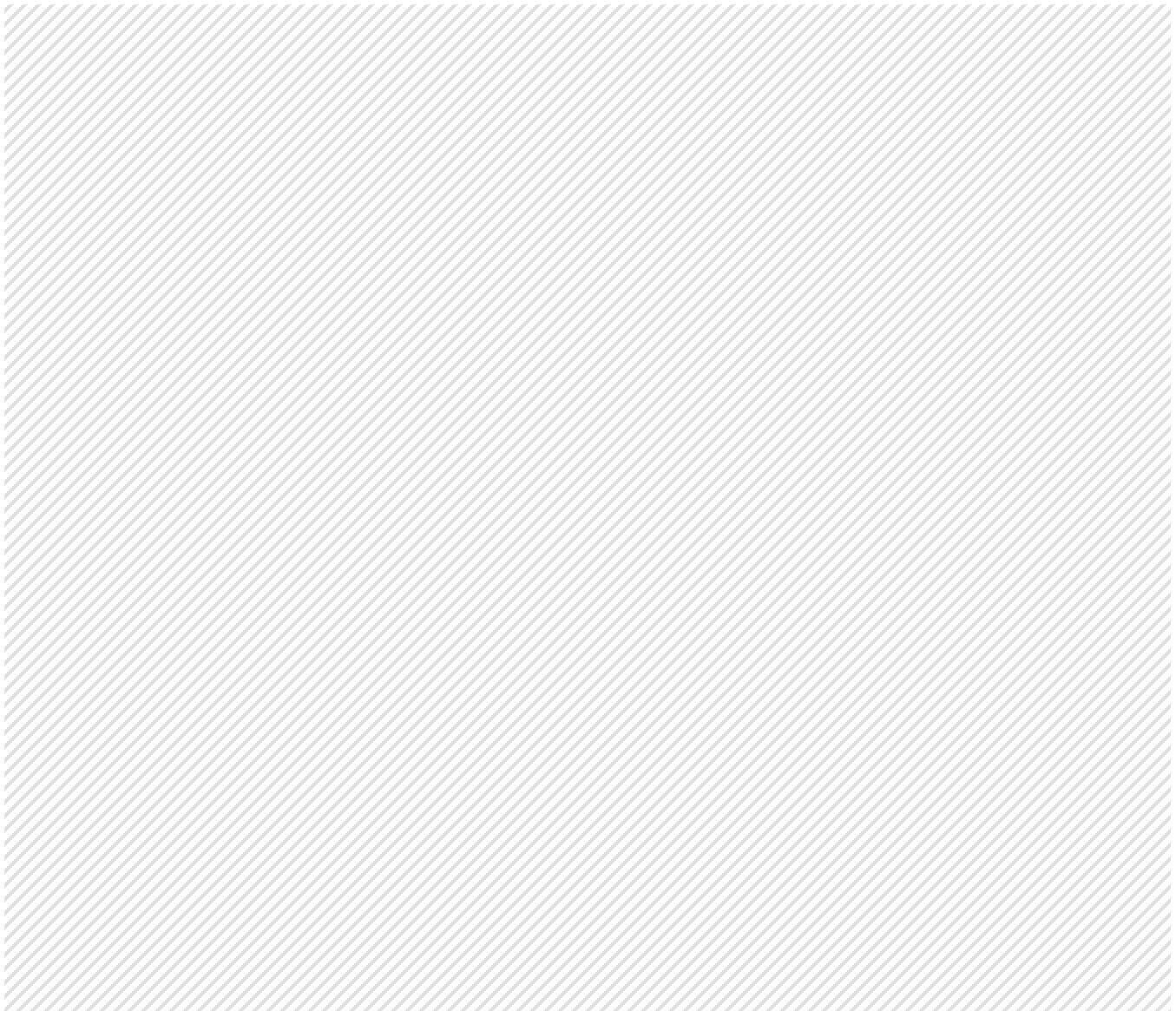


Documentating Patient Care

Core Competency Inservice

January 2020



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Introduction

Clinical record keeping is an integral component in good professional practice and the delivery of quality healthcare. Regardless of the form of the records, electronic or paper, good clinical record keeping should enable continuity of care and enhance communication between healthcare professionals. Consequently, clinical records should be maintained and updated where appropriate, by all members of the multidisciplinary team involved in a patient's care. Should the need arise patients themselves should have access to their records to understand what has been done and what has been considered. Clinical records are valuable as audits tools for quality and risk management and can be used when investigating serious incidents, patient complaints and compensation cases.

