you document these details in the client notes. If a client consistently refuses a medication, you should have detailed notes on why and what you did about the situation.

Objective and Subjective Data

Now that you have reviewed basic principles of documentation, there is another challenge that care providers have. Do you find it challenging to know the difference between objective and subjective data? Consider the following.

Examples of objective data would be your assessment data. This would include any client information that you obtained from your measurements and observations. More easily said, it would be client information obtained through your four or five senses – sight, hearing, smell and touch. In the case of an adverse client event, objective data would be the specific facts surrounding the event, not what you think happened.

Subjective data is the information obtained from "what the client said" and/or "what others, generally the family, said about the client". Your goal should try to be as objective as possible. To make subjective information more accurate, use direct quotes of patients or their families.

Inaccurate Terms

Have you noticed the use of unacceptable and inaccurate words and terms that describe client care or events in your practice?

Consider the following examples of using inaccurate terms to describe client care or status:

- Orientation status is a common way that care providers assess a client's mental status or memory. Some care providers use the word "alert" to describe a client's orientation status. Alert is an opinion that does not accurately tell the reader how you know that your client is alert. It is better to state that the client is "awake and aware of surroundings". Or you could document that the client is "oriented to time, person and place" if that is indeed the case. For orientation, it is more accurate to include time, person, and place assessments; not stating "oriented" or "oriented X 3". A care provider could question – oriented to what, where, when, why and how? Or you could document his answers or quotes to your questions regarding time, person and place. Remember that one care provider may differ slightly from another in how he or she expresses a specific client event. Documenting is not always done exactly in the same way by various care providers. It can be said that documentation is not a "black and white" issue.

- The monitoring of pain is an essential component of nursing care and is often underrepresented in client notes (Osgoode Law School, 2013). When describing pain, do not use the terms "intense, moderate or mild", unless these are the exact words of the client. It is best to use the pain scale of your employing facility or agency. If your employing agency or facility does not have a specific method to assess pain, it may be acceptable to assess pain on a scale of one to ten, with "one" being very mild pain and

"ten" being very severe pain. Be sure to state this. You would then document that you asked the client about his pain level and documented his corresponding response.

- The nutritional status of a client is an important factor in client health and wellness. When documenting mealtime intake, do not say" fair, good, poor". It is best to use percentages that describe the amount of food consumed. You may need to add additional notes in the client's progress notes if there are other issues surrounding meal time such as swallowing challenges or if you had to contact a health care professional or make recommendations for a dietician.

- Part of client assessment involves the description of wounds or lacerations. Use actual metric measurements and not inanimate objects such as fruit or coins of money in your descriptions. Use correct and approved medical terminology to describe drainage.

- "Tolerated procedure well" is a meaningless statement, as it does not give any indication that a client assessment was done. You need to have accurate assessment data to show that your client tolerated whatever procedure was done. It would be better to state that the client is "Awake and resting in bed. No complaints of pain." OR "Awake and resting in bed with no complaints of pain." Be sure to also include your vital signs and other assessment data in either the progress notes or on a specific form to show that the client is responding or recovering according to standards for that procedure.

- "Client's condition satisfactory." is also a meaningless statement, as there is no indication that an assessment was done.

You can most likely think of other inappropriate terms used in documentation. The following are words or terms used that are generally inaccurate:

- Good, poor, bad
- Small, medium, large – be specific with measurements if possible
- Seems, appears, apparently
- Accidentally
- Could be, may be
- Miscalculated
- Mistake, error
- Somehow
- Unintentionally
- A little, a lot
- Severe, intense, mild, moderate
- Stable
- Normal.

Other Strategies

Other strategies for accurate documentation include:

- Document only the care you provide and never ahead of time. Unregulated care providers should do their own documentation. If you are in a health care setting where unregulated care providers do not document, then you want to be sure that you name the unregulated care provider who was responsible for the client's care.

- If you find that the above or preceding entry in the progress notes was not signed, then you should locate the care provider as soon as possible to sign his or her notes. If this is not possible, it should be clear that there is a difference in handwriting and the pen used when you begin your charting, although this is not ideal.

- When documentation continues from one page to the next, you should sign the bottom of the completed page and the top of the next page with the date and time and state that it is continued from the previous page. Make sure that each page has the client's identifying information. (Lippincott, Williams & Wilkins, 2006)

- Remember not to document complaints from staff, poor care, or accusations. Keep your documentation strictly client focused.

- What about *co-signing* and *counter signing*? In some areas of health care, both co-signing and countersigning are terms that are used interchangeably and deemed to mean the same. However, a prudent care provider should know the definition of each of these terms according to his employer's policies and procedures. Generally the meaning of co-signing has shared accountability and means that you witnessed or participated in the care or event. This makes you legally responsible for entries or documentation that you co-sign. For example, if you take out a personal bank loan and your father co-signs your loan papers, then he is responsible for the debt in case you cannot pay the loan back to the bank. Therefore, if you co-sign another care provider's client notes, then you witnessed or participated in an event and are legally responsible for the care that was done.

  Countersigning usually means that you reviewed the entry and approved the care or orders given. Examples of countersigning would be signing your name and designation after reviewing and checking physicians' medical orders. You are signing for authentication (means true and correct) in this case. Sometimes when counter-signing, you may have to write a disclaimer (a short statement that clarifies your role in the signing procedure) before your signature.

  For example, if you have only reviewed your colleague's notes or a student's notes, then you would state that this entry was reviewed just before your signature e.g., *Lyn Harper, LPN/ Entry verified by Kate Smith, LPN*. If you are verifying a student's notes, then you would say that you reviewed them in accordance with employer policy but you would state that your signature does not indicate personal knowledge of the information documented by the student. For example, *Signed in accordance with policy. Signature does not indicate personal knowledge of above care/interventions. Cathy Jones, LPN*. (Mosby, 2006).

- In your client documentation, you generally do not use names of roommates or visitors, as this is a breach of their confidentiality.

Documentation Methods

Many care providers have used different documentation systems or methods throughout their careers. Some documentation systems function better in certain health care settings while others do not. Generally, an employing agency or facility chooses a documentation system that operates well with the types of clients in care and staff preferences. However, there is no perfect system that addresses all documentation needs. Prudent care providers learn to work well with the documentation system that their employer requires. They also provide ongoing input to their employer to see if the current system is addressing client data efficiently and accurately.

A care provider should not only know the method of documentation that is required by his employing facility or agency, but should be well familiar with the system. Employer policies and procedures and regular updates or in-services of the system should be communicated to staff in a timely manner. Within the same facility or agency, a special patient care unit may use a different type of documentation system as per hospital policy. As a care provider, are you well trained in the documentation system your employer uses? If you are, then this is the first step in completing accurate documentation.

Advantages and Disadvantages

All types of documentation systems have advantages and disadvantages, whether they are print (paper based) or electronic. There are two main categories of documentation frameworks: documenting by inclusion and documenting by exception. Documenting by inclusion is by far the most common. Charting by exception (CBE) is a documentation system that states only significant findings or exceptions to normal findings. Sometimes a tick form or checklist is used. Since the CBE system has so much subjectivity, there must be clear guidelines for what the "norm" or "normal" are. If there are abnormal findings, then you may be required to explain these findings in the client notes. However, the more times client information is repeated and entered, this increases the chances of discrepancy and error.

