Nursing Documentation 101

Module 3: Essential Elements – Part II

Handout

Module 3 – Essential Elements – Part II

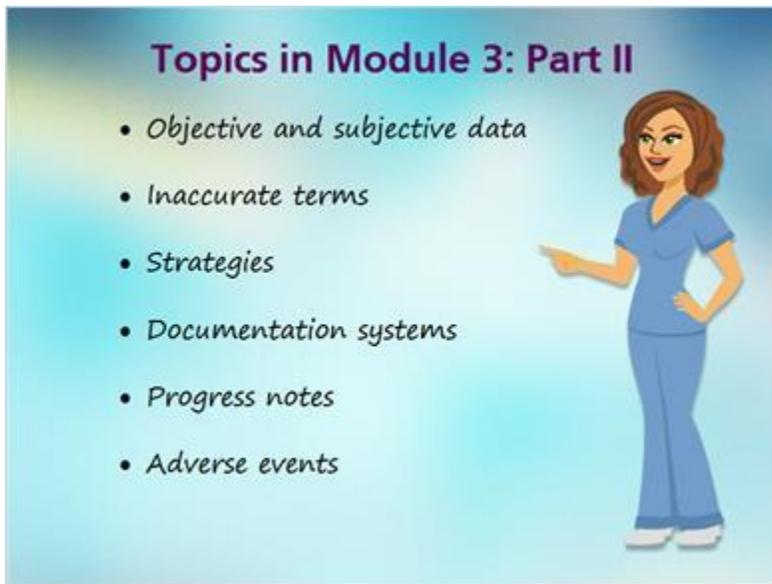## 1. Introduction

1.1 Welcome
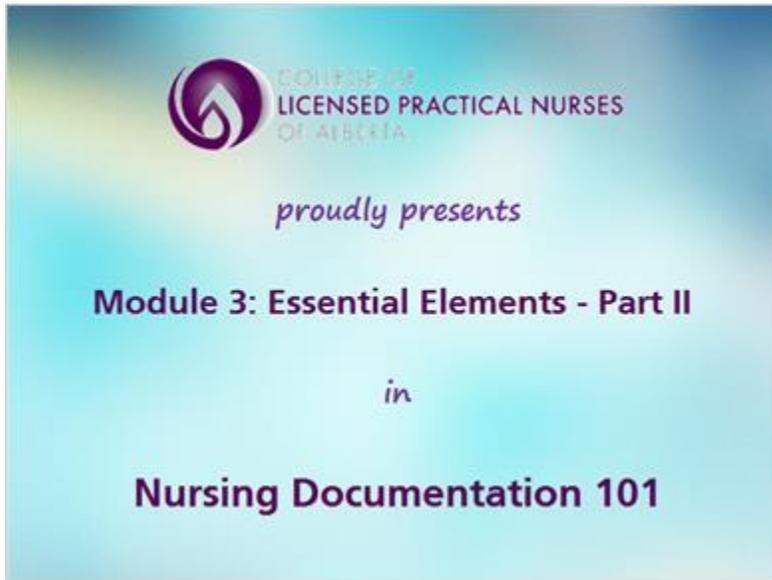
Narration

No narration, only music.

1.2 Topics

Narration

JILL: Hi … I'm Jill along with Mark. Welcome to Part II of Module 3 which is on the essential elements of accurate documentation.

MARK: In Part I, we covered a lot of good information about the basics of accurate documentation. What's left?

JILL: In this lesson we are going to discuss … objective and subjective data … inaccurate terms that should be avoided … strategies for documentation … types of documentation systems … progress notes … and documenting adverse events.

MARK: Great! Let's go.

1.3 Objective Data
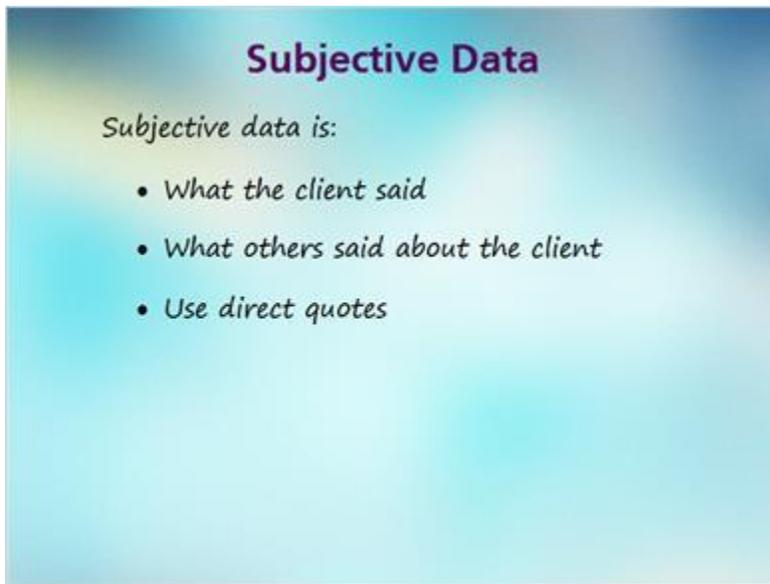

Narration

JILL: The first topic is the difference between objective and subjective data.

