



Nursing Documentation 101

Module 3: Essential Elements – Part I

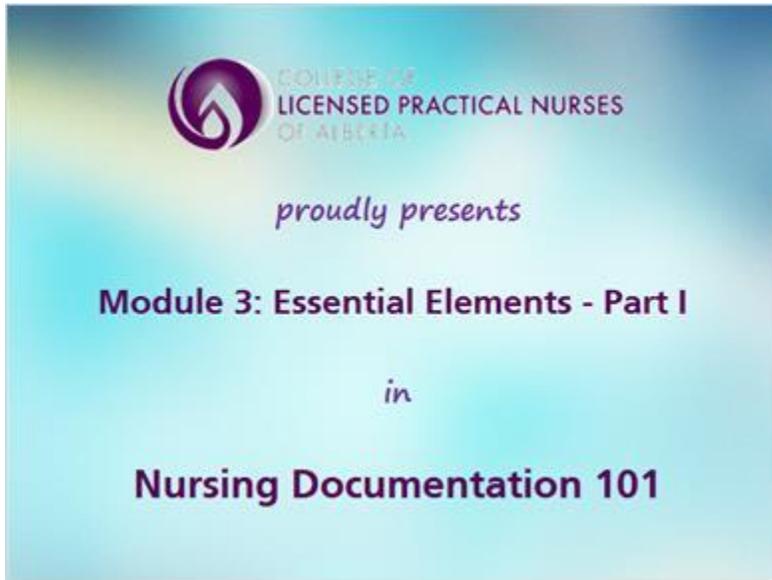
Handout

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Module 3 – Essential Elements – Part I

1. Introduction

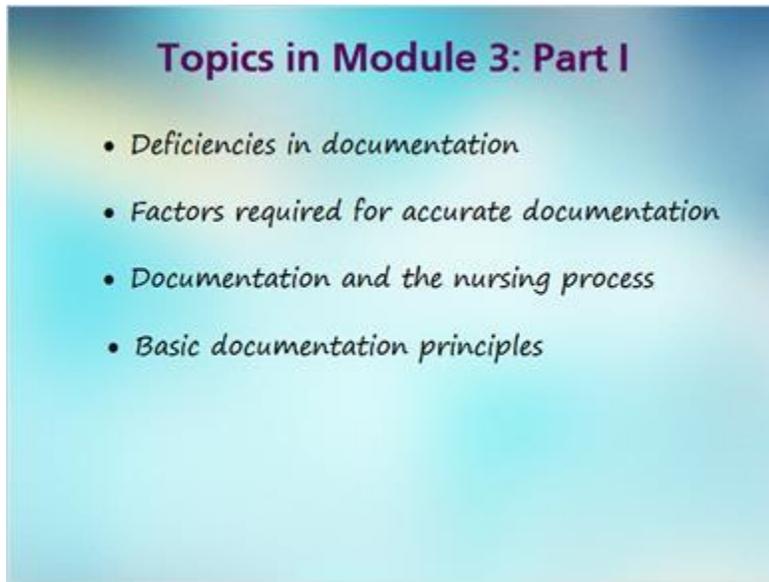
1.1 Welcome



Narration

No narration, only music.

1.2 Topics



Narration

JILL: Hi ... I'm Jill and with me is Mark. Welcome to Part I of Module 3 on the essential elements of accurate documentation. Are you ready to begin, Mark?

MARK: I sure am! What are the topics for this lesson?

JILL: We are going to talk about common deficiencies in nursing documentation ... the factors required to produce accurate documentation ... how documentation and the nursing process are related and finally some basic documentation principles.

MARK: Okay ... let's get started.