The majority of medical errors don't occur as a result of incompetence or recklessness by nurses or healthcare staff. They occur due to faulty systems and fragmented processes – with faulty documentation being a main culprit.

Documentation is a Necessity

- Serves as a summary of a patient's care, in all settings and across the continuum of care.
- Serves as a communication tool between shifts and disciplines. If you are working the night shift and wonder how far the patient walked in PT, you can go to the chart and find out.
- Used for reimbursement. If a procedure, medication, or care is not documented, then an insurance company is not likely to reimburse for such. As the saying goes, "If it isn't charted, it wasn't done," and isn't reimbursed. Likewise, it is a crime if a record is altered falsely to obtain additional reimbursement.
- Used for quality reviews and determining if standards of care are met. This is an important aspect of continuous quality improvement programs. The intent is to decrease unexpected events, improve outcomes, and improve patient satisfaction.
- In litigation, it is the patient's chart that is used to "tell the story." Therefore, it must reflect accurately the patient situation. A patient's record is generally admissible as evidence. And again, "If it isn't charted, it wasn't done."

State hospital licensing laws and regulations as well as The Joint Commission standards and Centers for Medicare/Medicaid Services specify required documentation in healthcare settings.

When documenting, keep in mind:

- Documentation should be as quantitative, i.e., measurable, and as factual as possible. Don't chart, "Pt. fell out of bed," unless you actually witnessed the event. Instead describe what you observed when you arrived on the scene.
- Avoid stating personal feelings about the patient. Don't say, "Mr. Jones is bullheaded, obnoxious, and a pain in the rear end". Instead describe Mr. Jones' behaviors as factually as possible.

- Documentation should be as timely as possible. Facts are less likely to be omitted when charting is done throughout the shift. This is of particular importance when recording changes in condition, medications, calls to physicians, procedures, etc.
- Your documentation should be legible and accurate. Handwriting that is difficult to read creates a negative impression. It is necessary that the author be able to read what she has written years later. Reflect on what you really mean. Be sure that you use only abbreviations approved by your institution.

Ultimately, rigorous documentation is for the benefit and protection of your patient, you, and your employer.

Quality Clinical Records

Advantages of keeping good clinical records and the disadvantages of poor clinical records

Good clinical records	Poor clinical records
Aid the sharing of relevant information and multidisciplinary team communication	Misinform healthcare professionals and patients
Aid coordination of care	Increase medico-legal risks
Aid continuity of care	Lead to unnecessary repetition of tests or other investigations
Aid informed decision making for patient management	Prolong hospital admission
Improve availability of data for risk assessment	Jeopardise patient care
Improve availability of data for root cause analysis in the investigation of serious incidents	Lead to serious incidents
Improve audit capabilities	
Provide informative evidence in a court of law	
Aid targeting of diagnostics and treatment plans without unnecessary repetition	
Improve time management	

Documentation Guidelines

The 5 C's of documentation are to be Correct, Complete, Concise, Consistent, and Cautious. Here are some specific guidelines to follow:

- Use military time. This eliminates guesswork - is it 7:00 p.m. or a.m.