It is prudent on the care provider's part to place an "N/A" (not applicable) to areas of a checklist or tick form that do not apply to a particular client's care, instead of leaving blank spaces. If a checklist is examined in the legal process, a lawyer could assume that some areas of the form were not done or not addressed by the care provider.

The vast majority of documentation frameworks are those of inclusion (data that describes both expected and unexpected outcomes). The following are some examples of inclusive documentation methods:

- Narrative is telling the client's story chronologically, in writing, with facts only, and using sound judgment and professionalism. This is the most traditional way of expressing client information. This client form may stand alone or be used with other tools such as checklists and flow sheets, depending upon the care setting. It is an extremely important

section of the client's health record or chart that detects changes in a client's condition and resulting interventions.

- Problem-Oriented Medical Record (POMR). This type of documentation method uses the nursing process that generates client problems. The care provider makes specific entries that are related to the client's problems while he is in care.

- Focus Charting or Data, Action, Response (DAR) documentation. This type of documentation uses client assessment data and tracks the actions of the care provider and the responses or outcomes of the client. It is similar to the nursing process.

- Block Charting is a documentation method that is done within a given time frame or shift. It is not recommended as it opens up legal issues, mainly because important assessment data is not captured at regular intervals. There could be much ambiguity (doubt) in detecting when a client's condition changed.

- SOAP (Subjective, Objective, Assessment, Plan) or SOAPIE (Subjective, Objective, Assessment, Plan, Intervention, Evaluation) or SOAPIER (Subjective, Objective, Assessment, Plan, Intervention, Evaluation, Revision). These are problem oriented approaches of documentation methods which include the nursing process that many interdisciplinary health teams use.

- AIR (Assessment, Intervention, Response). This is a quick and basic way for care providers to maintain efficiency and accuracy in their documentation. It is especially useful when an employing facility or agency has no specific documentation system.

- Problem, Intervention, Evaluation or PIE Documentation. Using this system, a care provider could ask the following questions and then document each response: What is the client's problem? What did I do about it? What were the results? Again, the nursing process forms the underlying framework.

Progress Notes

Progress notes are known by many names which may be confusing for a care provider. They are also known as interdisciplinary, nurses', client care, patient, team or narrative notes. Can you think of other names for forms that are used for recording client information? Whether using print-based or electronic documentation, one of the major challenges care providers have is completing timely, clear, concise and comprehensive progress notes.

Progress notes, or whatever name you know them by, are completed in a narrative writing style. According to the College of Registered Nurses of British Columbia (2012), narrative documentation is a method in which nursing interventions and the impact or outcomes of these interventions are recorded in chronological order over a specific time frame. Narrative documentation may stand alone or it may be complemented by other tools, such as flow sheets and checklists. The major disadvantages of narrative documentation are wordiness and it is time consuming.

Adverse Events

You learned in a previous module that caring for clients in a health care setting carries a high degree of risk or injury. Adverse events are unexpected events that have increased potential or risk to cause client harm or injury. Although it is prudent for a care provider to document clearly, concisely and comprehensively at all times, there are adverse client events that require dutiful care and attention. Can you think of some client care events that have an increased risk or injury?

The following adverse events require particular attention when documenting:

- A client or visitor fall, no matter how minor it may seem. Injuries from falls may not be evident for several hours or days. Falls are a common source of lawsuits.

- Equipment failure has a great potential to harm or injure a client. What did you do about the equipment problem? Will you explicitly document equipment failure in a client's record? No, you would most likely document equipment failure on a special form or incident report.

- An unplanned return to surgery is an unexpected event. The events prior to the return to surgery are critical and must be documented with significant client details. These notes most likely will be consulted to see why there was a return to surgery and how this type of adverse event could be prevented in the future.

- A care provider cannot predict which medication error will require intervention. Although all medication errors are reported, one that requires intervention must be documented precisely.

- A hospital or facility acquired infection is an adverse event that could result in client injury or even death. Documentation details must be written completely.

- An unexpected death of a client, whether in care or not, is an adverse event. Injury or death may not be evident until the client has been discharged.

- If a client or family member threatens a lawsuit or threatens you personally, you must pay prompt attention to the threat and complete your documentation fully in the client's notes and/or on a special form. You must document what your reactions were and to whom you reported this threat. You also need to document the response of the individual you reported the issue to.

- If a client receives injuries from criminal activity or abuse, you must document very carefully, as these injuries generally lead to a court case in the legal system.

In this module you have learned about documentation deficiencies and what you can do to correct or minimize these. You now understand how the nursing process links both directly and indirectly to the system or method of documentation your employing agency or facility requires. You also learned that most documentation methods of inclusion employ narrative documentation. If adverse events occur, be sure to use extra care and attention in your documentation.

Key points

- Illegible hand writing is one of the most common deficiencies in documentation.

- Approved abbreviations, correct spelling, grammar and terminology contribute to accuracy in your documentation.

- Documentation methods or systems link directly or indirectly to the nursing process.

- You must know and apply correct basic documentation principles before you can perform accurate documentation.

- Progress or client notes are a primary area where an exchange of client information occurs.

- Application of accurate documentation principles is especially important during adverse events.

- There are several types of individuals or situations that may contribute to adverse events. Be watchful of these.

Now you are ready to apply the knowledge you have obtained in the previous modules. Using principles of accurate documentation, the next modules will discuss some common documentation situations of care providers. Would you like to improve your documentation skills by reviewing examples of accurate and inaccurate documentation?

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Module 4
Legal Issues – Your Documentation is Evidence

Specific Learning Outcomes

Upon completion of this module, you will be able to:

- Explain how a client's record is both a legal and medical document
- Define legal terms used in assessing practice and documentation
- Describe documents that lawyers request in a potential lawsuit
- Describe what lawyers are considering when advocating for a plaintiff or a defendant
- Explain how nursing documentation is used throughout the legal process
- Discuss documentation practices for reducing your liability
- Describe steps of the legal process for potential or actual lawsuits
- Explain how your documentation is reviewed by your College.

Introduction

In the previous modules, you have learned that documentation must meet legal and professional standards. Accurate documentation ensures compliance with provincial legislation, employer by-laws, policies and procedures and College standards and practice guidelines.

This module is not a substitute for a care provider who is seeking legal advice. This module does not reflect legal practices from province to province; however, it will discuss an overview of the legal process.

Let's now take a closer look at the legal process when there is a potential or an actual lawsuit. In Canada, lawsuits are generally initiated within two years of an adverse event, except in the case of a child or minor. However, the lawsuit may drag on for years, until a trial occurs.

The Legal Process

A client's health record is the main communication tool that the health care team uses; it is also a legal document. It tells the story of the client's situation. It enables others to understand the treatments and care that the client did or did not receive. From a legal standpoint, the client's chart or record becomes the evidence if a lawsuit is initiated. Documented care is just as important as the actual care. The legal system assumes that care was not done if it has not been documented. This implies that failure to document care means that there was failure to provide care, (Lippincott, Williams & Willkins, 2009).