1.3 Common Deficiencies



Narration

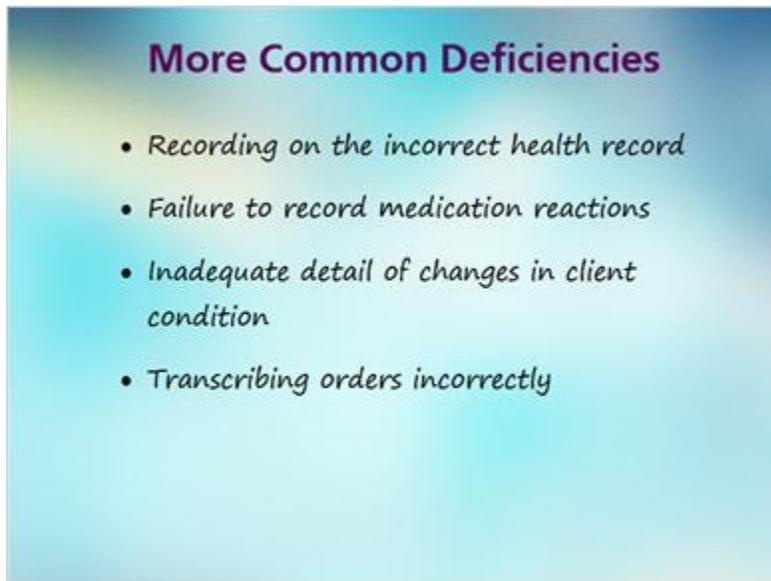
JILL: Let's start with a discussion about some common deficiencies. Let's do this one together Mark. I will begin. One of the most common complaints with written documentation is that of illegible or messy handwriting. It is preferable to print your client notes if you have hard-to-read handwriting. Ask your colleagues if they can understand your handwriting.

MARK: 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 agency's policies and procedures. A cursive signature is much more difficult to reproduce or falsify than a printed signature.

JILL: Another common deficiency is failing to record pertinent health or medication information. Remember that past health related experiences or medications prescribed assist the healthcare team to make the best possible choices for a quick and speedy recovery.

MARK: Failing to record medications given is an issue. This can have drastic consequences, as a client could inadvertently receive another dose of medication that may be injurious or life threatening. And related to that, is failing to document a discontinued medication or treatment. A client could continue to receive a medication or treatment that is damaging or injurious.

1.4 More Deficiencies



Narration

MARK: Continuing on with the common deficiencies ... is 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 client's 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 client is then in question.

JILL: Another deficiency is 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.

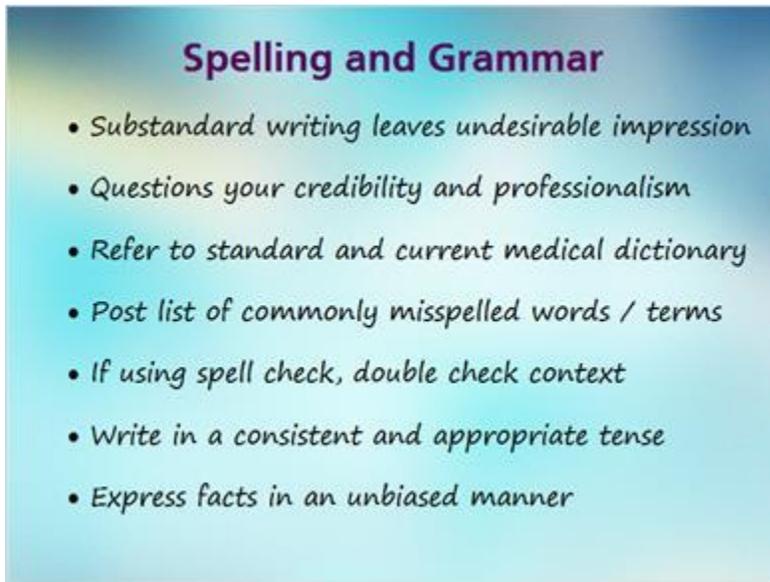
MARK: Another one is not providing adequate detail of changes in the client's condition. You must work on finding a balance between excessive wordiness and necessary client details. Missing details have often been cited in lawsuits and this reflects on inadequate or incorrect care.

JILL: Transcribing orders incorrectly or transcribing inaccurate orders is an issue. Special precautions must be taken with telephone orders. Numbers and dosages 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. If the physician 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.

JILL: Anything on this list of deficiencies that surprises you Mark?

MARK: No, not really. I have encountered, and have probably been guilty of contributing to, some of these problems. It is a great review of what we need to focus on in our documentation.

1.5 Spelling and Grammar



Spelling and Grammar

- *Substandard writing leaves undesirable impression*
- *Questions your credibility and professionalism*
- *Refer to standard and current medical dictionary*
- *Post list of commonly misspelled words / terms*
- *If using spell check, double check context*
- *Write in a consistent and appropriate tense*
- *Express facts in an unbiased manner*

Narration

JILL: Over the new few slides, we are going to examine these common documentation deficiencies in greater detail. Let's start with spelling and grammar.

MARK: Okay, that is as basic as it gets!

JILL: 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 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.