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- Write legibly
 - Use black permanent ink for entries
 - Date and time all entries
 - Don't document a symptom such as shortness of breath without charting what action you took
 - Be as quantitative as possible, e.g., write "400 cc's" instead of "large amount"
 - Allow no blank spaces - draw a line through the space to the end of the page
 - Make no erasures, obliterations, or 'whiting out', on any portion of the medical record
 - Use factual entries only. The medical record is no place for opinions, assumptions, or meaningless statement such as 'had a good day'
 - Use correct spelling, punctuation marks, and grammar. Do not use colloquialisms or slang
 - Ensure that the correct name and other identifying information appear on each page of the medical record
 - Confine abbreviations to those adopted by healthcare delivery system
 - Document as soon as possible after the care is given
 - Document persons in contact with the patient, i.e., physicians, family – including what was discussed, any response, any new orders etc.
 - Never countersign anything unless you can attest to the accuracy of the information e.g. narcotic count
 - Document any unusual incident that occurs, e.g., falls
 - Document whenever a patient leaves the nurses care, e.g., for diagnostic work, off the unit to walk
 - Document patient transfer
 - Document consent for, or refusal of treatment
 - Document patient and/or family teaching/discharge planning
 - Document the existence/disposition of any personal belongings of the patient (dentures, glasses, jewelry, money)
 - Document patient responses to medication, treatments, and procedures
 - Adhere to agency/institution policies regarding documentation
 - Use 'late-entry' or 'addition to nursing note' when it is necessary to add omitted information to an existing entry

Documentation Challenges

An outside reader should be able to review a patient's record and reconstruct the patient situation, no matter the setting.

The following are some common problems encountered in charting

- Documentation when vital signs or other assessment parameters are abnormal. The nurse must not only document the finding, but his/her actions as well.
 - Did you call the physician or decide to monitor the patient longer?
 - If you contacted the physician, were new orders received or none?
 - Failing to notify the physician or to document such places the responsibility on the nurse.

The following is a list of eight documentation mistakes commonly encountered in litigation

- Failing to record pertinent health or drug information (e.g., allergies and chronic health problems that should be recorded on the admission sheet)
- Failing to record nursing actions
- Failing to record that medications have been given
- Recording on the wrong chart

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- Failing to document a discontinued medication
 - Failing to record drug reactions or changes in the patient's condition
 - Transcribing orders improperly or transcribing improper orders
 - Writing illegible or incomplete records

Thorough documentation of changes in a patient's condition, physician contacts and subsequent orders, completion of the orders, and evaluation of their effectiveness can keep the physician, nurse and hospital out of legal issues

Cardiac arrest (codes) and other emergency changes in patient condition are difficult to document. Events are occurring in rapid sequence and it is difficult to keep track of interventions and the time. Most crash carts have recording sheets that streamline the process. Other emergency situations may be more difficult to reconstruct. Be sure that your notes are later recorded in the chart.

Transfers within and between institutions must be recorded. On a related note, communication about such transfers does not tend to be well documented. The verbal transaction often times does not look like the written transfer orders.

Countersigning or co-signing documentation implies that you reviewed the entry and agree with the observations. It does not necessarily imply that you personally performed or witnessed the action. It is most desirable that the person making the observation be the one who actually records the event. This is not always possible or realistic, particularly when unlicensed assistive personnel are utilized. However, there is no legal requirement that the person documenting must be a licensed professional. It is often the policy of the organization that documentation be performed by a licensed professional.

Pre-charting should be avoided. Documenting something that hasn't taken place yet leaves you legally and professionally liable.

Confidentiality issues should be documented carefully. If a patient gives you permission to talk to a family member about her care, document that permission.

Personalities should be left out of your documentation. Don't use the chart to express your personal opinions about your patient, the patient's family, or co-workers. Worse, don't express an opinion about the care provided by yourself or your co-workers as these can be red flags for litigation.

Against Medical Advice (AMA) is a term used with a patient who checks himself out of the hospital against the advice of his physician. While it may not be medically wise for the person to leave early, in most cases the wishes of the patient are considered first. The patient is usually asked to sign a form stating that he/she is aware that they are leaving the facility against medical advice, and the AMA term is used on reports concerning the patient. The AMA form does not necessarily protect the physician from future legal implications regarding the case. Therefore, documentation must be thorough. Document any patient comments made while leaving AMA or refusing treatments and ensure that AMA and treatment refusal forms are correctly filled out and signed. When

a patient refuse to sign an AMA or treatment refusal form, document the patient's statements, describe the patient behavior, any other witnesses to those statements; and have your observations countersigned by a colleague who witnessed the statements and behaviors that you documented.

