COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

Nursing Documentation 101

Module 2: Importance of Accurate Documentation

Handout

Module 2 – Importance of Documentation

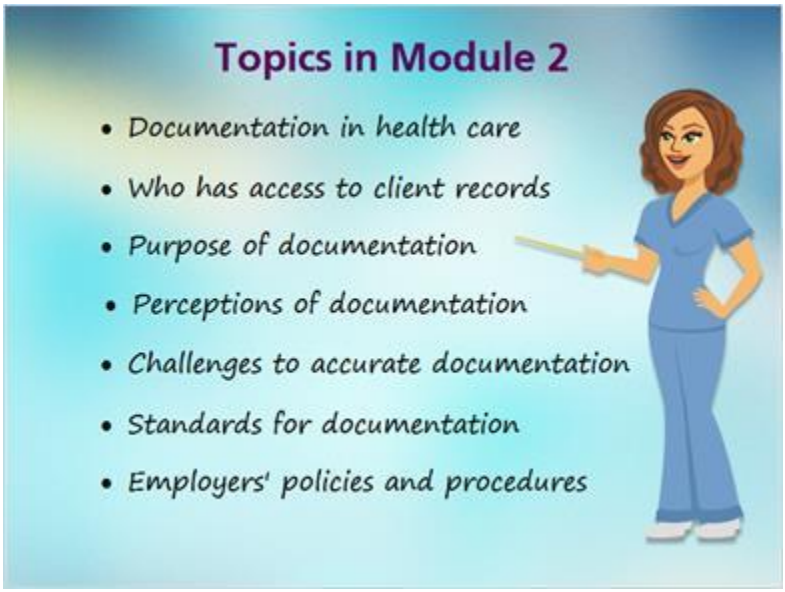
1. Introduction

1.1 Welcome

Narration

No narration, only music.

1.2 Topics



Narration

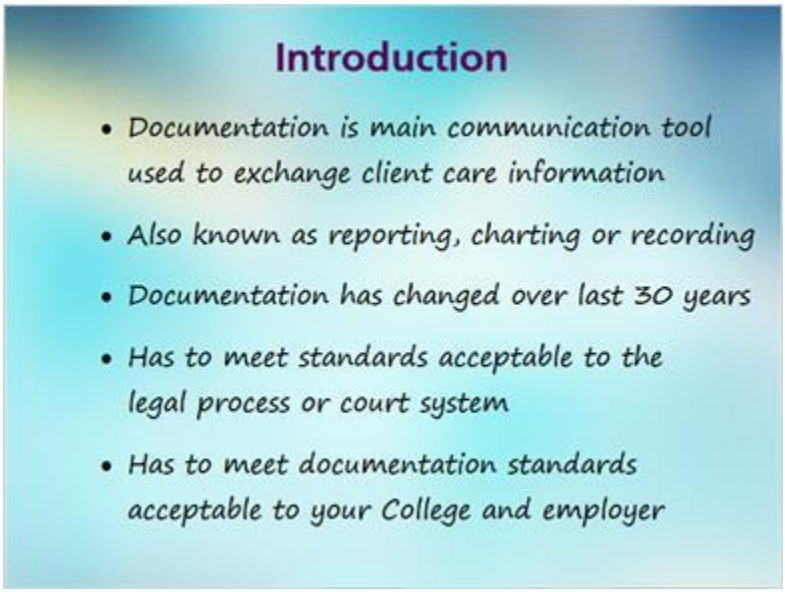
JILL: Hi … I'm Jill and with me is Mark. Welcome to Module 2 of this Nursing Documentation Course.

MARK: Hi Jill. What are we talking about in this Module?

JILL: We are going to start by describing documentation in the context of health care. Then we will briefly outline the different organizations and individuals that have access to client health records. Next, we will review the purpose of documentation and the different perceptions that care providers have of documentation. We will then identify the challenges experienced in completing accurate documentation. We will briefly review some standards for accurate documentation. Finally, we will describe the role of employers' documentation policies and procedures.

MARK: Sounds interesting … let's get started!

1.3 Introduction



Narration

JILL: Documentation is one of the main communication tools that health care providers use to exchange client information. It is also known as reporting, charting and recording.

Documentation has changed significantly over the last few decades. Mark, did you know that a typical client record 30 years ago in a hospital ward would be "Good day, no visitors today, good night, slept well, appears stable and tolerated procedure well"?

MARK: Are you kidding me? Hey, I wish I was born 30 years earlier as documenting was a lot simpler then! (*chuckles*) I guess that this type of documenting is no longer acceptable.

JILL: That's right Mark. It would be viewed as ineffective and inappropriate in today's health care world. Furthermore, there was no evidence of ongoing assessment and re-evaluation of client condition and risks.

MARK: So what was responsible for the way we have to document now?

JILL: Well, what would be your guess?

MARK: Hmmm … If I were to take a guess, I would say "lawsuits"?

