COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

Nursing Documentation 101

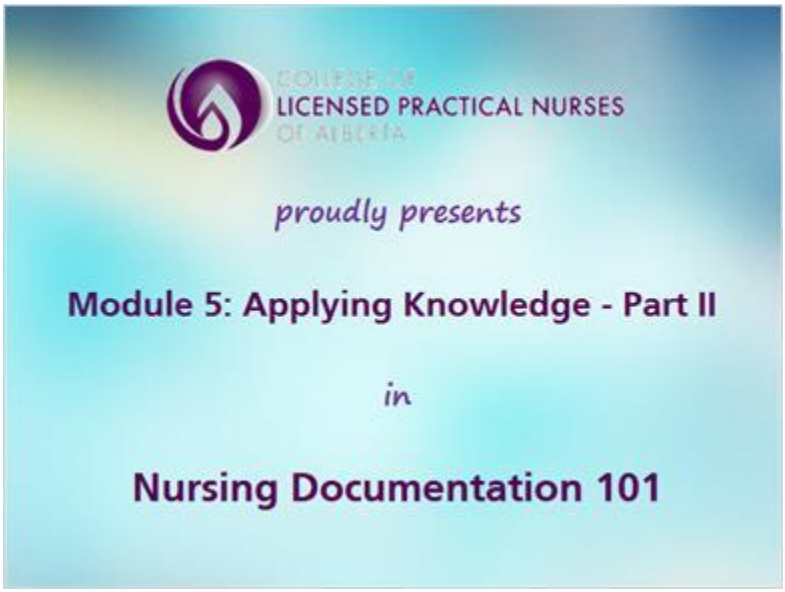
Module 5: Applying Knowledge – Part II

Handout

Module 5 – Applying Documentation Knowledge – Part II

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 II of Module 5 … Applying documentation knowledge to practice.

MARK: What are the topics or situations that we will be covering in Part II?

JILL: We will discuss how to document the following: health literacy … teaching of clients … family interactions … client meetings … medications … falls … transfers … and finally … cardiac arrest.

MARK: Sounds interesting. Let the talking begin!

1.3 Health Literacy

Narration

JILL: Health literacy means that a client has the necessary knowledge and skills to access health services, and understand his or her health needs.

A care provider teaching a client who is not health literate needs to focus on three main questions. 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?

Let's now talk about client teaching.

1.4 Client Teaching

Narration

JILL: The next topic is documenting client and family teaching. Mark, why don't you do this one?

MARK: Okay. Client or family teaching is an important aspect of the care provider's role; it is often done while a client is in care or part of impending discharge.

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.

Teaching a skill may need to be organized in several sessions. Before any client learning and teaching is prepared, a care provider should asses if the client or family is ready to be taught. After the teaching, make sure that the client or family understands what they need to do.

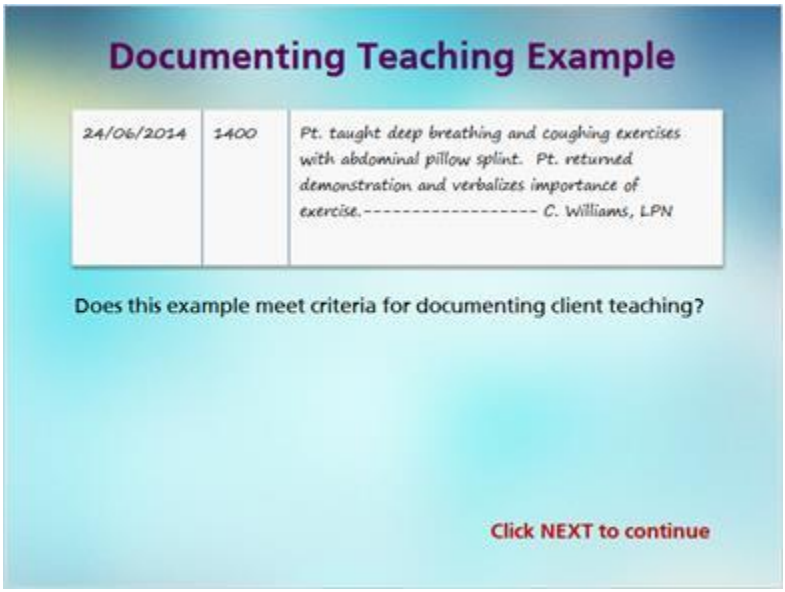
1.5 Documenting Teaching

Narration

JILL: When documenting a client or family teaching session, be sure to include … learning goals … barriers … equipment or supplies used … printed materials given to the client and … how you evaluated the client's learning.

