The Best Defense is a Good Documentation Offense

3.8 Contact Hours

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Objectives

After completion of The Best Defense Is a Good Documentation Offense, the participant will be able to:

1. Explain why documentation is important to health care providers.
2. Identify the basic information that is required when documenting in the medical record.
3. Describe those particular issues that require documentation in the medical record.
4. Discuss the emerging documentation concerns regarding the faxing and computerization of records.
5. Determine documentation Do’s and Don’ts.
6. Compare differences in documentation issues that are specific to nurses versus certified nursing assistants.
7. State the characteristics of satisfactory documentation.
8. Evaluate the medical record documentation issues in selected legal cases.
9. Explain how documentation may evolve in the future to meet emerging needs.

“If it’s not in the medical record, it didn’t occur.”
Barbara E. Calfee,
Nurses in the Courtroom: Cases and Commentary for Concerned Professionals
The Best Defense is a Good Documentation Offense

CONTENT OUTLINE

I. Why Is There So Much Hoopla About Documentation Anyway?
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   b. Federal Regulations
   c. Client History
   d. Reimbursement Issues
   e. Protection at Litigation

II. What Basic Information Should I Be Sure to Document in the Medical Record?
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   b. Client History
   c. Interventions: Medical, Social and Legal
   d. Observations: Objective and Subjective
   e. Outcomes
   f. Client and Family Response
   g. Authorship: Your Signature and Credentials

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IX. What’s Does the Future Hold?
I. WHY IS THERE SO MUCH HOOPLA ABOUT DOCUMENTATION ANYWAY?

The old saying "if it's not documented in the medical record it was not done" has never been more timely as state and federal governments continue to enact legislation to protect various healthcare consumers. Consider the increased interest in the elderly that occurred in the late '80s and early '90's. As a result, legislation and regulations emerged relating to long term care facilities and new litigation (lawsuit) possibilities occurred. Proper documentation reflects the quality of care that you give to your clients and is evidence that you acted as required or ordered.

To avoid litigation, health care providers must comply with established standards of care.

Standards of care arise from:

1. Regulations based on state and federal legislation or statutes. Regardless of the term used, they are the law.
2. Practice guidelines, such as the American Health Care Association Long Term Care Guidelines.
   - Facility policies/procedures
   - Expert witnesses

When dealing with statutes and regulations, it is important to understand those in your own state. Violating any one of them would make you and your employing facility automatically negligent (not exercising the degree of care that a person of like training and experience would do under the same or similar circumstances) without the right to defend yourself. A claim of negligence requires that there be a duty owed by one person to another, that the duty be breached and that injury is the result. On the brighter side, proof of your compliance to any particular statute or regulation can be used in your defense to show that you did follow a standard of care.

Practice guidelines and facility policies/procedures are not laws. Failure to follow them does not mean that you are automatically negligent. What it does mean is that it will be up to a jury to decide whether or not you were negligent. Practice guidelines and facility policies/procedures are often introduced as standards of care by a prosecuting attorney trying to prove that negligence has occurred. On the other hand, a defense attorney will use the same guidelines and policies/procedures as evidence that standards of care were met.

Expert witnesses are used by both prosecuting and defense attorneys to establish standards of care. Depending on the kind of legal case, an expert witness could be a nurse, a doctor or a facility administrator, etc. They are usually individuals who are well known and respected in their field. An expert’s role is to explain to the jury the standard of care based upon their particular expertise. They are allowed to use articles, practice guidelines, policies, etc. to prove their point. The jury will interpret the opinions of the expert witnesses and determine for themselves if negligence has occurred.

Although your employer should periodically update their policies/procedures and keep you informed about new or revised standards of care and/or state legislation, it is still your responsibility to get that information for yourself so that you can minimize your risk of liability.

Along with keeping yourself informed, it is also critical that you value doing complete and accurate documentation in the medical record as yet another means of avoiding liability. It is well known that the medical record can change the entire climate surrounding a lawsuit. In fact, medical records, in
themselves, may be the very source of a lawsuit. Not only is complete and accurate documentation a means of telling the story of a client's health care history over time, but it is also often required to justify reimbursement of services that are provided to a client. When that reimbursement is coming from programs like Medicare and Medicaid, denial of those funds would certainly be a critical situation in facilities caring for the elderly and/or the poor.

Failure to document or faulty documentation on your part is risky behavior that should be avoided. Knowing that, it is highly suggested that you obtain a copy of the documentation standard (policy) where you are employed and become very familiar with it. Questions you may have can be directed to either your immediate supervisor or a member of the education department in your facility.

Here is a fictional case that exemplifies how negligence may be interpreted in court:

A 17-year-old was partially paralyzed and severely brain damaged after an accident. He was admitted to the hospital for intensive rehabilitation. Soon after, his parents told his nurse that a part on the right side of his wheelchair was missing and that they saw scratches on his right arm. The nurse observed the scratches but did not document them in the medical record.