Do Not Resuscitate (DNR) orders must be documented carefully in order to avoid going against a patient or family's wishes for care. Institutional policies and state laws vary so it is your responsibility to know how your institution address the DNR and how it must documented.

Documentation Errors

Documentation errors are common. It is important to correct errors properly. Proper procedure for written documentation is to draw a single line through the word or phrase and write the correction on the same line, if possible, or above the line. Date, time, and initial any corrections. You may write additional information in a later note and may even refer to the earlier correction.

- Never obliterate an error; use a single line so that even the error remains readable.
- Refer to a documentation error as "an incorrect entry" or "a mistaken documentation" and be careful of words such as "error" or "mistake" in case they could be interpreted as a clinical error, rather than a documentation error
- Use caution whenever you use words such as "error," "by accident," "unsure," and "confused." These words can give the impression that you may have compromised patient safety and can come back to haunt you in a court of law.
- Avoid expressing opinions and stick to a factual description of what occurs

Example: The prescriber has ordered 4 mg. of morphine for cardiac pain. The patient received 8 mg. The following is an appropriate documentation of the occurrence. Patient received 8 mg. morphine IV at 1800 for cardiac pain. Vital signs 100/60, 80, 20. Dr. Jones notified, but gave no orders. Will continue to monitor the patient.

Documentation Tools

Flowsheets are designed to streamline the documentation process. However, flowsheets are only as good as the information that is input on the flowsheet. These documentation tools should be developed with the staff's involvement and be periodically reviewed and updated to assure that they represent the needs of the unit.

Other documentation systems such as SOAP notes, PIE charting, or charting by exception can be effective. But it is only as good as the information provided. Assuring competency of such systems is important, as implementation of these systems varies widely by institution and by individual staff nurses. Therefore, a huge responsibility is placed on staff development and management for education and assuring that procedures are followed. When using one of these systems ensure that you know the parameters of what should be documented. And always, as a rule of thumb, ask yourself, "Does this document accurately reflect my patient's story?"

Event Reports

Event or Incident reporting is frequently used as a general term for all patient safety event reporting systems. Initial reports often come from the frontline personnel directly involved in an event or the actions leading up to it rather than management or patient safety professionals. Voluntary event reporting is therefore a passive form of surveillance for near misses or unsafe conditions, in contrast to more active methods of surveillance such as direct observation of providers or chart review using trigger tools. Incident reports are used to communicate unusual or unexpected events. Three examples of situations that require an incident report are patient falls, medication errors, and wrong site surgery. The incident form is completed and kept separate from the patient's chart.

Incident reports are primarily a risk management tool used for the following purposes:

- As a non-punitive tool used to identify potential liabilities and correct them before becoming a loss to the organization
- As a tracking tool for trending information to determine the frequency and severity of specific adverse occurrences
- To plan corrective actions to further the improvement of processes and promote safer patient care
- To give Risk Management a head start on claims prevention and claims management
- To meet the requirement for annual reporting of incident reports to specific national regulatory associations
- Incident reports are also used in Peer Review Committee meetings. Peer Review is a process whereby the quality of the services provided by the healthcare staff is evaluated by equivalently trained personnel. In the Peer Review Committee meetings, incident reports are used to determine remediation, counseling, education, and or discipline.

Depending on specific state law, the event report is a confidential document that is protected from discovery in a lawsuit. The incident report should never be copied, placed in the patient chart or referred to in the patient chart.

Abbreviations and Official Do Not Use List

The issue of approved abbreviations has heated up in the last few years due to the research and intense interest by Joint Commission. Research has shown that confusing abbreviations are a major cause of sentinel events and thus JC published an official "Do Not Use" list of potentially confusing abbreviations. Memorize this list, as JC requires facilities to strictly monitor and enforce the avoidance of the following abbreviations.