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.

1.6 Teaching Example



Narration

MARK: Here is an example of how to document a teaching session. Remember to click the NEXT button to continue.

1.7 Family Interactions

Narration

JILL: Families or significant others are an extension of a client and generally wish to be involved in, and informed about, the client's care. It is good practice 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.

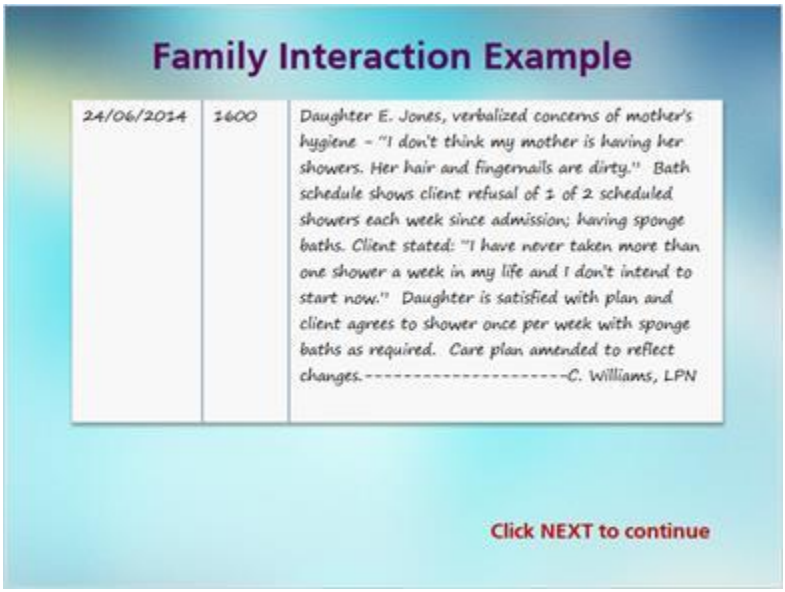
Sometimes a heartfelt apology for a complaint and keeping families informed can prevent threats or actual lawsuits. You want to keep your client's family informed so they can assist you in your care for the client. Remember that they know your client best.

You need to record date and time of conversations and questions from families. Use 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 made to community resources in the progress notes, even if there is special referral form to use.

1.8 Family Example



Narration

MARK: And here is an example of documenting a family interaction.

1.9 Client Meetings

Narration

JILL: Next is client meetings and sessions. Mark?

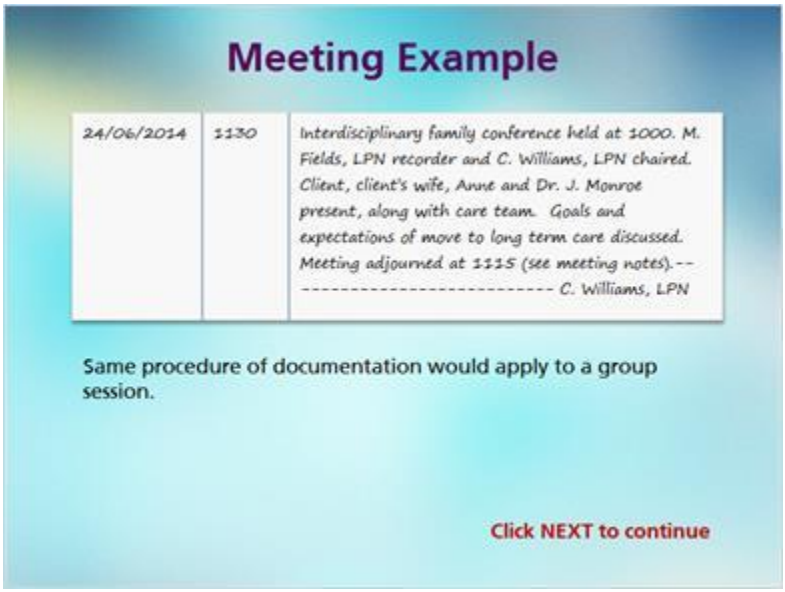
MARK: Mental health units, long term care facilities, and home care clients often have care or case conferences with family involvement to discuss if care needs are being met or for discharge planning.

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.

1.10 Meeting Example



Narration

JILL: This is an example of documenting a meeting.

1.11 Medications

Narration

JILL: Incorrect management of medications is one of the most common areas where lawsuits occur.

You need to check when the medication was last given. Next, you need to document when and why the client requested the medication … the intensity or level of pain … type and location of pain.