Later the patient’s hip became red, swollen, and increasingly painful. His mother also reported these symptoms to the nurse, who again failed to document them. When the patient was finally diagnosed with a broken hip, his parents sued. The court found the hospital negligent and awarded the patient a large monetary award (Charting Made Incredibly Easy, 2012, p. 231).

You probably didn’t become a nurse in order to master the art of charting. You probably didn’t get into the field to prevent a malpractice suit from occurring. You most likely do not spend your waking hours fantasizing about documentation. How could you possibly want to chart, let alone enjoy it when it keeps you from giving direct patient care…but in reality, documenting is patient care! (Charting Made Incredibly Easy, 2012, p.v. foreword).
II. WHAT BASIC INFORMATION SHOULD I BE SURE TO INCLUDE IN THE MEDICAL RECORD?

Before we address the basics of documentation, I would like to talk about the need for all your documentation to be legible to anyone who may read it. If you know you have poor penmanship, begin to print. Your printing will make life much easier for the person who is reading or transcribing from your notes. Now that you’re printing, let’s talk about the basics.

It sounds trite but be sure to include the date and the time you wrote your entry. The date should include the year; the time should indicate am or pm. Don’t chart in blocks of time such as 0700 to 1500. This makes it hard to determine when specific events occurred.

Other essential information to record is: the client's history (including unhealthy conditions or risky health habits such as scalp lice, smoking, failure to take prescribed medication, etc.). A client’s history is usually reflective of trends and may offer valuable hints about what to expect in the future. It is important that you chart any subjective (what you hear) and objective (what you see) observations (especially changes in health status such as the emergence of a productive cough, difficulty in breathing or feelings of anxiety or depression). Document any actions that you did in response to any of your observations and the client’s response to your actions. These responses to your interventions are commonly called client outcomes.

Client outcomes (including those that are deviations from what you expected) should be charted in the record. For example: If a client is in pain, observe and document how that pain is experienced both objectively (what you see) and subjectively (what you hear). Record where the pain is and the level of intensity or severity (perhaps you will use a pain scale to do that). Record the medication and the backrub you give to relieve the pain and whether or not those actions were effective, i.e., did the pain persist, recur, or go away?

It is a good idea to document the client, family member or significant other’s actual response (verbal or non-verbal) to any aspect of care provided even if you were not the one providing it. Doing so indicates that you have evaluated the results of care. It is perfectly acceptable to chart the client’s verbal responses in the record as long as you use quotation (”) marks. Non-verbal responses should be described in as much detail as possible.

Be sure to record your full name, credentials and job title in the required section on documentation forms. Some forms will ask you to record your initials as well. Your signature must be in cursive writing so a word of final caution: do take the time to sign your name legibly.

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Documenting the Basics

- Chronology: Date and Time
- Client History
- Interventions: Medical, Social and Legal
- Observations: Objective and Subjective
- Client Outcomes
- Client and Family Response
- Authorship: Your Full Name, Title, Credentials and Signature
III. OKAY, I’VE GOT THE BASICS, NOW WHAT?

Other information that needs to be recorded in the medical record includes any education or instructions you give to the client, his family or significant other. A pre-printed, standardized check off (✓) form may be used where all you have to do is check off (✓) or initial what you have done. The only time you may have to write any notes is when something is specific or unique to this particular client... something that can't be included on a standardized check off (✓) form. Check off (✓) forms are great as they save documentation time, but remember: if you do not check off items as required, it means that legally the care was not done.

Anytime a client, family member or significant other is given a referral to a community resource, it should be recorded. And it is obvious that any authorization or consent for treatment is a documentation priority so that legally, permission to provide care has been given.

There is more to record even if what we are now going to talk about does not get recorded into the medical record per se. I'm referring to phone calls that we receive. Phone calls can contain information for which we have obligations, such as advice given to a client or a physician phone order. To protect yourself in these kinds of phone conversations, a telephone log is recommended to document client and/or physician calls. The log can be retrieved to refresh your memory and provide evidence if the need arises.

Pre-printing such a log so that all you have to do is record the required information is optimal. The respective logs should include the following information (NSO, 2020):

<table>
<thead>
<tr>
<th>For A Client Call:</th>
<th>For A Physician Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Date and time of call</td>
<td>✓ Date and time of call</td>
</tr>
<tr>
<td>✓ Caller's name and address</td>
<td>✓ Physician's name and “T/O” to indicate order</td>
</tr>
<tr>
<td>✓ Caller's request or chief complaint</td>
<td>✓ Verbal order, written word-for-word</td>
</tr>
<tr>
<td>✓ Advice you gave</td>
<td>✓ Documentation that you've read back the order, to be sure you heard it correctly</td>
</tr>
<tr>
<td>✓ Protocol you followed (if any)</td>
<td>✓ Documentation that you've transcribed it according to your facility's policy</td>
</tr>
<tr>
<td>✓ Other caregivers you notified</td>
<td>✓ Your name</td>
</tr>
<tr>
<td>✓ Your name</td>
<td>✓ Your name</td>
</tr>
</tbody>
</table>
IV. I'M WORRIED ABOUT ELECTRONIC RECORDS: WHAT DO I NEED TO KNOW?