According to Crawford and Whelan (Osgoode Law School, 2013), regarding the justice system, "good notes will save you and no notes can destroy you". Therefore, your documentation practices can make the difference between positive and negative legal outcomes. Because your documentation is a legal necessity, your documentation may also be used to investigate a complaint to your College

or it may be used in a coroner's inquest. Accurate documentation ensures compliance with the legal requirements of provincial laws, employer by-laws and policies and procedures and College standards and practice guidelines.

Once a lawsuit is commenced, all relevant information regarding the case must be collected. This information is disclosed and shared by both legal teams, the facility or agency, and the care providers who were either directly or indirectly involved with the case. Documents investigated not only include the client's full record, but also includes medication records such as MAR (Medication Administration Record), dispensing records, professional responsibility forms and incident reports.

Other documents that may be investigated include work schedules, number of clients on a given unit, shift trades, staff on vacation, ill days and those who are on their days off. Physician appointment documents and credentials may also be examined. Human resources files or pertinent employment files that contain performance reviews, family complaints, and interpersonal memos regarding the incident may be examined. Lawyers may even go as far back as requesting the academic grades of a care provider and whether this individual has engaged in professional development activities as part of fulfilling their professional responsibilities. There may be a review of mandatory education and training records. Policies and procedures of the employer may be examined to ensure that the employer expectations are clear for care providers. Any internal memos or notes to staff regarding an event will be previewed.

Although incident reports are generally confidential, they are always reproducible should a legal issue arise. Some agencies or facilities have a client relations department that deals with family concerns and records interviews or meetings held with family and/or staff. Although e-mails may be deleted from a computer, they are reproducible and may be used as evidence. Personal notes, sticky notes or a journal of a serious client issue which has been kept privately by care providers may also be demanded by the legal system.

The Players

In a potential lawsuit, there are lawyers who act on behalf of the plaintiff (the one who initiates or begins the lawsuit and claims injury or death or damages). There are also lawyers who act on behalf of the defendant(s). The defendants could be a physician, facility or agency and the person or persons who are accused of wrongdoing.

Although you may never be named as a defendant in legal case, you may be called to testify (tell the truth of the facts) at a discovery or during a trial. You will no doubt depend on your documentation and not your memory to respond to questions regarding client care.

Because the client chart or record has the most comprehensive record of care, it is used to establish the events and has the facts of what occurred. Since the legal system ultimately wants to prove cause and effect of damages or injuries, the court accepts the actions and the communications in the client record as proof that these events did occur. The court relies heavily on the client record to reconstruct events.

Lawyers for the plaintiff use documentation to prove that the standard of care was breached or not met. The client record is inspected to see that the care was competent, safe and appropriate, as well

as completed. The plaintiff's lawyer is looking for lapses in charting, errors, amendments, deletions, inconsistencies and vague entries. He or she is trying to draw inferences or conclusions of sub-standard practices. They often engage experts to obtain critical opinions which greatly add to the costs of a lawsuit. If documentation was done before the care was completed, a plaintiff's lawyer could argue that the care was never done. Likewise, if the care was completed after the fact and documentation did not indicate a late entry, a plaintiff's lawyer could argue that the care was altered. Late entries after a serious incident involving death or injury may be viewed with suspicion.

Defendants (those being sued or those accused of wrongdoing) are attempting to prove that the standard of care was met and that the care was safe, timely and appropriate for the client. The defendant's lawyer is trying to prove that the actions of the care provider are prudent, reasonable and that there is no causal link (trying to prove cause and effect) between the actions of the care provider and the client's injury or death. He or she is attempting to show that there were no lapses in the documentation, errors, inconsistencies or vague entries. Sometimes, an unbiased, health care expert is hired to verify that the defendant's documentation and actions did not breach the standard of care.

No matter what method of documentation is used, the client record should be able to determine the following (Osgoode Law School, 2013):

- What happened (the event)
- To whom it happened (right client record)
- By whom it happened (who was involved)
- When it happened (right time, day)
- Why it happened (motivating factors)
- The result of what happened (damages, injury or death).

Problem Areas of Documentation according to the Lawyers (Osgoode Law School, 2013)

1. *Not recording at the time of the event* – long delays in documentation create negative impressions of the care provider; flow sheets can be used to assist in documentation of events.

2. *Recording someone else's actions* – you record only what you saw, heard or did.

3. *Recording out of chronological order* – this is confusing to understand the care provided; you need to be careful with late entries.

4. *Not recording concisely, factually, and clearly* – have you provided significant details on client care and adverse events? Is your documentation objective? Is your writing legible?

5. *Recording infrequently* – recording is to be done promptly with the changing condition of the client and according to facility or agency policy; frequent documentation prevents charges that nothing was done or inadequate care was provided. For example, since post-surgical cases are considered higher risks (a client has been under an anesthetic, may have an

incision or surgical wound and might be experiencing a great amount of pain), it is generally facility policy to monitor vital signs every fifteen minutes or as per physician orders.

6. *Not recording corrections clearly* – these need to be timely, honest and forthright and according to employer policies and procedures. You need to document corrections in such a manner to avoid implications that there is something to hide. When correcting a late entry, you need to state the date, time, reason and your signature. The incorrect information must still be legible. Forensic hand writing specialists have methods of detecting changes to incorrect information.

7. *Recording inaccurately and incompletely* – the client record should contain assessments, identification of health issues, plan of care, implementation of care and the evaluation of care. Remember that time and details matter.

8. *Facility or agency policies that are not realistic* – a care provider may need to address these with administration or management if documentation or other polices relating to documentation are not realistic or require updating. Do you know your facility or agency policy when a client asks to see his health record? Ensure each department has reasonable policies that have clear standards of acceptable practice and policies that are agreeable to all. Each unit or specialized area of care may have specific documentation policies.

Electronic Documentation

In a legal sense, electronic client documents that require review have their challenges. Chronologies are much more difficult to construct. Because of templates with most electronic systems, there are numerous blank areas when an electronic record of care is printed out. Some systems have no or limited narrative notes which are very important to reconstruct client events. Because care providers may complete electronic documentation toward the end of their shift, this may create an inference that the client was not actually monitored. Staff who have inadequate keyboarding skills may do less electronic documentation, which may give evidence that client was not monitored routinely.

Tips for Improving the Legal Status of Your Documentation

- Develop usual or your own practice statement to rely on if your memory fails. For example, it should be your usual practice to shred draft client notes each day; to talk in person to the receiving care provider(s) using SBAR (Situation, Background, Assessments, Recommendations). These personal practice statements will protect you in the legal process.

- Incident reports are used as evidence first by the agency or facility in internal investigations. Be careful of the language and terms you use when completing these. You do not want to use the terms "mistake" or "error" as these words can be used to determine that something you did or did not do was your fault. Remember to write about facts only, be objective and do not write accusations or blame.

- If you keep personal notes that are laden with opinions and accusations, be prepared to share these with both legal teams. It is generally not in your best interests to keep private files and notes on client care events.

When a Lawsuit Proceeds (Overview)

1. A facility or agency has immediate involvement when an incident or adverse event that involves serious client injury or death has occurred. At this point the client's record and all other reports and documents that are related even in a small way to the case are examined by the facility or agency legal team.

2. The plaintiff (individual or family) files a statement of claim that he or she was injured or harmed by the defendant(s) who could be physicians, care providers or a facility or an agency. The details surrounding the harm or injuries that the client experienced are presented.