DO NOT USE	USE INSTEAD
U	Write out "units"

IU	Write out “international units”
Q.D., QD. , q.d.,qd	Write out “daily”
Q.O.D., QOD, qod, q.o.d.	Write out “every other day”
Trailing zero (X.0 mg) Absent leading zero (.X mg)	Write “X mg” Write “0.X mg”
MS	Write “morphine sulfate”
M_{SO4} and MgSO₄	Write “magnesium sulfate”
< or >	Write greater or less than
Abbreviations for drug names	Write drug names in full
Apothecary units (Drams, Scruples, Grains)	Use metric units (Meter, Liter, Gram)
@	Write “at”
cc	Write “ml” , “mL” or “milliliters”
ug	Write “mcg” or “micrograms”

Electronic Medical Records

Electronic medical records are digital versions of the paper charts in clinician offices, clinics, and hospitals. EMRs contain notes and information collected by and for the clinicians in that office, clinic, or hospital and are used by providers for diagnosis and treatment. EMRs are more valuable than paper records because they enable

providers and clinicians to track data over time, identify patients for preventive visits and screenings, monitor patients, and improve health care quality.

U.S. healthcare organizations have been transitioning from paper-based medical records to electronic health records for over a quarter of a century. They allow organizations to minimize the high rate of medical errors occurring throughout the healthcare industry and act as a tool for increasing patient safety and decreasing the overall cost of healthcare. EMRs are easy to search, and update, and provide tools like reminders, alarms, and automated processes that improve clinical accuracy.

Recognizing the role that EMRs can play in transforming health care, in 2003, the Institute of Medicine issued a group of eight key functions for safety, quality, and care efficiency that EMRs should support.

- Physician access to patient information, such as diagnoses, allergies, lab results, and medications.
- Access to new and past test results among providers in multiple care settings.
- Computerized provider order entry.
- Computerized decision-support systems to prevent drug interactions and improve compliance with best practices.
- Secure electronic communication among providers and patients.
- Patient access to health records, disease management tools, and health information resources.
- Computerized administration processes, such as scheduling systems.
- Standards-based electronic data storage and reporting for patient safety and disease surveillance efforts.

Using electronic medical records presents a major change for those who are accustomed to paper records. One issue is that of maintaining confidentiality. Computerized records have extensive systems of checks and balances built in to help assure confidentiality. Methods to protect computerized information may be administrative, technical, or physical.

Administrative Protection of EMRs

- Policies, procedures, and standards should be in place to protect the records
- Educational programs of an ongoing nature are essential
- Responsibilities should be made explicit, and users held accountable
- Performance appraisal based on use of standards, with opportunities for re-education or discipline as indicated
- Security precautions will not entirely eliminate the risk of corruption. Managers must decide on the level of risk that is acceptable considering time, cost, and manpower
- Ongoing re-evaluation of security measures is necessary

Technical Protection of EMRs

- Login procedures can deter unwanted access. Users must not share their login names or passwords. Some systems may require a card or utilize fingerprints, retinal patterns, etc.
- Monitors should be programmed to sleep after a period of non-use. Once the screen is blank then a user will need to login again
- Level of access may be based on role or "need-to-know." Users should be assigned a level of access. It is not necessary for a dietary worker to access a patient's lab data, just the type of diet ordered
- Audit trails provide information about who accessed what information and who attempted to access unpermitted information

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- Data encryption is a means of protecting data

Physical Protection of Computerized Information

- Monitors should be placed in locations that the general public will not easily see.
- Theft protection devices (cables, alarms, etc.) should be employed
- Physical access to computers should be limited. A computer with access to an extensive database should not be kept in a remote but easily accessible area. Don't put the computer in a back hallway! Terminals in public areas can be programmed to allow limited access to data
- Disaster preparations are essential. Procedures must be developed to handle all sorts of disasters. Although nurses will not be directly involved, they will need to know of backup procedures.

Healthcare professionals need to be aware of who accesses a patient record (electronically or hard copy).

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