Email and fax are great methods for expediting the transmission of written documents. However, according to the American Health Information Management Association (a division of the American Hospital Association), there are certain safeguards that you should take to protect the confidentiality of your clients when transmitting records using these methods.

**SAFEGUARDS FOR FAXING**

- Before faxing, call the intended recipient to say that it's coming.
- Ask the recipient to send a return fax verifying receipt of the information.
- On the fax cover sheet, clearly note that the accompanying material is confidential. If at all possible, block out identifying data and have the recipient of the fax agree to be present when the fax comes through at the other end.
- If you don't receive verification of receipt, check your fax machine's internal log to determine where the fax was sent.
- If it went to the wrong number, send another fax to that number asking the recipient to destroy the material.

A quick, three (3) check system for faxing (somewhat like the system used for giving medications) is a handy reminder to use when faxing. It goes like this:

1. **Check** the number before you dial
2. **Check** the number on the fax machine display
3. **Re-check** the number before you press the send button

Are you doing some of your documentation on a computer? I'm sure your answer is a yes. Using electronic medical records allows easier communication of information and also eliminates the problems associated with handwriting that is hard to read. Remember that your computerized documentation is as legal as when you manually chart in the medical record. Therefore, you need to be just as careful in following all of the policy and procedures related to computer charting as when you manually chart. Reducing your legal risk and providing secure computer records is easier if you use the following guidelines (NSO, 2020).

**COMPUTER CHARTING GUIDELINES**

- Double-check the information that you enter.
- Indicate whether a physician's order is written or verbal, whether it was given in person or by phone, and when you make the computer entry.
- Never tell anyone your password. Change it often in case someone should guess it and try to use it later (most facilities automatically change it every 45 – 90 days).
- Don't allow anyone else to use the computer with your password logged in. Any entries they make will be stamped with your electronic signature.
- Tell your immediate supervisor if someone is using your code.
- Don't leave client information displayed on the computer screen.
- Log off the computer when you're not using it.
- Retrieve any printouts immediately.
• Follow your facility’s policies and procedures for computer entries and error corrections.
• Ensure that appropriate backup files are kept.
• Know your state’s rules and regulations and your facility’s policies and procedures for patient data, confidentiality, and disclosure.
• If you are using a laptop to document at work and you are allowed to take it home with you, do not be tempted to let members of the family use it for personal reasons.
• Once notes are entered into the computer, they become a permanent part of the medical record and shouldn’t be deleted or edited at a later time without an explanation that’s documented, signed and dated.

As we leave the topic of computers, it bears repeating that as with any other form of documentation:

Good computerized documentation not only can help you in court, but it can also keep you out of court in the first place.
V. CAN YOU MAKE DOCUMENTATION EASIER FOR ME?

I can sure try to make it easier for you to document. Here are some Do's and Don’ts for Charting (NSO, 2020).

THE DO’S THAT MAKE CHARTING EASIER

- Check that you have the correct chart before you begin writing.
- Make sure your documentation reflects the nursing process and your professional capabilities.
- Write legibly.
- **Use a permanent black ink pen**...other colors do not Xerox well.
- Chart completely, concisely and accurately (“Tell it like it is.”).
  - Write clear sentences that get right to the point.
  - Use simple, precise words.
  - Don’t be afraid to use the word “I.”

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**Here is an example of both incorrect and correct nursing note documentation:**

**Wrong Way:** Communication with patient’s family begun today to specify the manner in which his condition is progressing and suggest a probable consequence of that progression.

**Right Way:** I contacted Mr. Boondoggle’s wife at 1415 hours. I explained that his cardiac status was worsening and that he was being prepared for a cardiac catheterization procedure scheduled for 1600 hours.