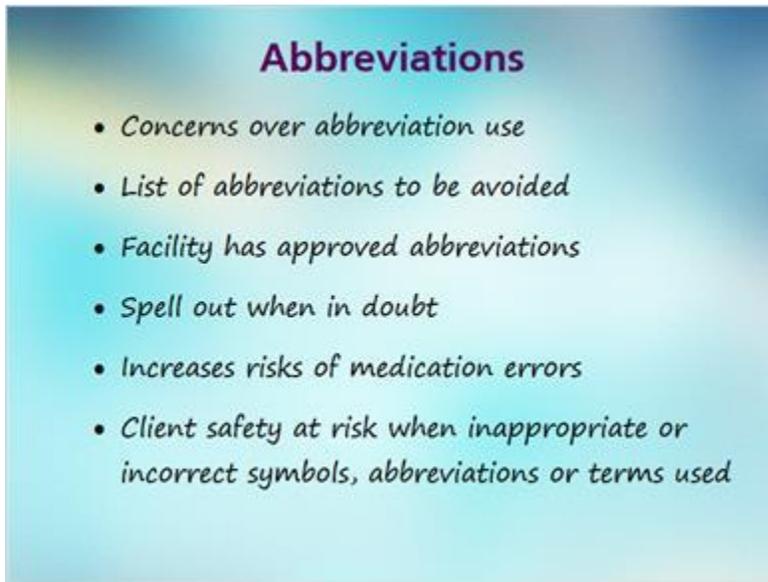
Post a list of commonly misspelled or confusing words, especially ones linked to medications.

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”.

You should strive for consistent and appropriate writing tense and express facts in an unbiased manner.

MARK: All this is so basic to good documentation that I think we often take it for granted. We don't pay enough attention to doing it right!

1.6 Abbreviations



Narration

JILL: The next topic we are going to examine is abbreviations. Why don't you do this one?

MARK: Sure. I noticed that over the years the approach to abbreviations has changed. I think this is mostly because abbreviations have caused some issues with communication and client safety.

There are lists of prohibited abbreviations and terms that should NOT be used, as they have been found to jeopardize client safety. Your facility should have policies and procedures with approved abbreviations and terms along with a list of abbreviations that must be avoided!

It is best practice to spell out the word when you are in doubt! This is especially important if you receive physician orders over the telephone.

To reduce medication errors, pharmacies are labeling medications with full spelling of dosages and directions. Physicians are required to spell out these out as well. Be careful of the location of the decimal point and zeros in handwritten 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.

JILL: Good points Mark. To show you how problematic abbreviations can be, we have a short exercise for you on the next slide.

1.7 Abbreviations Exercise

Abbreviations Exercise

What do the following abbreviations mean:
Hold mouse over icon to see the answer(s)

- FOF 
- FOB 
- FLK 
- D/C 
- LOC 

These abbreviations are inappropriate and may contribute to unsafe client outcomes

Click NEXT to continue

Narration

No narration.

1.8 Nursing Process



Narration

JILL: Now we are going to take a look at the nursing process.

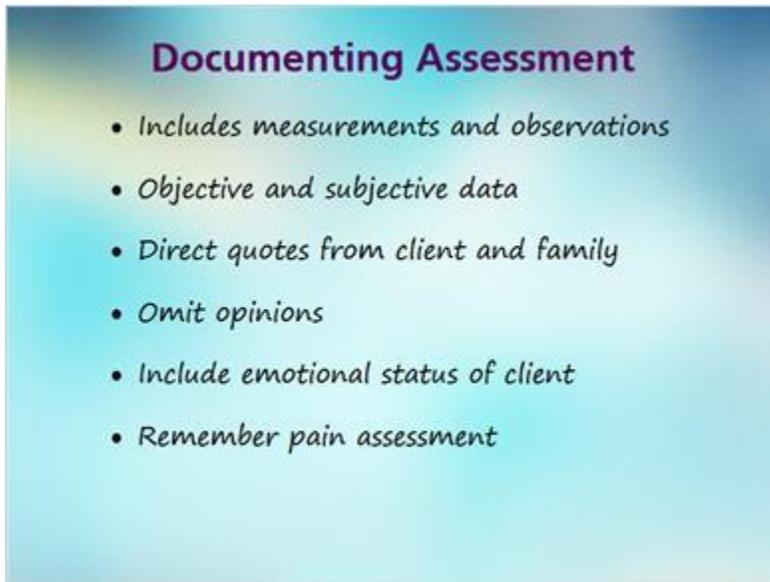
MARK: What does the nursing process have to do with documentation?