JILL: You are probably right Mark! Documentation is now defined as any written or electronic information or data about client interactions or care events that meet both professional AND legal standards. Legal standards refer to how your documentation will be examined by the courts.

And of course, once regulatory Colleges and employers ended up in court, they also improved and expanded their policies, procedures and standards related to documentation.

MARK: So what you are telling me Jill, is that everything I document about a client and his or her care MUST stand up in a court of law?

JILL: You got it!

MARK: That is one scary thought!

1.4 Concerns

Narration

MARK: So with all these new professional and legal requirements, we must be doing a much better job documenting these days, huh?

JILL: Not really Mark. 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. This is in sharp contrast to the many care providers who believe that their charting is "good" or "adequate."

As well, College committees and practice consultants agree that deficiencies in documentation are a significant issue. Employers and care providers themselves have similar concerns about inadequate or inappropriate charting.

MARK: Okay, now you really got my attention! I want to know what these documentation deficiencies are, and better still … how to fix them.

1.5 Environment

Narration

JILL: Mark, did you know that a recent study concluded that the risk for injury or death for a client in health care was greater than extreme sports such as bungee jumping or sky diving?

MARK: Really? Perhaps I should quit my nursing job and become a bungee instructor. At least I wouldn't have to do all this documenting.

JILL: Also, the World Health Organization found that client safety is a global health issue. Their data suggests that 8 to 12 percent of persons admitted to hospital will experience adverse events.

MARK: Really? All the more reason to communicate effectively and document accurately!

JILL: That's right.

1.6 Who is looking

Narration

JILL: Let's now talk about what individuals and organizations have access to client health records.

MARK: That's easy … anyone who provides care has the authority to view the client's document.

JILL: That's right Mark. But the list is a little longer. Let's take a look at other possible parties that have access to client health records.

Accreditation groups have a great interest in client safety and may review records for safety concerns.

Regulatory colleges may examine your documentation as part of their regulatory role. Investigations of members often cite inadequate or inappropriate documentation.

Your employer considers documentation when looking for ways to improve performance and productivity.

Your colleagues examine documents so they can detect important client changes and administer the best possible care.

Coroners or medical examiners review charts as they are looking for facts leading up to a sudden or unexpected death.

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

Lawyers, 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.

The client and his family have rights to see what is written about them. The employing agency owns the record; however the client owns the information that is written about him or her.

MARK: Jill, so are you telling me that every single thing I write on a client's chart has the potential to be seen by any or all of the people you just mentioned?

JILL: That's correct Mark. That is why 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.

MARK: The thought of having all these people evaluate MY documentation is enough to make me paranoid!

JILL: Or be very careful!

1.7 Methods

Narration

JILL: 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, and electronic means such as e-mail and electronic health records.

Traditionally, care providers do well with oral communication; however written communication needs improvement.

Regardless of the method of documentation, it requires timely and constant attention to detail to communicate relevant client information.

1.8 Frequency

Narration

JILL: How often a method of documentation is utilized, depends on several factors: complexity of client needs … acuity of client condition … and agency policies and procedures.

Regardless of a client's condition or needs, the care information becomes part of the permanent client's health record.

And finally, evidence shows that accurate documentation improves clinical outcomes, processes of care and professional practice.

MARK: Makes sense to me.

1.9 Purposes

Narration

JILL: Now on to the purposes of documentation. Mark, can you think of some reasons why we have to document the care we provide clients?

MARK: The main reason is so that the others caring for the client know what has been done so far.

JILL: Yes, this is known as communicating changes in a client's condition and providing continuity of client care. Other reasons?

MARK: To show that I have done my job.

JILL: That's right. Care providers are responsible and accountable for their own practice and documentation is part of that accountability. Standards of practice and competencies are linked indirectly and directly to your documentation. Another reason?

MARK: The only other reason I can think of is to meet legal requirements.

JILL: Correct. A chart or client record is one of the main documents of evidence in a court of law.

Another purpose of documentation is that it 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.

The last purpose of accurate documentation is that it can be an important source of data for improving client outcomes and practice.

MARK: I'm not sure what you mean. Can you give me some examples?

JILL: Sure. Many medical studies and client care research projects gather data from your documentation. Your client 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.

MARK: Wow … I had no idea that my notes were that important!

1.10 Perceptions

Narration

JILL: Health care providers have varying perceptions of documentation. Let's take a look at some of these. Many say that it takes years to become proficient at documenting.

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, client care activities usually take priority to documentation and little time is devoted to recording.

MARK: I can certainly relate to the last two points. I did not go into nursing to become a technical writer. I want to be able to care for people and help them get better. Also, we tend to be very busy where I work. The client's needs always come first and sometimes there is little time left to document.

JILL: I can certainly empathize with what you are saying Mark. However, research shows that health care providers who are most successful with documentation are those who view documentation as an integral part of the nursing process.