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- Chart the time you gave a medication, the route you gave it and the client’s response.
- Chart precautions or preventive measures used, such as bed rails.
- Include the following information when documenting nursing procedures:
  - What procedure was performed
  - When it was performed
  - Who performed it
  - How it was performed
  - How well the client tolerated it
  - Adverse reactions to the procedure, if any (Charting Made Incredibly Easy, 2012, p. 286)
- Record each phone call to or from a physician, including the exact time, message, and response (use that phone log we just talked about earlier).
- Chart what you feel is important data from visits by physicians or other members of the health care team such as the dietician, social worker, etc.
- Chart as soon as possible after giving care…don’t wait to chart until the end of your work day.
- Chart a client’s refusal to allow a treatment or take a medication. Document the reason why the client refused…this is a good time to use the client’s own words in quotations.
• If you don’t give a medication, circle the time and document the reason for the omission.
• Chart client’s subjective data (what the client perceives and the way they express it) by directly quoting it. This is a time to use quotation marks (“”).
• If you remember an important point after you’ve completed your documentation, chart the information with a notation that it’s a “late entry.” Include the date and time of the late entry.
• If information on a form such as a flow sheet doesn’t apply to your client, write NA (not applicable) in the space provided.
• Chart often enough to tell the whole story.
• Use only commonly used or approved abbreviations and symbols (Kozier, 2000, p.200).
• Document discharge instructions including any referrals to home health agencies and other community providers as well as any patient teaching that was done.
• Post a list of commonly misspelled words or confusing words, especially terms and medications, regularly used in your work setting. Remember many medications have very similar names but different actions.
• When documentation continues from one page to the next, sign the bottom of the first page. At the top of the next page, write the date, time and continued from previous page.
• Make sure each page is stamped with the client’s identifying information.

THE DON’TS OF CHARTING

• Don’t chart a symptom, such as “c/o pain,” without also charting what you did about it.
• Don’t alter a client’s record...this is a criminal offense. Here are the four don’ts, or red flags, of chart altering that are to be avoided:
  o Don’t add information at a later date without indicating that you did so.
  o Don’t date the entry so that it appears to have been written at an earlier time.
  o Don’t add inaccurate information.
  o Don’t destroy records.
• Don’t use shorthand or abbreviations that aren't widely accepted or at least not accepted in your facility. If you can’t remember the acceptable abbreviation, then write out the term.
• Don't write vague descriptions, such as "drainage on bed" or "a large amount."
• Don’t give excuses, such as "Medicines not given because not available."
• Don’t chart what someone else said, heard, felt, or smelled unless the information is critical. In that case, use quotations and give credit to the individual who said or experienced it.
• Don’t chart your opinions.
• Don’t use language that suggests a negative attitude towards your client such as the words stubborn, drunk, weird, loony or nasty.
• Don’t be wishy-washy. Avoid using vague terms like “appears to be” or “apparently” which make it seem as though you are not sure what you are describing or doing.
• Don’t chart ahead of time...something may happen and you may be unable to actually give the care that you've charted. And that goes for charting care given by others...don't do it.
• Notes filled with misspelled words and incorrect grammar are as bad as those done in illegible handwriting. Information may be misunderstood if such notes end up in a court room.
• Don’t record staffing problems.
• Don’t record staff conflicts.
• Don’t document casual conversations with your colleagues.

Charting care that you haven’t done is considered fraud.

Hold on, there's more! Here are some other noteworthy Don'ts:

• Don’t use white out or an eraser...if you make a mistake, draw a single line through the entry and write mistaken entry rather than error. The word “error” could seem to indicate that a mistake in care, not documentation, was made. Write in the correct entry as close to the mistaken entry as possible and sign with your first initial, last name and title (Eliopoulos, 2017, p. 71). Also writing “oops,” “oh no” or “sorry” or drawing a happy or sad face anywhere on a record is unprofessional and inappropriate.
• No empty lines or spaces... fill in the empty line or space with a single line to prevent charting by someone else (Kozier, 2000, p. 200).
• No writing in the margins.
• Don’t mention any incident or accident report in the medical record...document only the facts of an incident and never write the words “incident report” or indicate that you have filed one.
• Don’t use words associated with errors or ones that suggest that the patient’s safety was in danger such as: “by mistake,” “accidentally,” unintentionally,” “miscalculated,” “confusing.”
• Don’t name a second patient...doing so violates that patient’s confidentiality. If you have to refer to a second client, do so by using the word “roommate” or the room number.
VI. WHAT IS THE DIFFERENCE IN THE WAY THAT NURSES DOCUMENT VERSUS CERTIFIED NURSING ASSISTANTS?

Nurses use a variety of formats to document. Not all are permanent parts of the medical record. Listed below are the different formats and a brief description of each. Perhaps you recognize a format used in your own facility. Regardless of the format used to chart, it is a formal, legal document that details a client's progress. Once again, it bears repeating that if "it is not in the record, it was not done." So make sure whichever format you are using, it is complete and accurate.

DOCUMENTATION (CHARTING) FORMATS

**Nursing Care Plans**... Most care plan forms have three (3) columns. One is for a nursing diagnosis, a second column is for nursing actions or interventions, and a third column is for expected client outcomes of care. The nurse must develop a care plan for each client usually within a specified amount of time after the client enters a facility for care or service.