3. The incident or adverse event is investigated by lawyers and facility risk managers. Interviews are conducted using the client documents. Do you see your role here in making sure that your documentation is clear, concise, comprehensive and timely?

4. The defendant(s), sometimes represented by the facility's lawyer, makes a statement in response to the plaintiff's statement of claim. Do you see why it is so important to follow facility agency policies and procedures? If you did not follow policies and procedures, do you think the facility lawyer would want to represent you?

5. In the disclosure phase, lawyers will examine all relevant documents and will decide which ones are significant to use in the case. Do you think that your client notes or progress notes will be inspected?

6. During Oral Discovery (Examinations for Discovery) a representative from the agency or facility is produced to answer questions. All named individuals in the statement of claim may be examined or questioned by the plaintiff's lawyer. If you are questioned, your statements may be used if a trial goes ahead. Your documentation and your practice will be scrutinized in much detail and may be sent to unbiased care experts to see if you met the standards of care by what you documented. This is because judges and juries are not qualified to know if the standard of care was met or not.

7. A pre-court settlement between the opposing parties may be made at this point. If agreements cannot be reached, then a trial date is set. This process may take years. Do you think your memory will fade with the passing of time? You may be called to testify in court, but you can be sure that your documentation will be examined. Although a lawsuit may span years, the good news is that very few lawsuits go to trial.

Key points

- A client's health record is both a legal and medical document – the facility or agency owns the record, however the client owns the information in it.

- Your memory can fade with time, but your documentation becomes your memory.

- Accurate documentation ensures compliance with the legal requirements of provincial legislation, employer by-laws, policies and procedures, College standards of a profession and practice guidelines.

- Lawyers have the authority to request all types of client records, hospital records, and staffing records and schedules. They may even request records of a care provider's work history and education credentials.

- No matter how skilled a care provider you are, gaps and inconsistencies in your documentation will undermine your credibility.

- Discrepancies and inaccuracies discredit the care provider.

- Because of the many complex clients receiving care services, your memory fades with time.

- Lawsuits and trials may span years; the client's record is your evidence or recorded memory of the events.

- Not documented means that the care was not done.

- Timely, clear, concise and comprehensive documentation portrays quality care.

- A care provider's continuing education activities may be examined to see if he or she has kept current as per employing agency policies and procedures.

- Anyone reviewing the client record must be able to determine what happened, the time, who was involved, and why and if there were any motivating factors.

- A plaintiff is the individual (or family) who is claiming injuries or damages.

- A defendant is the individual who is being accused of wrong doing or incompetent care.

- Documentation experts are hired by the plaintiff's and defendant's team to support each side.

- Lawyers for the plaintiff are attempting to prove that the standard of care was breached and that these breaches caused the injuries or death.

- Lawyers for the defendant are attempting to prove that the standard of care was not breached and that there is no connection between the care received and client injuries or death.

- Your College may examine your documentation to determine your competence, observance to standards of care and to see if you followed your employer's policies and procedures.

Reflective Questions – Take away thoughts

1. Are you able to remember all care interventions of six clients from a week ago or what happened to a client several years ago?

2. Do you document each time with the knowledge, skills and attitude that your documentation may be inspected or examined by the legal system?

3. Do you provide input to your employer regarding documentation practices and policies?

4. Are you keeping current with continuing education and professional development activities as per your employing facility or agency policies?

5. Are you striving for accuracy in your documentation to meet your College's standards of practice and competencies?

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Module 5
Applying Documentation Knowledge and Principles

Specific Learning Outcomes

Upon completion of this module, you will be able to:

- Apply knowledge and principles of accurate documentation to care provider activities, client situations and professional issues for safer or positive outcomes.

- Analyze accurate/inaccurate examples describing care provider activities, client situations and professional issues

- Distinguish between accurate and inaccurate documentation.

NOTE: Employing agency or facility's policies and procedures take precedence over the examples and the protocol discussed in this course.

In the previous modules, you learned about the importance of accurate documentation, how accurate documentation is linked to your legal and professional responsibilities and the essentials of accurate documentation.

In this module, you will learn how to apply documentation knowledge and principles to many common care provider, client and colleague situations. This module will provide you with knowledge and skills to improve your documentation, regardless of the health care setting you work in.

There are literally hundreds of documentation situations that health care providers may encounter in their practice. By reviewing the following situations, you will obtain many documentation strategies.

Admission

Care providers are frequently involved with admission of clients into health care services. You may be required to use an admission form, narrative or progress notes and client history, or a combination of these documents to complete the admission process.

- The *admission form* is a very important part of the client record when a client first comes into care. It includes physical and psychological assessments of the client and may include the social, spiritual and financial situations of the client. If an admission form is part of the client's record, it is best to state if the form was partially or 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 ones with a "yes" or "no" answer while open ended questions are ones where a client gives you a verbal answer. Since these types of questions may have bias or interpretation challenges, remember to use exact quotes from the client, even if the client uses English slang.

- In some care settings, there may not be an admission form, but the care provider will 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. Both the admission form and the client history provide client data that is usually linked to the determinants of health. This is so the care provider may accurately use the nursing process in planning the client's care.

For example, consider a client who recently had a stroke, lives in an apartment and is assigned to your care. The admission form may have a checklist where a client lives and "apartment" is one of the choices. However if the apartment building has no elevator, this may mean significant mobility issues for the client. Or does the client live on the first or ground floor? You might assume that all apartments have elevators, but that is not always the case. Sometimes it is necessary to ask a few more questions to obtain accurate client information.

The following are additional strategies to improve your documentation:

- 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, increases the odds for mistakes or errors. This is also not an 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 and is not addressed in the admission form. Can you think of an example of important information in a client's care that would not be in the admission form? Perhaps he or she was threatened by a family member or he has made statements to you that could involve elder abuse? Or she has financial issues that make it difficult to provide for basic living expenses?

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

- Most facilities or agencies require that the admission process is 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 facility or 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. You may wish to review the information in the previous module on co-signing and counter-signing, as more than one care provider completing admission or a procedure has legal implications.

- 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 (memory loss). You need to document who provided the client's information to you and their relationship to the client.

- Besides the general admission process of a client into care, another area to consider is admission to your care unit. (This area will be expanded on inpatient transfers in the latter part of this module.) 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.

Review the following admission notes to a care unit. Is there something more that may be documented that is often missed?

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

Fig. 5.1

The emotional status or pain severity of a client is often omitted, however in the above example it should be on the assessment admission form, in which case there would be no need to repeat this information in the progress notes.

Consent to Treatment or Procedure

Consent may be expressed verbally or in writing or it may be implied by the client's or a legal decision maker's actions such as a nod or permitting the health care provider to continue on with a treatment or procedure. A decision would be made by the client or a legal decision maker. Consent involves the following (Covenant Health, 2013):

- The medical condition of the client (diagnosis)
- Purpose and proposed nature of the treatment or procedure
- Risks and benefits
- Alternatives
- Consequences of not undertaking the treatment or procedure.

The documentation for consent would then 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 (Covenant Health, 2013). There should be no abbreviations used on the consent form.