JILL: Because nearly all documentation systems use the nursing process, whether overtly or covertly as a guide when documenting client details. Do you remember the five steps in the nursing process Mark?

MARK: I'd better! Let's see ... we start with assessment ... then nursing diagnosis ... then planning ... implementation ... and lastly we evaluate the outcomes.

JILL: Very good. Let's now review in more detail how the nursing process applies to documentation.

1.9 Assessment



Narration

JILL: Let's begin with 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. One study found that from client experiences, care givers 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 as pain may often be a warning sign of a significant change in a client's recovery.

MARK: Good reminder on the emotional status and pain. I think we sometimes overlook documenting these symptoms.

1.10 Nursing Diagnosis



Narration

JILL: On to 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.

1.11 Planning



Narration

MARK: How is planning related to documentation?

JILL: Planning 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.

MARK: Ah ... okay.

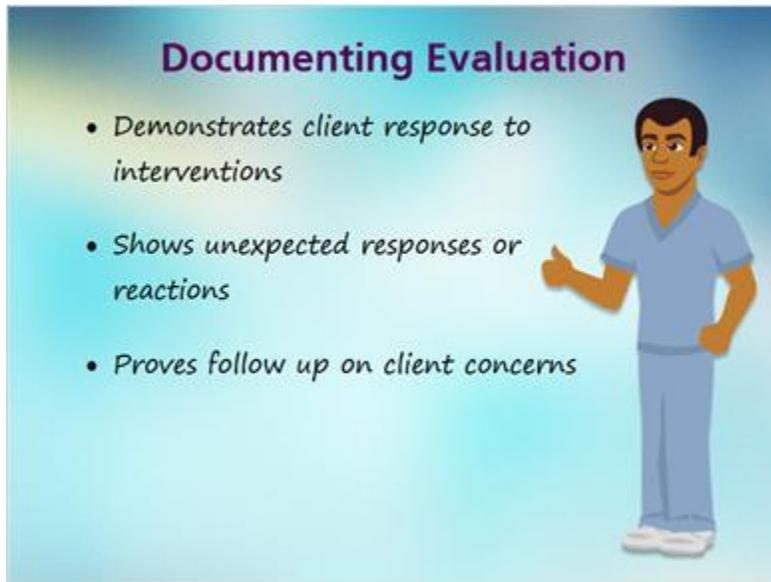
1.12 Implementation



Narration

JILL: The next step in the nursing process is implementation. Implementation is your appropriate interventions or what you did and the care events you performed. Once again, it is prudent to document ALL that you did for the client, because in the legal system, undocumented care means that it was not done! Documentation may be done on special forms, checklists or client progress notes.

1.13 Evaluation / Outcomes



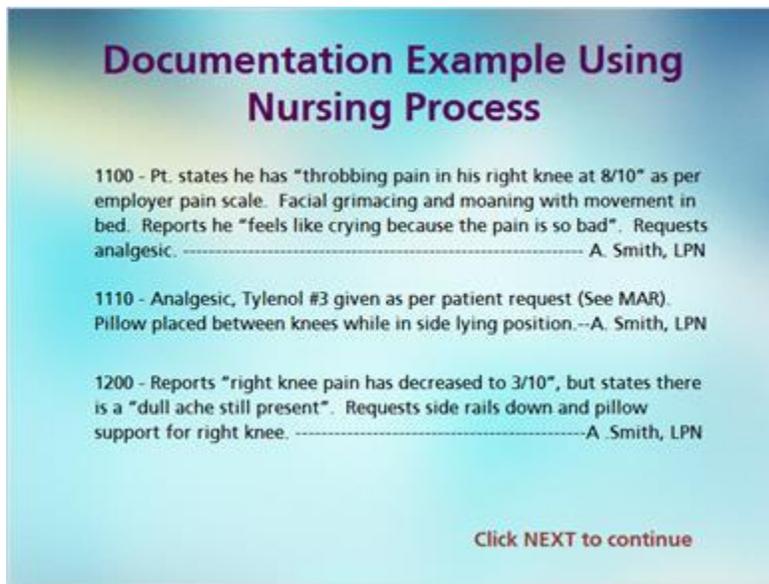
Narration

JILL: The final step in the nursing process is evaluation or outcomes. This is the client's response to your interventions and includes any unexpected response, if that happens. When documenting outcomes, this proves that you followed up a concern and demonstrates how the client responded to your intervention.