MARK: That's easy … objective data is hard, independent data, while subjective data is your opinions and perceptions.

JILL: Yes, something like that. Objective data is measurements and observations obtained through four of your 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.

1.4 Subjective Data

Narration

JILL: Subjective data is the information obtained from "what the client said" 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 clients or their families.

MARK: Got it! Use objective data whenever possible. If you are using subjective data, use direct client or family quotes.

1.5 Inaccurate Terms 1

Narration

JILL: In this section, we will discuss the "no-no" words.

MARK: No-no words? What do you mean?

JILL: These are the unacceptable and inaccurate words and terms that describe client care or events in your practice. They should be avoided in our documentation.

MARK: Ah, I see what you mean.

JILL: The first one is about documenting mental 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.

Care to do the next one, please?

MARK: Sure. The monitoring of pain is an essential component of nursing care and is often underrepresented in client notes. 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 agency. If your 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 record his corresponding response.

JILL: 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.

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

JILL: "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."

MARK: Here are a few more inappropriate terms that should NOT be used in documentation … good, poor, bad and small, medium, large. These are vague and imprecise terms that should be avoided.

1.6 Inaccurate Terms 2

Narration

JILL: Continuing with our list of inappropriate terms … seems, appears, apparently … accidentally or miscalculated … could be, may be … mistake or error.

MARK: Yes, I can see that some of these terms are vague and can be interpreted in different ways by different care providers. Words such as "accidentally, mistake, error" will cause you a heap of trouble if the documents end up in court!

JILL: And finally, a few more terms to avoid … somehow … unintentionally … a little, a lot … stable … normal.

MARK: I'm going to keep this list of unacceptable terms handy, and every once in a while review them as I am doing my documentation.

JILL: That's a good idea.

1.7 Strategies

Narration

JILL: Now we are going to discuss several strategies for accurate documentation. Let's do these together Mark. I'll start.

The first strategy is that you should document ONLY the care you provide and never ahead of time.

MARK: If you find that the 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 recording … although this is not ideal.

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

JILL: In some areas of healthcare, both co-signing and countersigning are terms that are used interchangeably and deemed to mean the same. However, you should know the definition of each of these terms according to your 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. 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 in this case.

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

1.8 Documentation Systems
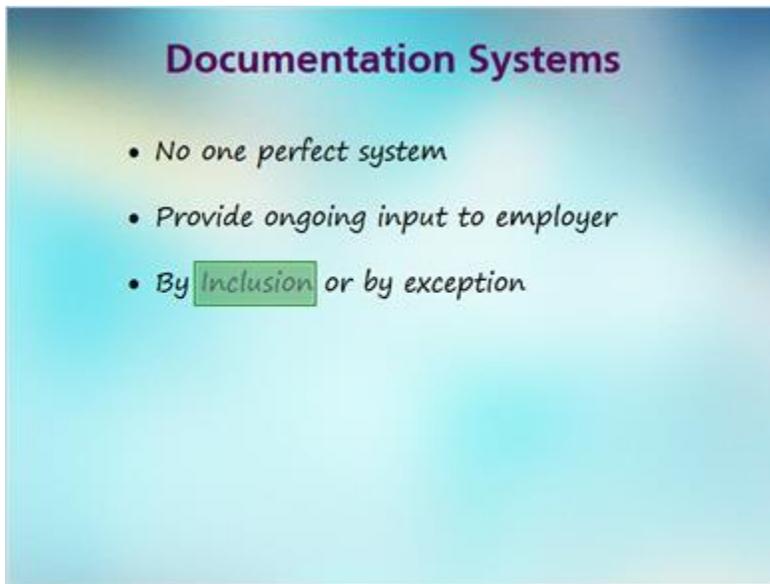
Narration

JILL: This next section is a general overview of documentation systems. 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. You must learn to work well with the documentation system that your employer uses. You should also provide ongoing input to your employer to ensure the current system is addressing client data efficiently and accurately.

MARK: If I remember correctly, 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 or 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 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.