Witnessing a consent form only gives evidence of the form being signed and is not evidence of the consent process. If a client expresses doubt about consent and requires further explanation, the witness shall not sign and refer the client to the health practitioner. This is generally the physician or other care practitioner who has legal and professional authority to perform the treatment or procedure.

If a new consent form is used or if there are changes to the existing one, this must be done according to employing facility or agency policy and procedures. If a client withdraws consent, risks must be documented in the client health record. It must also be noted on the consent form that the client consent is no longer valid.

Refusal of treatment

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

Physician or health care professional notification

Most care providers must notify a physician or health care professional of changes in a client's condition, laboratory or test results and client or family concerns. Can you recall other reasons why you have had to contact a physician or health care professional?

A change in a client's condition is one of the most common reasons for establishing contact with a client's physician. When doing so, you must document the correct date and time and exactly what you told or reported to him or her. You must include the health care professional or physician's name and his or her response by quoting them.

Consider the following information that was documented by a care provider:

28/02/2014 – 2215 –"Physician aware of client's deteriorating condition".–C. Williams, LPN

The above statement is vague and does not include the necessary elements of accurate documentation when notifying a physician. It does not meet legal and professional standards. The physician or health care professional should be named, the time of notification and method of communication noted. You must also include what you reported in your exact words. When in discussion with a physician, you must also document exactly what the physician told you. If there are new orders, you should make a note in the progress notes to alert staff that there are new orders. If there were no new orders, you should state that also.

The following example demonstrates how a physician or health care professional is notified in an acute care setting, regarding a change in a client's condition:

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

Fig. 5.2 (Mosby, 2006)

Now take a few moments to reflect what principles you use when notifying a physician or health care professional:

- Correct date and time
- Method of communication
- Name of doctor/care practitioner
- Why you telephoned – be specific
- New orders received or no new orders

- Use exact words of the physician or care practitioner.

If you have reason to believe that the physician or health care professional is not responding appropriately to your concern, then it may be necessary to activate the chain of command and complete an incident report or a professional responsibility form. In the client record, you would document the times of the physician contacts, but you would not document that the physician ignored your requests or that you filled out an incident report.

The following example crosses professional boundaries and has several deficiencies when notifying a physician of a change in a client's condition.

24/06/2014	2215	Client's physician notified X3 by telephone of client's deteriorating condition. No responses from physician. Supervisor notified and chain of command activated as per hospital policy.----------------C. Williams, LPN

Fig. 5.3

The following is an *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.

24/06/2014	2130	Dr. D. Spence notified by telephone of client's elevated temperature of 39.5 C (t).-----------C. Williams, LPN
24/06/2014	2145	Dr. D. Spence notified by telephone of client's elevated temperature of 39.5 C (t).-----------C. Williams, LPN
24/06/2014	2200	Dr. D. Spence notified by 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

Fig. 5.4

Likewise, in reporting laboratory or other test results, it is important to name the test and if new orders were received or there were no new orders. Be sure to document if messages were left and with whom.

When reporting significant client details to a supervisor or nurse in a charge, it is not acceptable to document "supervisor aware of client's deteriorating condition". A prudent care provider would state the name of the supervisor or charge nurse (unless this is contrary to employer policy) and also document exactly what he or she reported to the supervisor in regards to the client's deteriorating condition. Do not use the word "aware"; it is better to state "notified" or "informed" and the method you used for the communication. Also document the supervisor's response and instructions received.

Telephone Calls and Messages

Care providers use the telephone and voice messaging systems regularly in communications with the health care team. This includes calls made and calls received. What are the essential elements of telephone calls and voice messages? 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. The following is an example of how to contact a physician in regards to a client's abnormal lab test.

| 24/06/2014 | 1300 | Dr. K. Lull's clinic notified by telephone of client's elevated WBC. Message left with K. Thorowsky, LPN--------------
--------------------------------C. Williams, LPN |

Fig. 5.5

Physician Telephone Orders

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. Physicians who text their orders may be doing so inappropriately, unless your employing agency has policies and procedures to approve this method.

What are the essential elements when receiving orders over the telephone? You should write down the orders immediately on the physician order form while the physician is talking on the telephone. Be sure to write the date and the time and complete the orders verbatim, or exactly as told. Numbers in regards to medication dosages particularly need to be clear. For example, you should use the words, "one, and seven" and not "seventeen" when dealing with numbers. 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 may have to ask another care provider to listen to the orders if there are challenges with hearing or telephone reception.

After the orders are received, you would on the next line write: VTO (verified telephone orders) if this is an acceptable abbreviation by your employing agency or facility and confirm the orders were correct. 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. Be sure to have the physician sign his orders within the policy time period, otherwise you could be held liable (responsible in a legal sense) for practicing medicine without the authority to do so.

The following is an example of a physician telephone order:

| 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----------------- |

Fig. 5.6

In the above example, you could write out "verified telephone order" instead of VTO.

Post-Operative Care

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.

Study the following post-operative documentation example and see if you can locate deficiencies.

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

Fig 5.7

Did you locate where improvements could be made?

The following are deficiencies from the post-operative example:

- 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 report from another care provider (transfer of care) when received on the unit? SBAR (Situation, Background, Assessment, Recommendations) will be discussed later in this module.

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

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

- When a client is first received into your care, vital signs should be documented first in the progress notes. A care provider reading the progress notes could get further client information on the vital signs and assessment's form.

- Breath sounds that are normal should be described as "clear on auscultation" or even just "clear".

- Capillary refill should be stated accurately; for example as "less than 3 seconds".

- "Appears to be sleeping" is a vague statement; it is preferable to state that "the client is resting with eyes closed, but awakens or opens his eyes when his name is called"

- "Arouses" could mean sexual arousal; it is better to state that the client "awakens".

- The location of the palpable pulses should be stated.

- Oriented to time, person and place is more accurate than "oriented". You may use exact quotes to verify that the client is oriented.

- BS could mean blood sugar. It is better to describe the bowel sounds in the four quadrants e.g. high pitched, low pitched.

- Post-operative clients often have nausea – there is no mention that this was part of the care provider's assessment.

- It is best to include any teaching and if safety measures were implemented before you left the client's room. Were side rails used? Call bell should be accessible, and not just "handy". "Handy" is slang (improper English).

- IV infusions should state the type, rate, site and other details.

- Pain assessment was done and is something critical to monitor in a post-op client.

- Emotional status of client could be included in this example.

The following is an improved documentation example of a post-operative client:

| 24/06/2014 | 1100 | 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 and client verbalized its use. IV of 100 ml D5/0.45 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 facility post-op policy.-----C. Williams, LPN |

Fig 5.8

Since admission of a post-op client has increased risks for adverse events, it might be advantageous in this example to state if side rails were used. Because it is not documented, the reader implies that no side rails were used.

Discharge from Care

Care providers may be assigned to handle discharges of clients from health care services. Discharge planning typically begins when a client first comes into care, as health care services have limits. Depending upon the care setting and medical condition of the client, the time frame of a client who is in care may be hours, days, weeks, months or years.

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. How may a care provider legally and professionally document the end of the of client and care provider relationship?

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. The discharge instructions will depend upon the client's diagnosis and tailored to his medical needs.

A prudent care provider will engage 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 forgets the instructions. In Alberta, the Health Link telephone line may be used for additional health information.

A care provider should complete a final physical assessment, including vital signs, in case there are atypical 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.