Agency policies and procedures must be followed with scheduled and PRN medications. PRN medications are documented on the Medication Administration Record or MAR. 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.

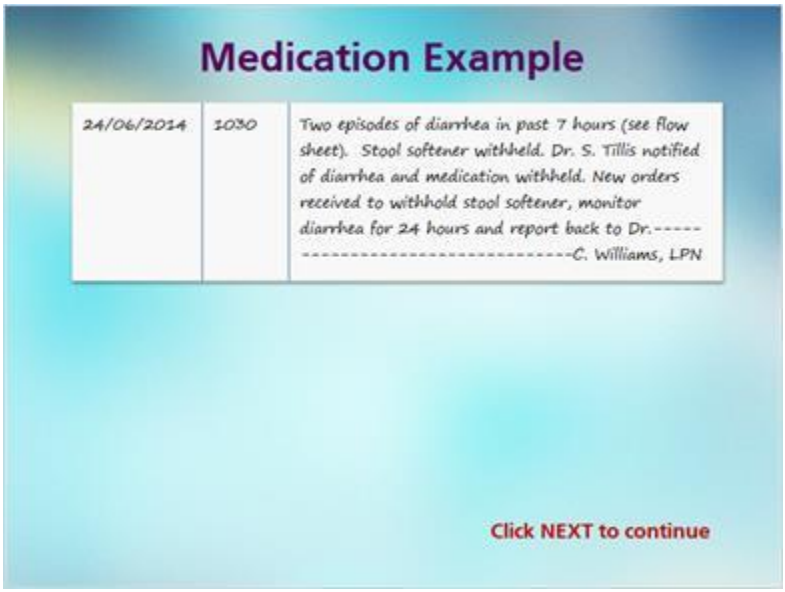
If medications are being withheld, you need to document why and if anyone was notified. See the example on the next slide.

MARK: Another documentation application is on medication errors. Errors or mistakes occur in all types of industries. You may recall that healthcare services have high risks. One of the most common areas of lawsuits involves the incorrect use of medications.

All medication errors require documentation, as you do not know ahead of time which medications may cause serious injury or death. The word "error" or "mistake" should NEVER appear in your documentation.

An incident report should also be filed, but no mention of this should be made in your documentation.

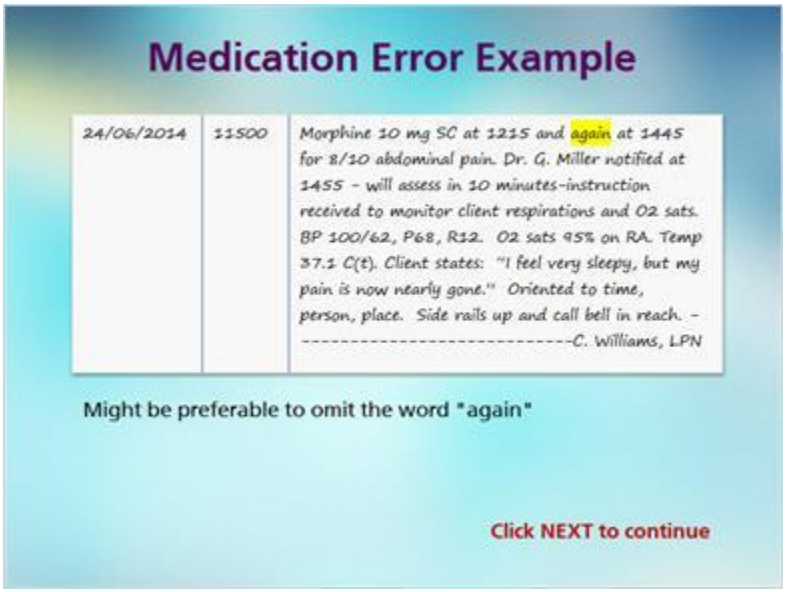
1.12 Medication Example



Narration

JILL: Here is an example of how to document if medications are withheld.

1.13 Med Error Example



Narration

MARK: This is an example of the correct way to document a medication error.

1.14 Client Falls

Narration

MARK: Our next topic is 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. 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.

1.15 Falls Prevention

Narration

JILL: Most employers have fall prevention policies. These policies usually cover such thing as …

- A falls risk assessment on admission and a review annually or as dictated by client's condition
- Documentation that includes assessments, plan of care and interventions
- Documentation of safety measures put in place.

Mark, what safety measures do you find effective in reducing falls?