MARK: Now I understand how the nursing process relates to documentation. It would be useful to see how this works in practice.

JILL: Coming up.

1.14 Nursing Process Example



Documentation Example Using Nursing Process

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. -----A. Smith, LPN

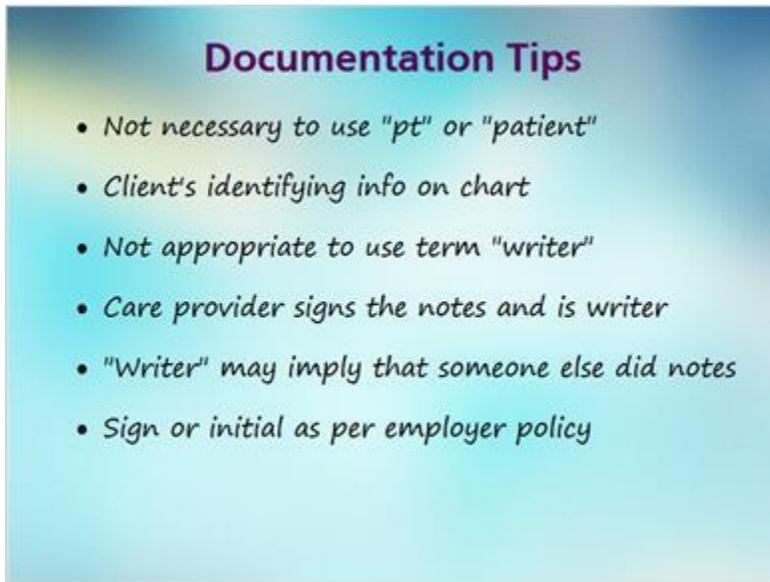
Click **NEXT** to continue

Narration

JILL: Here is a 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.

MARK: This example helps a lot! I can now understand how the nursing process is related to the how we document.

1.15 Documentation Tips



Narration

JILL: Here are a few tips about documenting using the nursing process. In the 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.

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.

MARK: Hmmm, yes these are useful tips to remember.

1.16 Basic Principles 1



Narration

JILL: For the remainder of this lesson, we will review 10 basic documentation principles. First we list them, and then we will discuss each in a bit more detail. Mark, why don't you tell us what the first 5 are?

MARK: Okay ... they are ... use the correct client chart or record ... write neatly and legibly ... use correct spelling and grammar ... document in chronological order promptly ... correct errors or late entries appropriately.

1.17 Basic Principles 2



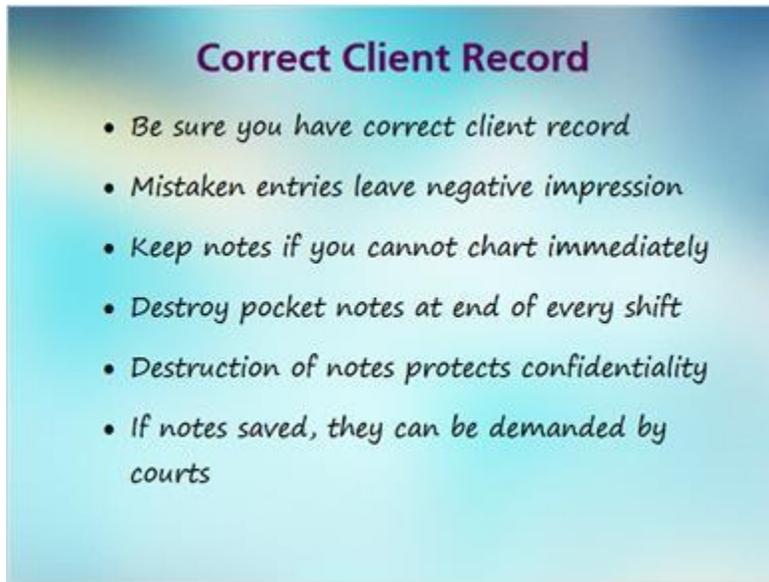
Narration

JILL: And the last 5 are ... sign correctly ... identify individuals ... maintain confidentiality ... use "not applicable"... record medication administration and any issues.

MARK: We have already talked about some of these.