**Standardized Nursing Care Plans**... These pre-printed care plans were created to save nurses time that they would normally spend in charting. These plans detail the standards of care for a given client with a particular problem, diagnosis or issue. Examples: A standardized care plan may exist for a patient with a problem such as Constipation Related to Immobility as a Result of Complete Bed Rest Following Bilateral Hip Replacement Surgery or with a diagnosis of Alzheimer's Disease or an issue like Failure to Comply with Prescribed Treatment for Diabetes. The plan is formatted so that the nurse merely has to check off care that is provided. If something occurs that is not already designated on the care plan, the nurse will individualize the care plan to include that issue by writing in a narrative note.

**Critical Pathways or Health Care Maps**... These tools may be pre-printed. They include nursing actions for a client with a specific medical diagnosis. They also specify care that the client should receive on a daily basis including but not limited to diet, medications, activity, treatments, etc. Pathways or maps have become very popular since managed care systems have emerged. They serve as a means of not only documenting but also monitoring care. Variances in providing care or achieving client goals or outcomes by the targeted dates indicated on the pathways is an immediate cause for scrutiny and investigation into why. The goal is to have the client progress according to the pathway or map goals so that the costs in providing that care are reimbursed to the facility by third party payers. Your facility will always challenge you to give the care more efficiently and effectively so that costs are kept to a minimum yet the quality of care remains high. Documentation will remain paramount in systems like this where micro-monitoring is becoming the norm of the day.

Now that you have reviewed some of the most commonly used documentation formats, let's take a look at the various methods that nurses use when they chart or document on any particular format.

METHODS FOR DOCUMENTING NURSES NOTES

**Narrative**... The nurse may be asked to chart in chronological order the events that occur including the gathering of information. A sentence structure is usually preferred although the use of columns to organize the narrative may be used. There may be a separate column for treatments, nursing observations, comments, etc. Narrative charting is time consuming so legibility is extremely important if the notes are to be understood by those reading them.

**SOAP**... this is an acronym for Subjective data, Objective data, Assessment, and Plan. Some facilities use the acronym **SOAPIE** in which Implementation (nursing actions or interventions)
and Evaluation have been added. And then, there is SOAPIER in which Revision is the last component. Following each letter of the respective acronym used, the nurse is required to chart information relevant to that particular term.

APIE... this is a more recent method which requires the nurse to include Assessment, Plan, Implementation and Evaluation. It is a method, which condenses client data into fewer statements by combining subjective and objective data into the Assessment section and combining nursing actions (what the nurse will do) with the expected outcomes of client care (what the client will get or experience) into the Plan component.

PIE... this is an acronym for Problems, Intervention and Evaluation of nursing care. The system consists of a 24-hour flow sheet combined with nursing progress notes. The notes are usually written as client problem statements using an approved nursing diagnosis. Problems are labeled "P" and given a number; nursing interventions are labeled "I" evaluations of the nursing action or intervention is labeled "E".

Flow Sheets... these are often called "graphic records" and are used as a quick way to reflect or show the client's condition. They are helpful records in documenting things such as vital signs, medications, Intake and Output, bowel movements, etc. The time parameters for a flow sheet can range from minutes to months. For example: In an intensive care unit a blood pressure might be recorded every 5 minutes while in a clinic setting a weight may be recorded only once a month.

Focus Charting... the term focus was coined to encourage nurses to view the client's status from a positive perspective rather than the negative focus in problem charting. The system uses three (3) columns as indicated here. Note the information that is usually required in the third column titled Progress Notes (called the DAR):

<table>
<thead>
<tr>
<th>Date / Hour</th>
<th>Focus</th>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Charting By Exception... often called CBE... a system of charting in which only significant findings or exceptions to standards or norms of care are recorded or charted. Flow sheets or charts are used in which check off (✓) marks are recorded. Recording an asterisk (*) means that a standard or norm of care was not implemented. The asterisk (*) also means that a narrative nurses note has been charted to explain why the standard of care was not met or satisfied.

Regardless of the system of documentation that is used, nurses universally use or refer to the Nursing Process as a guideline when they are charting. The Nursing Process contains the following four phases of nursing care:

1. Assessment...observing the client for signs and symptoms that may indicate actual or potential problems.
2. **Planning**... developing a plan of care directed at preventing, minimizing or resolving identified client problems or issues.

3. **Implementation**... of the plan of care that has been developed; includes the specific actions that the nurse needs to take to activate that plan.

4. **Evaluation**... determining whether the plan of care was effective in preventing, minimizing or resolving identified problems.

**FACT Documentation System**: the computer ready FACT system incorporates many CBE principles; it helps caregivers avoid documenting irrelevant information, repetitive notes and reduces the time spent in charting. The FACT format uses:

- **An assessment and action flow sheet**: to document ongoing assessments and actions. Normal assessment parameters for each body system are printed on the form along with planned actions. You can individualize the flow sheet according to your specific patient’s needs.