The following is an example of discharge documentation. Please review it.

| 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 |

Fig. 5.9

You should do a final assessment, including vital signs.

Discharge against Medical Advice

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".

However when a client signs this release document, it does not mean that the care provider is completely released from care responsibilities. 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.

Review the following example when a client discharges himself. Are the key points from above addressed?

| 24/06/2014 | 2100 | 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 |

Fig. 5.10

In the above example, there is something omitted in the documentation. Do you know what it is?
Answer – A final vital signs check is not mandatory but best practice.

Health Literacy

Health literacy is linked to client and family teaching. Health literacy means that a client has the necessary skills to enable access to and understand his or her health. There are several hundred thousand new Canadians annually who have access to health care.

A care provider who teaches a client who is not health literate needs to focus on these three main questions, so that the client understands the teaching or instructions of the care provider. The client should be able to answer the following key questions in his or her own words:

- What is my main problem?
- What do I have to do?
- Why is it important for me to do this?

Client Teaching

Client or family teaching is an important aspect of the care provider role; it is often done while a client is in care or part of impending discharge. There may be employing facility or agency policies and procedures on client teaching.

Client teaching may be formal, according to a plan, and using specific forms and teaching materials or informally done when the client or family asks a question. A client's learning can be of the cognitive type that involves retention of knowledge, or it may be affective learning that involves feelings and attitudes, or the learning may be of a psychomotor type that involves the learning of a skill.

Teaching a skill with a return demonstration for evaluation may need to be organized in several sessions. Before any client learning and teaching is prepared, a care provider may need to asses if the client or family is ready to be taught.

Have you considered how a care provider would document a client teaching session? When documenting a client or family teaching session, be sure to include learning barriers, goals, equipment or supplies used, printed materials given to the client and evaluation.

Evaluation is an important step of client teaching, as it may determine if a client returns to care. How did you evaluate the learning? Did you evaluate the learning verbally, return demonstration or by some other method? You may also include in your documentation responses of the client or family.

Does the following documentation example meet the criteria for documenting the teaching that was done with a client? Are you able to recall the key points when preparing a client or family teaching session? Review the following example:

24/06/2014	1400	Pt. taught deep breathing and coughing exercises with abdominal pillow splint. Pt. returned demonstration and verbalizes importance of exercise.-------C. Williams, LPN

Fig. 5.11

Family Interactions

Families or significant others are an extension of a client and generally wish to be involved in or informed about client care. It is best to listen attentively and take family issues or complaints seriously. You do not want to argue with family members or defend your actions. Families are under great stress and need to be kept informed when a loved one is in care, particularly if the client is very ill. Sometimes a heartfelt apology for a complaint and keeping families informed can prevent threats or actual lawsuits. You want to keep your client's family informed so they can assist you in your care for the client. Remember that they know your client best.

If there is great sensitivity to an issue, your supervisor may need to become involved. You need to date and time conversations and questions from families by using direct quotes. If an unusual event occurs, you document who you notified, your conversation and his or her responses. Sometimes you may need to explain something or provide some aspect of teaching to the family. You also document referrals you made to community resources in the progress notes, even if there is special referral form to use.

Consider the following family interaction example:

24/06/2014	1600	Daughter E. Jones, verbalized concerns of mother's hygiene – "I don't think my mother is having her showers. Her hair and fingernails are dirty." Bath schedule shows client refusal of 1 of 2 scheduled showers each week since admission; now having sponge baths. Client stated: "I have never taken more than one shower a week in my life and I don't intend to start now." Client has been planting garden seeds. Daughter is satisfied with plan and client agrees to shower once per week with sponge baths prn. Care plan amended to reflect changes.---C. Williams, LPN

Fig. 5.12   (Mosby, 2006)

When dealing with families, what are key points to remember?

- Listen attentively and apologize with no excuses – a sincere apology can prevent a lawsuit

- Families know the client best and can assist you in client care – engage them in a supportive role. Document your conversations using dates, times and direct quotes

- Document any teaching or explanations you have given and to whom, as there may be several family members. You may need to consult the client's personal directive or ask the client to find out who the family contact is in some situations.

- You may need to document if a supervisor has been involved with family issues.

Client Meetings

When and where might a care provider encounter client care meetings or group sessions? Mental health units, long term care facilities, and home care clients often have care or case conferences with family involvement to discuss if care needs are being met or for discharge planning.

Only meetings that are pertinent to the client's care and well-being require a notation in the client's record. You may state in the client notes who the recorder and chairperson were and who was present. You do not want to duplicate the meeting minutes in the progress notes, but may state a few general discussion points and the client's response if that is appropriate. Make a notation in the progress notes to view the detailed meeting minutes that are generally kept in the appendix (section at the end of a client record that has additional information and details).

Review the following example of a client meeting that was held.

| 24/06/2014 | 1130 | Interdisciplinary family conference held at 1000. M. Fields, LPN recorder and C. Williams, LPN chaired. Client, client's wife, Anne and Dr. J. Monroe present, along with care team. Goals and expectations of move to long term care discussed. Meeting adjourned at 1115 (see meeting notes).-------------------------- C. Williams, LPN |

Fig. 5.13

Are you able to recall the key points when documenting a client conference, meeting or session? The same procedure of documentation would apply to a group session.

Medications

Incorrect management of medications is one of the most common areas where lawsuits occur. Employing facility and agency policies and procedures must be followed with scheduled and PRN medications.

Your documentation must show evidence that an assessment was done prior to the administration of Pro Re Nata (PRN) medications (Covenant Health, 2013). PRN medications are documented on the Medication Administration Record (MAR). The MAR may not have space for documenting significant details such as a pain assessment. You need to check when the medication was last given. Next, you document when and why the client requested the medication, the intensity or level of pain, type and location of pain.

In your post assessment of a PRN medication, be sure to document the client's response, side effects and therapeutic effectiveness according to the expected action and route of the medication. Document other pain reduction strategies you may have implemented or recommended. If the prescribed pain medication is not controlling the pain, you may have to report this to a supervisor or the client's physician. You will then document according to what you have already learned about reporting a change in a client's condition and contacting a physician.

If medications are being withheld, you need to document why and if anyone was notified. The following is a documentation example of medications being withheld.

| 24/06/2014 | 1030 | Two episodes of diarrhea in past 7 hours (see flow sheet). Stool softener withheld. Dr. S. Tillis notified of diarrhea and medication withheld. New orders received to withhold stool softener, monitor diarrhea for 24 hours and report back to Dr.----------------------C. Williams, LPN |

Fig. 5.14

Medication Errors

Errors or mistakes occur in all types of industries. You may recall that health care services have high risks. One of the most common areas of lawsuits involves the incorrect use of medications. All medication errors require documentation, as a care provider does not know ahead of time which medications may cause serious injury or death. The word "error" or "mistake" should not appear in your documentation. An incident report will also be filed, but no mention of this should be made in your documentation.