1.9 Inclusive Systems 1
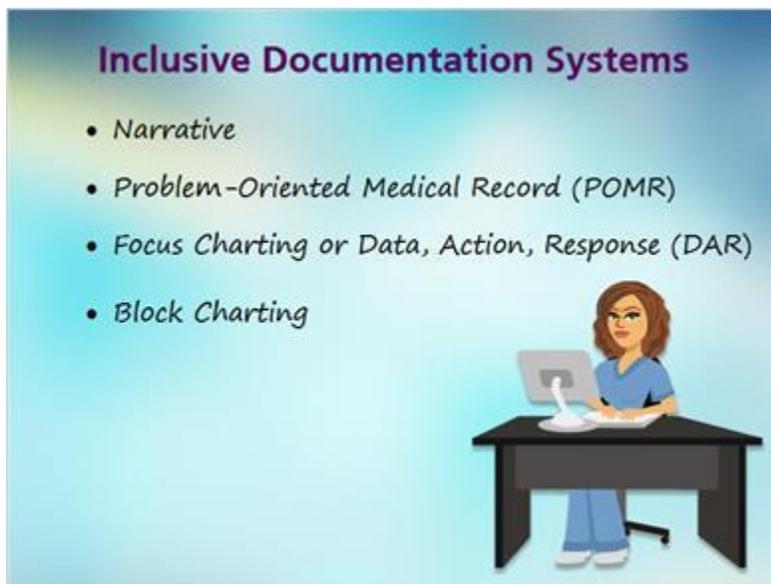
Narration

JILL: Good description of the two types Mark. Now let's take a closer look at the inclusive systems. Narrative is a good place to start. 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 documenting 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 that detects changes in a client's condition and resulting interventions.

Do you want to describe problem-oriented medical record, Mark?

MARK: Okay. Problem-Oriented Medical Record is a type of documentation method that uses the nursing process to describe client problems. The care provider makes specific entries that are related to the client's problems while he or she is in care.

JILL: Focus Charting or Data, Action, Response – DAR – documentation is a type of documentation that 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. Next one Mark.

MARK: 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 in detecting when a client's condition changed.

1.10 Inclusive Systems 2
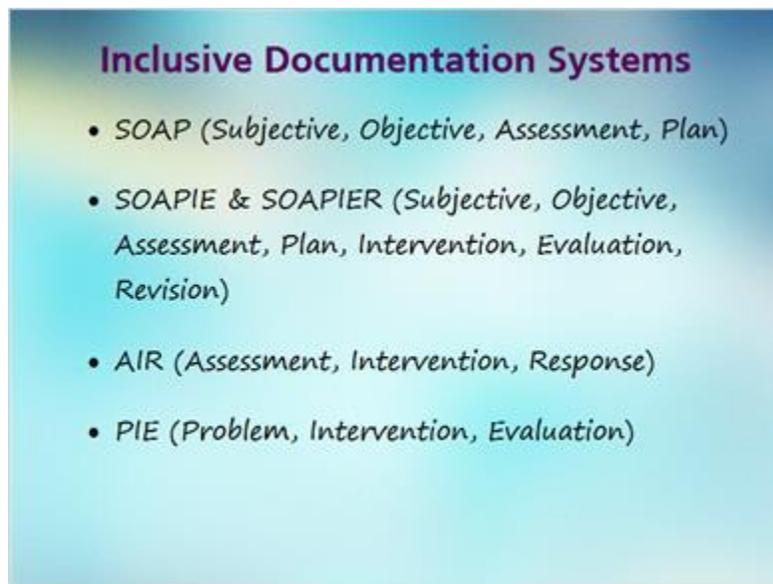
Narration

JILL: Continuing on with inclusive systems … SOAP and its variations are problem oriented approaches to documentation that includes the nursing process and which many interdisciplinary healthcare teams use.

MARK: AIR or Assessment, Intervention, Response … 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.

JILL: The last type of documentation system is PIE or Problem/Intervention/Evaluation. Using this system, a care provider would 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, notice that the nursing process forms the underlying framework.

MARK: That is quite a list Jill. However, I guess the good news for us is that we only have to become familiar with the one our facility uses.

JILL: That's right Mark.