- **A frequent assessment flow sheet**: this is where you document vital signs and frequent assessments. On a surgical unit, for example, you would use a postoperative frequent assessment flow sheet.

- **Progress notes**: requires an integrated progress record; you would use narrative notes to chart the patient’s progress and any significant events. As in FOCUS charting mentioned before, you would use the *data-action-response* method of charting.

Now that you’ve learned all you wanted to ever know about nurse’s documentation formats and methods, let’s take a look at how nursing assistants document their care. Over time nursing assistant documentation has changed. Where once they may have done some narrative charting, nowadays they chart most often on flow sheets or charts where only a check off (\(\checkmark\)) mark is required to indicate the care that has been provided. A **Daily Nursing Care Record** (see Appendix A) is one kind of flow sheet used by nursing assistants to document their daily care. Aspects of care such as the client's daily bath, oral, denture, and hair care appear on a pre-printed form. All the nursing assistant has to do is check off (\(\checkmark\)) the box next to the aspect of care after that care has been completed. Only rarely would the nursing assistant have to add a word or two of detail. An example might be in the recording of a bowel movement (BM), the nursing assistant may add whether or not the BM was small, moderate or large in amount.

> *It can be a tedious and time-consuming task for the nursing assistant to make sure that each and every box is either checked off (\(\checkmark\)) or is recorded with a zero which indicates to anyone reviewing it that the care was not done for whatever reason.*

> **For example:** the client may have refused the care; therefore, it could not be done.

Nursing assistants are required to immediately report care that was not done or was refused to their charge nurse or team leader. The nurse is then responsible for charting a narrative note as to why the care was not done as ordered. Although it is very time consuming for nursing assistants to check off (\(\checkmark\)) or enter with a zero the many boxes on the flow sheets provided for them to record care, it is important for the nurse to encourage and monitor their charting efforts. Remember, if absences appear on flow sheets, then, legally, care was not offered or provided. Since nursing assistants report to nurses, it is a nursing responsibility to periodically monitor nursing assistant documentation for accuracy and completion. Randomly auditing nursing assistant documentation is an effective continuous quality review.
monitoring endeavor that, over time, could become a rewarding nursing assistant activity. But first, nurses need to ensure that nursing assistants have the time available to them so that they can accomplish the level of charting that is expected of them.

Doing random quarterly reviews of all nursing documentation should be an annual goal in all facilities considering the legal ramifications of absent or faulty documentation.

Doing random auditing of records indicates that there is a healthy concern about charting accuracy and completion.
VII: CAN WE LOOK AT SITUATIONS WHERE DOCUMENTATION WENT WRONG?

You bet! Let’s take a look now at some real legal cases where nursing documentation was, or soon became, a critical issue in the case. We will begin with Ketchum vs. Overlake Hospital Medical Center, 1991, in which Ms. Ketchum’s family filed suit against Overlake Hospital contending that Ms. Ketchum suffered severe brain damage, caused by what they felt was negligent nursing care. Their complaint focused on the care Ms. Ketchum received in Overlake’s Intensive Care Unit on the night shift back in 1980 following an operation in which an aneurysm in her brain was surgically clipped.

The bottom line in the case was whether or not the night nurse caring for Ms. Ketchum had accurately and completely assessed, documented and reported changes in her condition during the night. A nurse expert witness for the prosecution testified that the nurse had not adequately documented symptoms of client deterioration such as respiratory distress, an elevated pulse and sluggish pupils. The expert nurse also testified that the night nurse had not notified the physician of the changes in his client’s condition.

The defense nurse expert witness testified that the nurse had satisfied the standard of care for a patient with Ms. Ketchum’s condition regarding both assessment and documentation. Moreover, this expert testified that the nurse had fully and appropriately informed the client’s doctor about her condition in three phone calls she had made to him that night.

Although this case had to return for a new trial due to a technicality, it appears from the nurse experts’ differences of opinion that this particular nurse’s documentation of the assessment she did on Ms. Ketchum that particular night may still be a pivotal issue in this lawsuit.

Another interesting case is Jarvis vs. St. Charles Medical Center, 1986, in which Ms. Jarvis suffered a leg fracture in a skiing accident in 1981, which was subsequently surgically reduced. Concerned about a condition called compartment syndrome (swelling prevents blood from reaching a muscle compartment), the doctor left orders for nurses to perform certain tests and observations on an hourly basis and to call him if problems developed.

Nurses did call the doctor on one evening to report problems, which he immediately alleviated. However, on one particular morning the client’s leg was white and had no pulse when the doctor examined her on his morning rounds. He had not been called during the night with any report of problems, but some of the leg tissue was indeed dead and the client had to have more surgery to remove that tissue. The result was that the client had decreased use of the involved leg.