Please review the following documentation example of a medication error and what was done. Do you think it is necessary to use the word "again"? It might be preferable to omit the word "again".

| 24/06/2014 | 1500 | Morphine 10 mg SC at 1215 and again at 1445 for 8/10 abdominal pain. Dr. G. Miller notified at 1455 – will assess in 10 minutes-instruction received to monitor client respirations and O2 sats. BP 100/62, P68, R12. O2 sats 95% on RA. Temp 37.1 C(t). Client states: "I feel very sleepy, but my pain is now nearly gone." Oriented to time, person, place. Side rails up and call bell in reach. ---------------------C. Williams, LPN |

Fig. 5.15

Client Falls

Client safety is an integral part of client care. In Canada, medication errors and falls are the two most reported client safety issues (Rokosh, 2006). Although medication errors usually involve dosages, falls can lead to serious injury or death. Most falls in facilities are reported to occur at the bedside while a client is getting out of bed. You should know your employer fall prevention policies that include:

- A falls risk assessment on admission and a review annually or as dictated by client condition

- Documentation that includes assessments, plan of care and interventions

- Methods of communication to all care providers and client risks for falls

- Documentation of safety measures put in place such as bed rails "up", call bell, controls and personal items in reach, bed in lowest position, client teaching for getting up, environment pathway free of obstacles, proper lighting or whatever measures you have implemented.

Documentation of a fall should include:

- Client's condition when found
- Direct quotes from client
- Assessment and injuries identified
- Safety initiatives to prevent further falls
- Physician notification, communication, examination, diagnostic studies
- Family notification
- Evidence of ongoing monitoring
- Other reporting requirements as facility policy and procedures.

Client Transfers (Covenant Health, 2014)

In care facilities, client transfers between care units happen frequently. It is important that documentation is completed by both the transferring care provider and the receiving care provider. SBAR principles (situation, background, assessment, recommendation) are implemented when transfers occur and can easily be applied to handover or change of shift reports.

S - situation	Concise statement of problem; what is going on
B - background	Pertinent and brief info related to the situation; what has happened
A - assessment	Analysis and consideration of options; what you found or think what is going on
R - recommendation	Request/recommend action; what you want done

The following are examples of client transfers, excluding assessments that would be done before and after a transfer:

The transferring care provider would document the following:

29/05/2014   – 1015 – Pt. transferred from Unit 16 A to Unit 16 C. Report (using SBAR) given to C. Williams, LPN.---------------------------- L. Maddox, LPN

The receiving care provider would document the following:

29/05/2014 – 1030 – Pt. received to Unit 16 C from Unit 16 A. Report (using SBAR) received from L. Maddox, LPN.------------------------------- C. Williams, LPN

Cardiac Arrest

A cardiac arrest is both a high risk and stressful event for health care providers. In the event of a cardiac arrest or other emergency situations, it is permissible to assign a recorder to track the time, assessments, interventions and responses of the client. Usually a special form is used in the event of a cardiac arrest. Your employing facility or agency should have a documentation policy on emergency situations. A code record form has more detailed information and will become part of the client's record. The following example was posted in a client's record.

| 24/06/2014 | 0710 | Discovered by J. Ross, HCA unresponsive in bed without respirations or pulse. Code called at 0630. Initiated CPR with A. Barrow, RN. Code team arrived at 0635 and resumed resuscitative efforts (see code record). Dr. R. Mallon notified at 645 by telephone of code. Kim Voss, family notified at 0700. Transferred via stretcher to ICU by code team.----------------------C. Williams, LPN |

Fig. 5.16

The above example could be improved by stating the relationship to the family of Kim Voss.

Key Points

- Do not duplicate client admission information in the client's health record, as this increases errors and is a waste of time.

- Document consent discussions with clients.

- Document refusal of treatment discussions with clients.

- Witnessing a client's signature does not give evidence of the consent process.

- A change in a client's condition is one of the most common reasons for notifying a physician or care practitioner.

- Be professional with sensitive issues that involving physicians and other members of the health care team – no slanderous or critical remarks, accusations or blaming in your documentation.

- Be specific when reporting client information to supervisors – do not forget to document what the supervisor's comments or instructions were.

- Do not use opinions or vague statements when documenting – keep your documentation objective and factual.

- Discharge of a client from health care services generally means the end of a therapeutic relationship of the client and health care provider.

- A sincere apology to a family may prevent a lawsuit.

- Health teaching involves much more than repeating information to a client.

- PRN medications involve special documentation aspects.

- Since falls are an adverse event that usually result in serious injury or even death, you must know your facility or agency policy and procedures for assessing risks, prevention and documentation.

- Client transfers within a facility involve documentation by both the transferring care provider and the receiving care provider.

- Practice SBAR with not only transfer of clients, but with change of shift or handover of clients.

Take away thoughts

1. Are you ready to put into practice the knowledge and skills of this module so you can improve your documentation?

2. Remember that learning principles of accurate documentation is much easier than trying to memorize specific documentation examples.

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Module 6
Electronic Documentation

Specific Learning Outcomes

Upon completion of this module, you will be able to:

- Define informatics

- Compare written and electronic documentation

- Explain care provider responsibilities when using health care technology and electronic health records (EHRs).

The previous modules have mainly focused on hand written or paper based documentation and application of principles to ensure accuracy in your documentation.

Introduction

Technology is rapidly becoming the model for information services in health care. Informatics is the merging of medical and nursing science with computer science to better manage health related data and continues to expand in all health care settings (Mosby, 2006).

Most facilities in Canada today incorporate some type of electronic technology for record keeping. Canadian Nurses Protective Society (CNPS) (2014) reported from a Health Canada Infoway study approximately 75% of nurses use technology in practice and 50% use a combination of both paper based and technology.

Technology systems vary greatly among health care organizations and research has shown mixed results when comparing paper-based systems to electronic systems (Kutney-Lee & Kelly, 2011). Computerized documentation systems consist of complex, interconnected sets of software applications that process and transport data to and from the health care team. This data guides the health care team in providing safe, client-centred care while at the same time identifying client needs. Some systems gather not only data while the client is in care, but retrieve past client records from various agencies or facilities.

As the general population becomes more computer literate and with increased government support, a computerized or electronic system is fast becoming the standard for client records. It is called the electronic health record (EHR). The client's electronic health record contains the same components that a traditional paper-based health record would have: medical history, clinical status, laboratory and diagnostic test results, treatments and documentation of client care interactions. Regardless of whether paper-based or electronic documentation is used, the same principles of accurate documentation apply. Remember your documentation is not only your memory but also evidence of using the nursing process in caring for your clients.

The Electronic Health Record

When using electronic health records, the care provider must log on to either enter or retrieve client information. After entering a password, updated information such as lab tests or new physician's orders may be obtained. Electronic systems automatically record the care provider's name, along with the entry date and time. The care provider may use drop down menus to enter assessment data or significant client notes.

Errors may occur if cutting and pasting client notes when specific information does not relate to a particular client (Kelley, Brandon & Docherty, 2011). Drop down menus may be interpreted differently by care providers and this could result in client safety issues (Canadian Nurses Protective Society, 2014). It is impossible for an electronic documentation system to capture client specific data for each and every intervention.

From a legal standpoint, CNPS (2014) has learned that communication between health care providers has been inadequately documented in electronic records. Some researchers have even suggested that electronic documentation creates distance between care providers and decreases time spent in caring for clients (Laitinen, Kaunonen & Astedt-Kurki, 2010).