1.11 Progress Notes
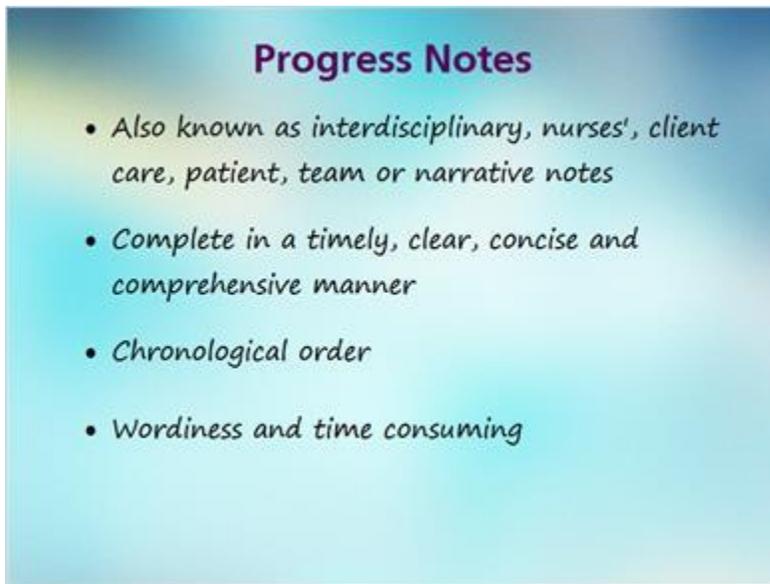
Narration

JILL: The next subject we want to discuss is progress notes. Mark, do you want to start this one?

MARK: Sure Jill. Progress notes are known by many names such as interdisciplinary … nurses' … client care … patient … team … or narrative notes.

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 are completed in a narrative writing style. 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.

JILL: Thanks, Mark. Now on to our final section in this lesson … documenting adverse events.

1.12 Adverse Events 1

Narration

JILL: Mark, what is an adverse event?

MARK: Something bad happens to a client?

JILL: Close enough. Adverse events are unexpected events that have increased the potential or risk of client harm, injury or death. While a care provider should document clearly, concisely and comprehensively at all times, adverse events require special care and attention. Why do you think that is the case Mark?

MARK: I would suspect that adverse events have the highest risks of ending up in a lawsuit.

JILL: I agree. 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. You should document equipment failure on a special form or incident report, and NOT on a client's record.

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, ones that require intervention must be documented precisely.

1.13 More Adverse Events

Narration

JILL: Mark, why don't you describe the rest of these?

MARK: Sure thing. 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.

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 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.

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 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.

JILL: Thanks, Mark. Just to summarize, we should be very careful in documenting the following types of adverse events … falls … equipment failures … return to surgery … medication errors … hospital infections … threats … unexpected death and … injury from abuse or criminal activity.

1.14 Key Points
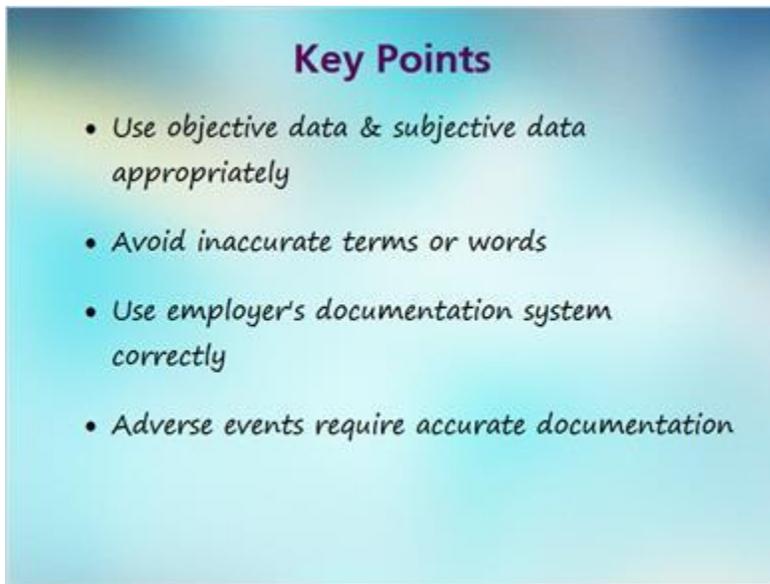
Narration

JILL: This brings us to the end of Part II of Module 3 on the essential elements of accurate documentation. Would you please summarize the key points Mark?

MARK: Okay. We deal with objective and subjective data when caring for clients. Where possible, we should use objective data.

We identified a number of vague and inaccurate words and terms that should NOT be used in our documenting.

We briefly examined the different types of documentation frameworks. The important point here is to be familiar with the system your facility uses.

We finished up the lesson emphasizing the importance of accurate documentation in recording certain adverse events.

Did I miss anything?

JILL: No Mark. Excellent job as always! Goodbye for now. Mark and I will see you again in the remaining modules of this nursing documentation course.

1.15 The End

Narration

No narration … just music.