During litigation, the court was asked to determine if inconsistent nurses notes regarding the testing and assessment ordered by the client’s doctor were indicative of substandard care that led to the client’s further injury and suffering. The court agreed that the faulty charting indicated less than optimal care, which resulted in the client’s current unfortunate condition. In fact, this case truly epitomizes the old saying that if the care was not documented, then it was not done. In this case, the record could not come to the nursing staff’s defense because for a four and one-half hour period no documentation of any assessment of the client could be found in the record. It was as though a nurse never looked at the client.
A third case highlighted in the January, 1997 issue of the NSO Newsletter (p.5) is **Ard vs. East Jefferson General Hospital** [Source: Ard v. East Jefferson General Hospital, 636 So.2d 1042 (LA, 1994)] where five days after quintuple coronary artery bypass graft surgery, a patient who was having respiratory problems was transferred out of the intensive care unit (ICU). But two days later, this patient, who had a history of myocardial infarction, stroke, and unstable angina, was readmitted with respiratory failure. Five days after that, he was again transferred from the ICU.

According to his wife, he became nauseated and short of breath after leaving the ICU for the second time. She pressed the call light several times before someone responded, she said.

His nausea worsened, then he vomited and began tossing and turning with pain. A nurse gave him a suppository at about 5:30pm.

From 5:30 to 6:45pm, the patient’s wife claimed she pressed the call light 10 or 12 times, each time asking for a nurse. She was told that a nurse wasn’t available. Her husband was having difficulty breathing. At 6:45 pm, he went into respiratory arrest. The patient’s wife ran into the hall and found a nurse, who initiated a code.

Despite resuscitation efforts, the patient died of respiratory and cardiac arrest two days later; he’d never regained consciousness. His wife sued the hospital for wrongful death.

At the trial, the nurse assigned to care for the patient disputed the wife’s testimony. She said she’d checked the patient at about 6 pm. However, her assertion wasn’t documented in the patient’s record. In fact, there was no indication that any nurse checked on the patient between 5:30 and 6:45 pm.

A nurse testifying as a nurse expert witness cited this as an example of serious breaches in the standard of care. Also, she said, the nurses’ notes and the plan of care failed to address the patient’s swallowing problems and high risk of aspiration. No swallowing assessment was done and the nurse didn’t do a full assessment of respiratory and lung status after the patient vomited.

A medical expert also testified that timely notification of the patient’s worsening condition might have changed the outcome. The patient could have been transferred to the ICU, where his chance of survival would have been better.

The trial judge ruled in the plaintiff’s favor. The hospital appealed, but the appellate court affirmed the lower court’s ruling. It also increased the amount of damages awarded to the wife from $50,000 to $150,000 and to the patient’s adult daughter from $10,000 to $50,000.

What is the lesson to be learned from this case? A high-risk patient requires complete assessment and frequent monitoring. And unless these measurements are documented, the court may not recognize that they’ve been performed. In this case the court didn’t believe the testimony of the nurse who claimed she’d checked the patient. The wife’s testimony, however, was consistent with the medical record.
VIII. HOW CAN YOU BE SURE THAT YOUR DOCUMENTATION IS SATISFACTORY?

Although we have only looked at three legal cases here, it bears repeating as we conclude our program on defensive documentation that we need to review our own notes to determine whether we are meeting the standard for what is considered satisfactory documentation within our respective employment facility.

There are several key words that come to mind. You might want to write them down on a note card, laminate it and carry it in your pocket. Periodically, review and evaluate your documentation. Here they are in alphabetical order:

- Chronological
- Comprehensive
- Complete
- Concise
- Descriptive
- Factual
- Legally aware
- Legible
- Relevance
- Standard abbreviations, symbols, and terms
- Thorough
- Timely

As said previously in this program, how you chart is as important as what you chart.

Therefore, chart only what you see, hear, feel, measure and count…not what you suppose, infer, conclude or think.
IX. What's Does The Future Hold For Nursing Documentation?

Word's out that the future may hold a national standardized medical record or chart format no matter where care is delivered. The result would be consistent documentation standards so that nursing employees would not have to learn a new or different system every time they changed jobs or transferred to a different position within the same facility. Imagine it! Even if you crossed state lines, you would see the same familiar chart format and standard method for charting.

The benefits of charting the same way no matter where you are seem fairly obvious. Hopefully, documentation would be even more accurate and complete wherever and whenever it is written. It also stands to reason that if you continue to use the same charting system, your documentation expertise should continue to improve. Keep documentation standards of care uppermost in your mind as you go about your daily work as a dedicated health care professional.
REFERENCES


Eskreis, Tina Rae, JD, BS, RN. Seven Common Legal Pitfalls in Nursing. AJN, Vol.98, No.4: April, 1998.


Directions: Circle the best answer to each question. Use a pencil to circle your answers. If you make a mistake be sure to completely erase it.