Advantages of Electronic Documentation

Electronic documentation has many advantages. It usually speeds up the time required to document and improves accuracy and legibility, although this is debateable if the care provider does not know how to use the electronic system correctly. Therefore, errors may easily occur.

Electronic systems reduce reliance on a care provider's memory as client information can often be completed in real time (at the bedside or at the point of care immediately after care is completed). Sometimes electronic documentation is done at a specific computer station or at a central location right after the care has been completed.

Electronic documentation systems have the ability to reduce redundant information and prevent recopying of the same client data. Computerized systems permit health care providers who have assignments in caring for a specific client to enter updated client data so, if required, other health care team members are immediately informed of changes.

Many computerized systems assist in the standardization of care by providing specific pathways and formats for entering client information. Most systems incorporate the nursing process. These systems may be interactive and prompt you with questions about assessment data and follow-up of the information that you entered. Some interactive systems require you to enter a brief narrative, while others demand a full narrative on client notes (CNPS, 2014). There may be mandatory reporting fields for assessment data which ensure that the care provider does not omit these. Some programs contain algorithms that guide a care provider through the nursing process to document client centred care. Some programs allow a care provider to update prescriptions or these may be done automatically when the physician changes a prescription.

There are software programs that have a discharge plan for health care services. Others have teaching components that assist care providers with clients who are in care or are being discharged

from care. Some facilities have voice activated documentation systems. These are more commonly found in operating rooms and other areas that require high volumes of structured reports.

You should remember that once you have access to various types of client information, the computer may guide you to a decision, but it will not make a clinical decision for you.

Your employing agency or facility generally chooses an electronic program that meets the needs of the health care environment and type of clients that you are assisting with care. Employers track budgets, client outcomes and care needs electronically. Some systems also have management reports, staff scheduling, staffing projections, client classification data, accreditation business and research data. Some systems provide mandatory teaching modules for staff.

Challenges of Technology

Technology also has its challenges. Electronic or computer based systems are expensive to design, implement and maintain. Employing facilities or agencies have large departments dedicated to the maintenance of electronic records.

Electronic systems demand increased staff training which can add tremendously to costs. In some systems, the care provider must have keyboarding skills and has to enter progress notes using a narrative format. A health care provider who relies solely on electronic documentation may interact less with colleagues and reduce collaboration with other health care providers who may have verbal input to ensure quality client care.

Electronic systems may malfunction and routine maintenance may prevent the access of timely client information. If electronic systems malfunction, there must be a back-up system to record significant client information – usually it is of the hand written type.

As with any type of electronic technology, there are hackers (individuals who gain unauthorized access to computer databases) who may violate client confidentiality or who can actually disrupt huge systems and destroy or change essential client information.

Electronic health systems are constantly being upgraded. Since there are new and improved technological innovations every year, it is a challenge for health care providers to keep up. Recent advances in electronic documentation include computerized systems that enable physicians to prescribe medications electronically. This system then produces an entry in the medication administration record (MAR). It has a built-in system that detects incorrect doses or medication interactions or abnormal laboratory results. Some medication systems have bar code technology where the client's bar code, the care provider's bar code and medication bar code all have to match. An alarm may be activated if a medication error is about to occur.

Confidentiality and Security

Protecting client confidentiality is a major issue for health care providers who document electronically. Some clients may withhold essential information from care providers, if they know that their personal information will be entered into a computer database. Canadian Nurses Protective Society (2014) outlines several requirements for security:

- User IDs (identifications)

- Strong passwords

- Time out feature

- Audits of usage

If precautions are not taken, a client's record remains open for others to view until the care provider logs off manually or a time-out feature automatically closes the record. Unauthorized persons could gain access to client records if a care provider forgets to log off, not just close off the screen.

A care provider's password should not be known or used by anyone else – your password is your electronic signature. The computer screen should not be viewed by anyone who is not directly associated with the client's care. This includes visitors or those who may be passing by. It is important that the care provider logs off when he or she has completed a client entry or has retrieved client information or has been interrupted and must leave the computer.

As with traditional client records, it is important that the right client record be retrieved for documentation. Documentation errors can be corrected before storage on the computer; however, once the information goes into storage, the information becomes permanent. In many programs, the incorrect information is corrected similarly to paper-based documentation. Don't forget to save your entries when documenting electronically.

Remember to follow your employing facility or agency's policies and procedures when making corrections electronically. An important safety feature of electronic documentation is having a back-up system for client files. Although computerized systems have safeguards to prevent accidental deletion of files, you must know your employing facility or agency's policies and procedures if this happens. Usually a supervisor or the information technology department must be notified immediately.

Mobile Devices

There are an increasing number of care providers who use smart phones and other mobile devices to communicate with members of the health care team or with clients by way of text messaging or e-mail (Canadian Nurses Protective Society-CNPS, 2013). Some care providers take photographs of wounds or skin and send these for assessments. If you are using these devices, you must be clear on personal and professional expectations and consequences.

There is much controversy whether mobile devices with applications (apps) should be permitted while care providers are on active duty (on the job). Depending upon the employing agency or facility and health care environment, mobile devices with apps may assist in timely and safe quality care. Some employers encourage care providers to use their own personal devices, while others have employer

mobile devices that care providers may use while on the job. For example, care providers may look up medication dosages and side effects, or locate employer policies and procedures easily.

With any type of technology, including mobile devices and apps, there are major issues surrounding breaches of client confidentiality. If encryption (an electronic security process that minimizes unauthorized use) of client information is not used, unauthorized individuals may have access to confidential information. Mobile devices are targets for thieves and may be stolen. This may result in huge breaches of client confidentiality. There are infection control issues when mobile devices are shared in a workplace setting. These devices have potential for abuse; they can become time wasters and distract you from performing safe and quality client care.

Key Points

- Health care organizations using technology for client health care input and retrieval of information are on the increase.

- Electronic client documentation systems are becoming widespread as the general population becomes more computer literate.

- Electronic health records (EHRs) are designed to effectively and efficiently guide the whole health care team in a client's care.

- An EHR contains the same components as a traditional or paper based health record.

- Your electronic entries on client care are your memory.

- Principles of paper-based documentation apply to electronic documentation for both input and retrieval of client data.

- It is your responsibility to become educated and trained in the electronic system your employing facility or agency uses.

- Transition from paper-based documentation to an electronic system has potential for risk and errors, if staff have not been educated and trained in the system.

- Your password is your electronic signature – log off when finished your documentation or if you are interrupted.

- Know the back-up system your employer uses in case of systems failure or times for scheduled computer systems maintenance.

- Computers cannot think and do not make clinical decisions for you; they can only assist you to make decisions.

- Know your employing facility or agency policy for correcting electronic documentation errors.

- Breach of confidentiality may occur if a monitor is left exposed or if you are viewing another client's records when you are not assigned to care for the client.

- Be sure of your employing facility or agency's policies when using mobile devices in your workplace.

- Be aware of both personal and professional consequences of using mobile devices in the workplace.

Reflection Time – Take away thoughts

Think about the following:

- Now that you have completed this module on electronic documentation, how do you feel about using an electronic client documentation system?

- Are you confident to transition from a paper-based documentation system to an electronic one?

- What are the personal and professional consequences of using mobile devices when caring for clients?

- How will you become proficient in the electronic system your employing facility or agency implements?

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