Nursing Documentation

MOORE COUNTY
HOSPITAL DISTRICT
EDUCATION DEPARTMENT

The Importance of Documentation

- Why do we document?

- Reflects the clients perspective, identifies the caregiver and promotes continuity of care by allowing other partners in care to access the information.
- communicates to all health care providers the plan of care, the assessment, the interventions necessary based on the client's history and the effectiveness of those interventions;
- is an integral component of interprofessional documentation within the client record;

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The Importance of Documentation

- Demonstrates the nurse's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the client receives, and transferring knowledge about the client's health history.
- Demonstrates that the nurse has applied within the therapeutic nurse-client relationship the nursing knowledge, skill and judgment required by professional standards regulations.
- Provides information in the event of legal action or concerns which is another reason accurate and appropriate documentation is so critical.

The Importance of Documentation

- Keep in mind, in most instances medical malpractice cases have a statute of limitation of two years to be filed.
- The case may not get to trial until years later.
- You may be called to court to discuss a medical case years after the event took place.
- Your documentation will be what you rely on, not your memory of the events.
- Be assured that the medical record will likely be scrutinized line by line and in part to ascertain whether legal standards have been met.
- An accurate medical record is the Nurses best defense.

Documentation Basics

- **Be accurate:** For example, do not use vague terms such as "good urine output." How many cc's are "good?" Chart the specific amount and what the urine looks like.
- **Chart objective information:** Chart only what you see, feel, smell, hear, etc. Do not chart what someone else observed unless the information is critical, in which case use quotations and attribute the remarks appropriately. Don't chart that the patient fell if you find a patient on the floor. Although this is likely what happened, unless you saw it occur, you can't be sure. Chart the incident as "patient found on the floor" and any assessment or relevant information.

Documentation Basics

- **Chart as soon as possible after care is given:** Do not chart medications or procedures before they are completed. It may seem like a time-saving trick to chart all of the routine meds ahead of time, although it's illegal and unsafe. However, if a patient refuses a medication, it is easy to forget to go back to the record and make the correction.
- **Use only approved abbreviations:** If unsure as to what the abbreviation may mean, spell the words out. What may seem like common-sense steps can significantly protect your patient and you. It is easy to take shortcuts or adapt our documentation into what coworkers may incorrectly do because we are busy.

Example relevant Clinical Info

- **Abnormal assessment**, eg. Uncontrolled pain, tachycardic, increased WOB, poor perfusion, hypotensive, febrile etc.+
- **Change in condition**, eg. Patient deterioration, improvements, neurological status, desaturation, etc.
- **Adverse findings or events**, eg. IV painful, inflamed or leaking requiring removal, vomiting, rash, incontinence, fall, pressure injury; wound infection, drain losses, electrolyte imbalance, +/-fluid balance etc.
- **Change in plan** (Any alterations or omissions from plan of care on patient care plan) eg. Rest in bed, increase fluids, fasting, any clinical investigations (bloods, xray), mobilisation status, medication changes, infusions etc.

Example relevant Clinical Info

- **Patient outcomes after interventions,** eg. Dressing changes, pain management, mobilisation, hygiene, overall improvements, responses to care etc.
- **Family centered care,** eg. Parent level of understanding, education outcomes, participation in care, child-family interactions, welfare issues, visiting arrangements etc.
- **Social issues,** eg. Accommodation, travel, financial, legal etc.
- **Professional nursing language** is used for all entries to clearly communicate assessment, plan and care provided. For example; 'TLC' does not reflect nursing care.

DO's and Don'ts of Documentation

- **DO's**
- Be sure you have the correct chart before you begin documenting
- Make sure your documentation reflects the nursing process and your professional capabilities.
- Be sure to chart patients response to medications administered.
- Document each call to a physician including the exact time, message, and response.
- Chart Patient care at the time you provide it
- Document date and time on any late entry.

DO's and Don'ts of Documentation

- **Don'ts**
- Don't chart a symptom, such as c/o pain without also charting what was done about it.
- Don't alter a patients record- this is a criminal offense
- Don't use MCHD non approved abbreviations. Posted on inside of centrals med room door.
- Don't document imprecise descriptions such as "bed soaked" or a " large amount"
- Don't chart care ahead of time- something may happen and you may be unable to actually give the care you have documented which would be considered Fraud.

DO's and Don'ts of Documentation

- Don't state your opinion:

  For example, your patient may be mean and rude , but it is not a good idea to document what a jerk he or she is, that would be an opinion not fact.

  Assessment documentation such as uncooperative or refused care would be acceptable.

- Don't write a novel:
- While you want to be accurate and clear on your documentation, you do not need to go over board .

  You need to document enough information to explain a patients condition or treatment and paint a clear picture.

Conclusion

- Remember, a patients chart is a Legal Document and can be used in court so please document only the facts pertaining to patient care, Not opinions or your feelings about other care the patient has received.
- You can always fill out a QA form for other Issues which is addressed and kept in house.
- these DO's and DON'Ts will not only save your patients day but can also save your career and license.

Thank You