JILL: Yes Mark we have. So part of this will be review and part will be new information. Let's start with the first principle which is making sure you have the correct client record.

1.18 Correct Record

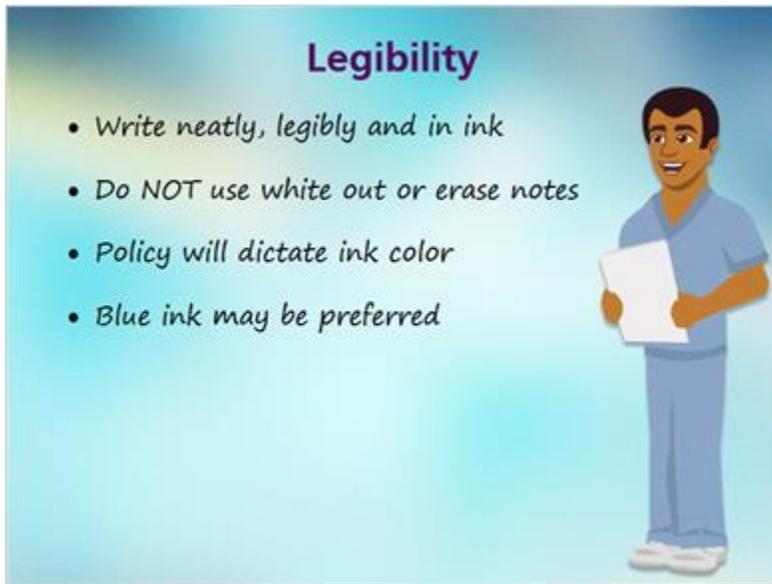


Narration

JILL: 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. These pocket notes must be destroyed after every shift, according to employing agency's 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.

1.19 Legibility

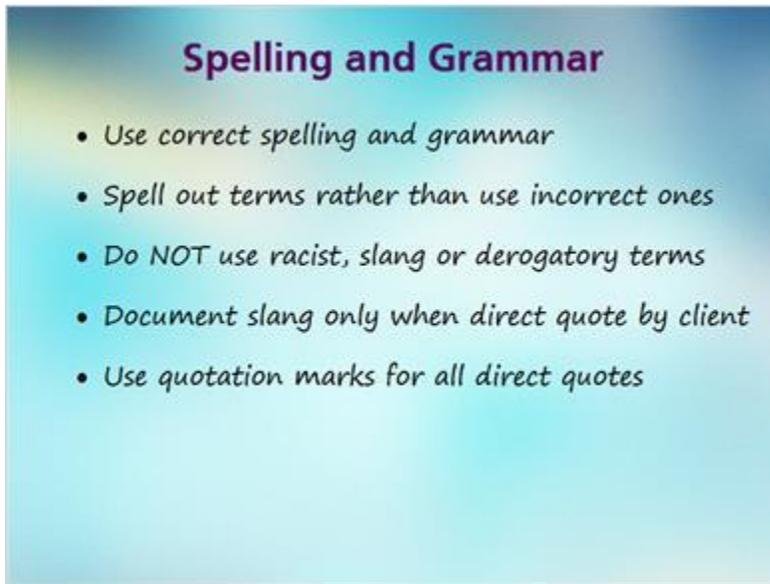


Narration

JILL: How about you do this one Mark?

MARK: The second principle is ... Write neatly, legibly and in ink. Do not use whiteout or erase notes. You may want to check your employer's policies and procedures as to whether to use blue or black ink. Some employers 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.

1.20 Spelling and Grammar



Narration

JILL: The third principle is ... 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. You may document slang when it is a direct quote by a client. Remember to place a direct quote in quotation marks.

1.21 Chronological Order

Chronological Order

- Document in chronological order promptly
- Makes it easier for others to know what events happened in what order
- Do not leave blank spaces in notes or entries

A desk calendar for March 2014. The calendar is white with a red header that says "MARCH 2014". The days of the week are listed at the top: SUN, MON, TUE, WED, THU, FRI, SAT. The dates are arranged in a grid. The numbers 2, 9, 16, 23, and 30 are highlighted in red. The calendar is shown at an angle, suggesting it's on a desk.

Narration

MARK: The fourth principle is ... Document in chronological order and document 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.

1.22 Errors and Late Entries

Errors and Late Entries

- *Should be corrected as per agency policy*
- *Use "mistaken entry" instead of error*
- *"Error" viewed suspicious by legal system*
- *Provide reason for late entry*



Narration

JILL: Errors or late entries are to be corrected according to your employer'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.