MARK: I find duct taping them to their beds seems to work very well. (long pause). Just kidding! The typical falls prevention steps include bed rails up, call bell in reach, bed in its lowest position, client teaching about how to get up, pathways free of obstacles and proper lighting. Although I recommend crazy glue as well. (laughs).

JILL: Duct tape and crazy glue may be effective, Mark, but I don't think they are an accepted protocol.

1.16 Documenting Falls

Narration

JILL: So Mark, what should you include when documenting client falls?

MARK: Documentation of a fall should include:

- Client's condition when found and direct quotes from client
- Assessment and injuries identified
- Physician and family notification
- Other reporting requirements as per facility policy and procedures.

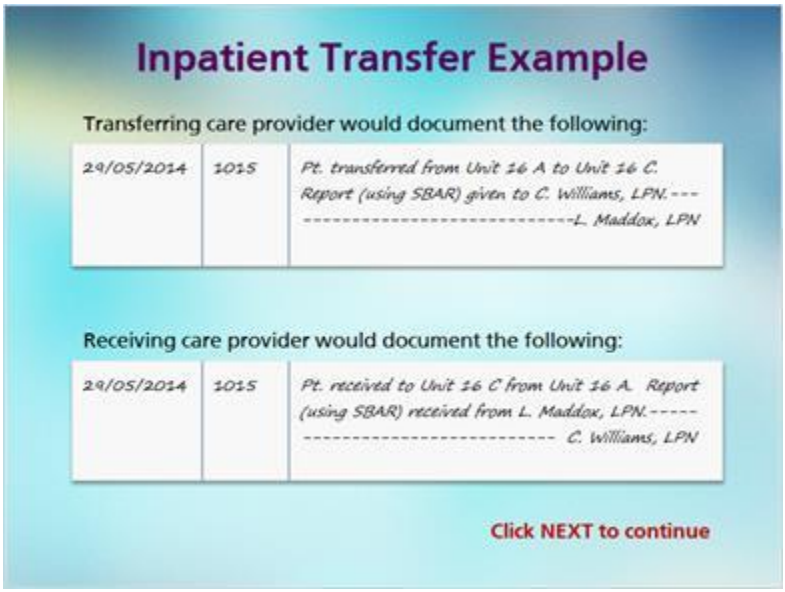
JILL: You can see that when documenting falls, you need to include all the relevant details.

1.17 Client Transfers

Narration

JILL: In care facilities, client transfers between 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.

1.18 Transfer Examples



Narration

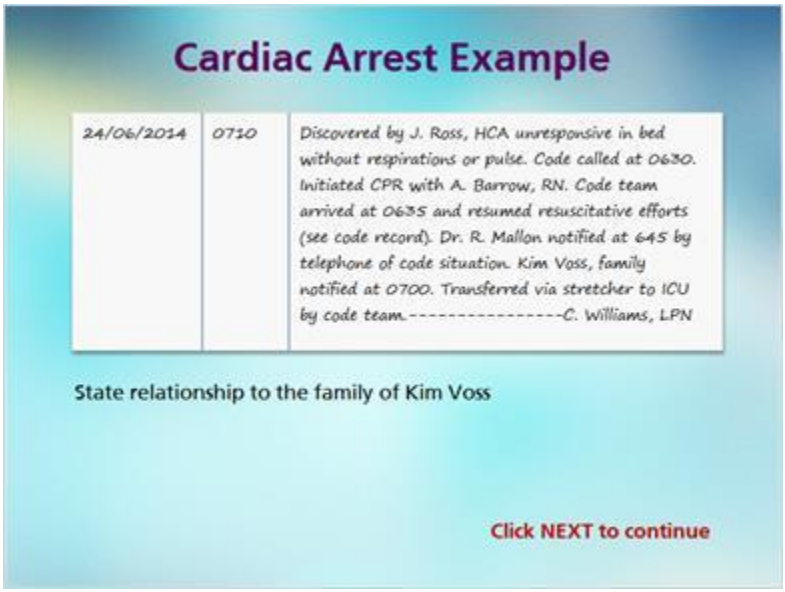
MARK: Here is an example of documentation that would be done before and after a transfer.

1.19 Cardiac Arrest

Narration

JILL: A cardiac arrest is both a high risk and stressful event for healthcare 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 facility 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.

1.20 Cardiac Example



Narration

MARK: On this slide is an example of how to document a cardiac arrest.

This brings us to the end of Part II of Module 5 on applying knowledge to documentation. I'm Mark along with Jill. See you again soon.

JILL: Bye.

1.21 The End

Narration

No narration … music only