1.11 Challenges

Narration

JILL: Let's continue with our discussion about the challenges to accurate and complete documentation. Mark, what challenges do you face?

MARK: The point we just discussed … a shortage of time.

JILL: Yes, that is a major challenge. Health education experts estimate that a nurse may spend between 15 and 25 percent of her working day documenting. Nurses working in acute care may spend between 25 and 50 percent of their time recording. Often, documentation is left for less busy times, usually at the end of your shift or work day.

MARK: Hmmm … documenting sure can take up a good chunk of your workday. So how do we save time when documenting?

JILL: Although a large amount of research has been done on nursing documentation, unfortunately there are few studies on how to make documentation less time consuming. What other challenges do you face Mark?

MARK: I am often tired and probably don't devote enough time and care to proper recording.

JILL: Yes, fatigue has been shown to contribute to deficiencies in documentation. At the end of the shift, you may not have the clear thinking processes required for recording. You may think about what needs to be documented, but often do not write it down. This is especially challenging when a client has numerous health problems and requires immediate attention. Any other challenges?

MARK: None that I can think off other than not enough time and being tired.

JILL: Well, here are a few more challenges. One is false beliefs. With technology becoming more common in health care, many care providers have a false belief that computers will do their "thinking" required for documentation. In fact, technology may create an addition challenge if you lack keyboarding skills to do the recording.

Another challenge is employer support. Some care providers have suggested that employing facilities take a more active and supportive role in assisting their employees to become more proficient in documentation.

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. This is particularly true with the frail elderly who have complex and chronic medical conditions that require more time for care.

Finally, 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 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.

MARK: That is some list of challenges!

JILL: Yes Mark. Although accurate documentation has many challenges, this does not mean that they cannot be overcome or minimized. There is help. Your College in its professional role provides documentation support by way of standards, practice statements, continuing education and practice consultants.

MARK: Ah, so there is help if I need it. Good to know!

1.12 Standards

Narration

JILL: Health care organizations have standards for documentation that generally encompass similar characteristics. Mark, why don't you review of these?

MARK: Sure thing.

First standard is client focused – Your documentation should be about the client. This includes the extension of his or her family, or someone who is legally named if there is no family.

Relevant – You should chart events that are relevant to a particular client's care and progress including the most important details.

Confidential – You and other care providers are bound by law to respect client confidentiality.

Clear, concise, and comprehensive – These are the 3Cs of accurate documentation. Hand writing must be clear and legible. Your grammar and expressions of care must enable others to understand what you have written.

Permanent and retrievable – Remember that client notes become a permanent and retrievable health record.

Accurate – One of the most common deficiencies in documentation is missing details. Lack of significant detail is also the most highly criticized in the legal process.

Chronological and timely – It is important to document in order of occurrence and chart as soon as possible after the event or care. This can be extremely demanding if you are caring for several clients with complex and multiple health issues.

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.

JILL: Great job Mark. These are pretty obvious, but we still need to pay attention to each one.

1.13 Employer's Role

Narration

JILL: Employing agency policies and procedures help care providers to document accurately. You should be familiar with these – what they are and where they are located. Also remember that policies may vary at different facilities and employers.

Also, it is important to provide feedback to your employer regarding their policies. This is particularly true if you feel some documentation policies are difficult to implement, or if you have some ideas of better ways to document.

MARK: Good to know that we can have a say about how documentation is done.

1.14 Employer's Policies

Narration

MARK: What types of things should an employer's policies on documentation cover?

JILL: They should address methods of documentation … forms used … who is able to document … approved abbreviations … how the date is to be entered … 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.

MARK: Okay.

1.15 Consequences

Narration

JILL: And our final topic in this Module has to do with the consequences of inappropriate or inadequate documentation. Mark?

MARK: A care provider could face loss of employment or suspension of his or her practice permit. No doubt, there would be personal stress, possible loss of income and perhaps legal expenses. An employing agency could face a lawsuit and negative publicity. One of the most serious consequences would be a severe injury or death of a client because your documentation was inadequate or inaccurate.

JILL: Yes, there are some serious consequences. But 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.

1.16 Summary

Narration

JILL: This brings us to the end of Module 2. Mark, care to summarize the key points we can take away from this module?

MARK: Sure thing Jill. First point is that documentation is the main communication tool for the exchange of client health information. Many organizations and individuals have access to client health records. Documentation has other legal and professional purposes, in addition to the exchange of client information. Care providers have both negative and positive perceptions of documentation.

Health care providers experience several challenges in completing accurate documentation.

We looked at some common standards for accurate documentation. And finally, our facility's documentation policies and procedures protect and assist us to complete accurate documentation.

JILL: Thanks Mark.

1.17 Reflection

Narration

JILL: Take a few minutes to complete this exercise. When done, click NEXT to continue.

I'm Jill along with Mark. We will see you again soon in the rest of the modules.

MARK: See you later.

1.18 The End

Narration

No narration … just music.