1.23 Signature



Narration

MARK: The next one is obvious and has already been mentioned. Sign correctly. Include your name and designation. There should be NO blank spaces after or before your name or designation.

1.24 Reporting



Reporting and Documentation

- *Identify supervisor / physician by name and designation*
- *Do not describe negative actions*
- *State follow-up expected*

The slide features a light blue background with a gradient. On the right side, there is a cartoon illustration of a man with dark hair, wearing a light blue short-sleeved shirt and pants, holding a white document. The title 'Reporting and Documentation' is written in a bold, purple font at the top left. The three bullet points are in a dark blue, italicized font.

Narration

JILL: 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 facility's policies and procedures. Do not describe negative actions of the physician or supervisor, but you would state what follow-up was expected.

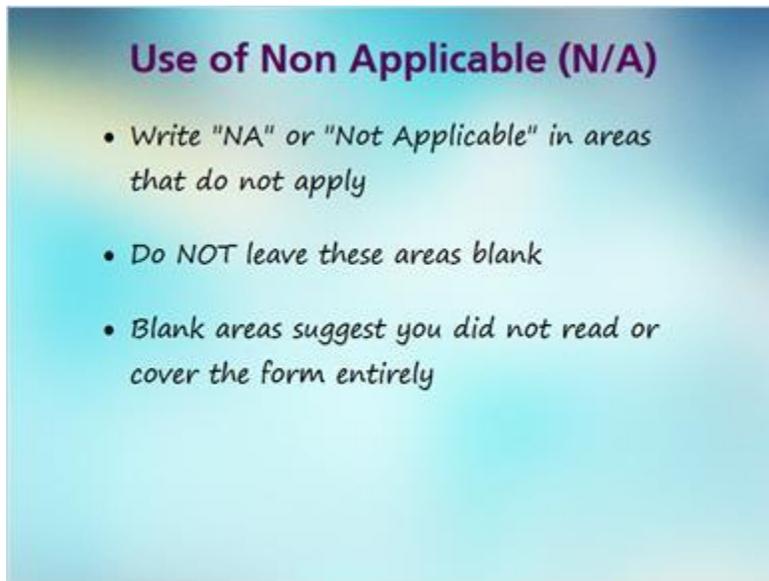
1.25 Confidentiality



Narration

MARK: Maintain client confidentiality at all times. You must know and follow all applicable laws and policies. You must keep in mind “who needs to know and why”. This includes other members of the healthcare 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. If you are in doubt, be sure to always check with your supervisor or manager.

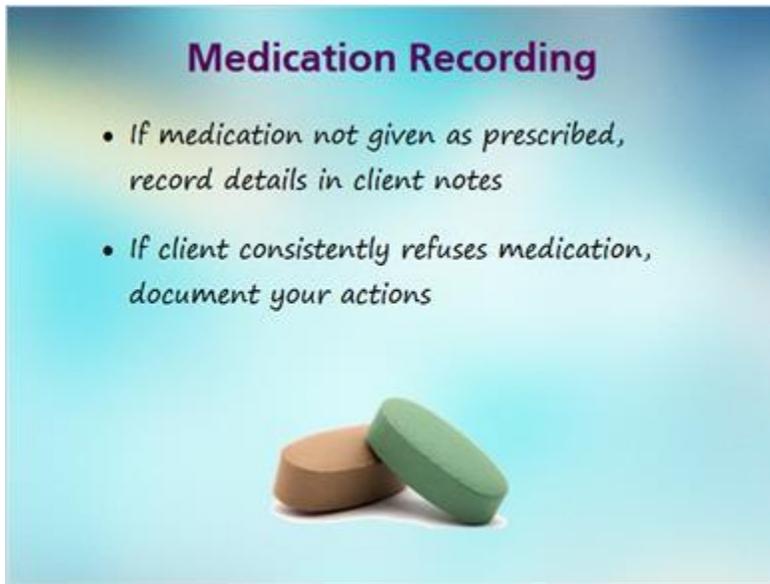
1.26 Use of NA



Narration

JILL: 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.

1.27 Medications Recording



Narration

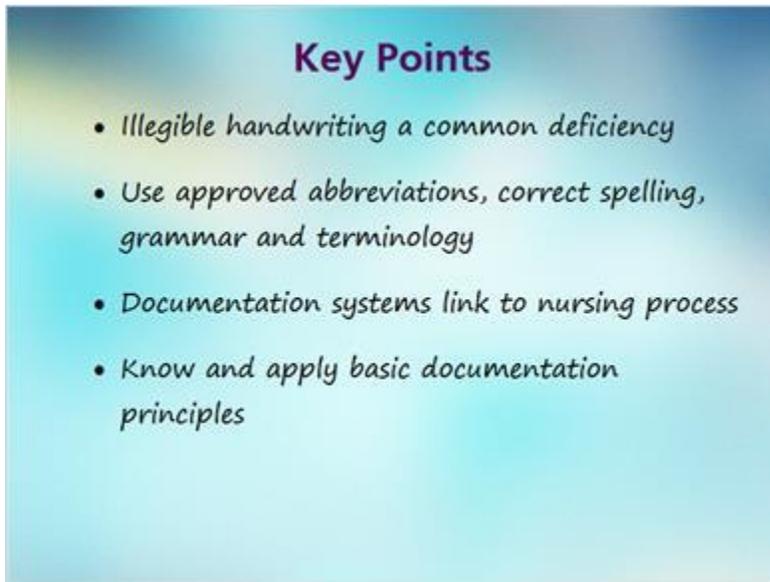
MARK: If you do NOT give a medication as prescribed, and there is no space to check it off on the Medication Administration Record, you document these details in the client notes. If a client consistently refuses a medication, you should have detailed notes on why and what you did about the situation.

JILL: And those are the 10 basic principles of documentation. Thanks for helping me out Mark.

MARK: Glad to. This brings us to the end of Part I of Module 3 on Essential Elements of Accurate Documentation. Do you want me to do the summary of key points for this lesson, Jill?

JILL: Yes, go for it.

1.28 Key Points



Narration

MARK: 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.

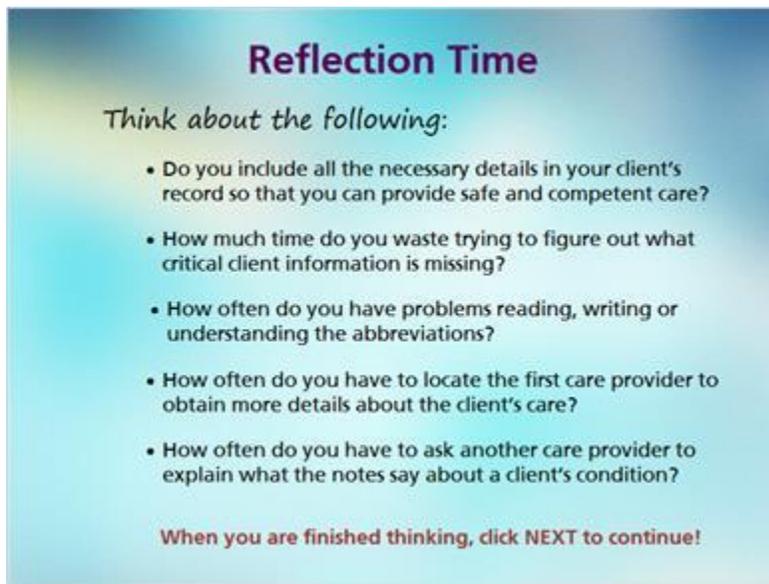
Documentation methods or systems link directly or indirectly to the nursing process.

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

JILL: Thanks for that. Before we go, I would like to remind you that on the next slide are some questions we want you to think about. When done reflecting, click NEXT to continue.

MARK: I'm Mark, along with Jill saying goodbye for now. We will see you again in the next module of this nursing documentation course.

1.29 Reflection

A slide with a blue gradient background. The title "Reflection Time" is in bold purple text. Below it, the text "Think about the following:" is in a cursive font. A bulleted list of five questions follows. At the bottom, a red instruction says "When you are finished thinking, click NEXT to continue!".

Reflection Time

Think about the following:

- Do you include all the necessary details in your client's record so that you can provide safe and competent care?
- How much time do you waste trying to figure out what critical client information is missing?
- How often do you have problems reading, writing or understanding the abbreviations?
- How often do you have to locate the first care provider to obtain more details about the client's care?
- How often do you have to ask another care provider to explain what the notes say about a client's condition?

When you are finished thinking, click NEXT to continue!

Narration

No narration.

1.30 The End



Narration

No narration ... only music.