1. From a legal standpoint, if you provide care and do not document it, then the care:

   A. was done  
   B. was not done  
   C. was done by yourself and a co-worker  
   D. was only half done

2. All of the following basic information should be included when you document in the medical record except:

   A. the date  
   B. the time  
   C. your name and title  
   D. the day of the week

3. A key issue in many malpractice cases is:

   A. documenting too much information  
   B. only documenting once in 24 hours  
   C. failure to document  
   D. erasing errors

4. All of the following statements are true except:

   A. Document incident reports in the medical record.  
   B. Do not use white out if you make a mistake.  
   C. Reasons care was not given should be documented.  
   D. Documenting ahead of time is not allowed.
5. If you forgot to put a check mark in the box on the flow sheet next to the words **Breakfast Given**, then legally

A. The patient did not receive breakfast.
B. The patient only ate 50% of his breakfast.
C. The patient received breakfast but ate nothing.
D. The patient refused breakfast.

6. On your way home from work, you remembered that you forgot to document something. You should:

A. forget about documenting it since you have finished work for the day.
B. go back and write what you forgot in the margin of the page where you already documented.
C. document it tomorrow using the notation "late entry" along with the date and time you are writing it.
D. call your place of employment and ask someone else to document it for you since you aren't there to do it yourself.

**TRUE AND FALSE**

**Directions:** Circle **T for True** or **F for false** in the following questions. Completely erase any errors.

**T** **F** 7. Any education or instructions given to a client or the family of a client should be documented in the medical record.

**T** **F** 8. Falsifying information in the medical record is not a criminal offense.

**T** **F** 9. Once a client has a discharge order, we do not have to document any instructions we give them about what they are to do once they are at home.

**T** **F** 10. It is okay to share your computer password with somebody else.

**T** **F** 11. When a nurse takes a verbal order over the phone she should document that she read the order back to the doctor to check that she heard it correctly.
12. To save time when she is extremely busy, a nursing assistant should be encouraged to document care on everyone before she provides care to anyone.

13. You should write your name so that anyone can easily understand your signature when they see it in the medical record.

14. When a client refuses care, you don't have to document anything because you did not give any care.

15. In the future the use of a standardized medical record form and a national standard for charting would help because a person would not have to learn a new system of documentation whenever they changed jobs.

16. Writing "confidential" on the fax cover sheet, which is placed over the medical record you are getting ready to fax is not recommended.

17. After drawing a single line through a mistake in your documentation and signing your name and title, you should also write “error” next to the mistake.

18. Sharing your computer password is not permitted even when it saves valuable nursing time that can then be spent giving direct patient care.
Evaluation

The Best Defense is a Good Documentation Offense

<table>
<thead>
<tr>
<th>Course Objectives &amp; Content</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tbody>
<tr>
<td>1. The activity was valuable in helping me achieve the stated learning objectives.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>2. The content was up to date.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>2. The number of credit hours was appropriate for the content.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<th>Teaching/Learning Methods</th>
<th>Strongly Agree</th>
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<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<tr>
<td>4. The teaching/learning methods, strategies, and slides were effective in helping me learn.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>5. The material was clearly explained.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>6. The answers to the post-test questions were appropriately covered in the activity.</td>
<td>5</td>
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<th>Overall Activity</th>
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<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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<td>7. The online course/download supported the achievement of the stated learning objectives.</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<td>8. The material was relevant to my professional development.</td>
<td>5</td>
<td>4</td>
<td>3</td>
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<td>9. Overall, I am pleased with this activity and would recommend it to others.</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>10. The content was presented free of commercial bias. *</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>11. Did the material presented increase your knowledge and/or understanding of this topic? *</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
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Continued on Next Page
* If you responded “No” to question 10, please explain why:

____________________________________________________________________________________________________________________________________________________

* If you answered “Yes” to question 11, what change do you intend to make?

____________________________________________________________________________________________________________________________________________________

What barrier, if any, may prevent you from implementing what you learned?

____________________________________________________________________________________________________________________________________________________

Cite one new piece of information you learned from this activity:

____________________________________________________________________________________________________________________________________________________

Additional comments/suggestions:

____________________________________________________________________________________________________________________________________________________

With my signature I confirm that I am the person who completed this independent educational activity by reading the material and completing this self evaluation.

Signature _________________________________ Date: _________________________
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In order to receive a certificate with contact hours you must read the information, complete the registration form (next page), evaluation form and the posttest. You may mail or fax the forms to Corexcel. Send to Corexcel, 201 Webster Building, 3411 Silverside Road, Wilmington, Delaware 19810 or fax them to 302-477-9744. If you decide to fax and pay with a check please note on the registration form, when the check will be mailed. We will mail you the certificate within a week after we receive your paperwork and payment as long as you achieve a 70% or better on the test. If you would like the certificate overnighted please send a check for $15 more with your registration, evaluation and test. Thank you for ordering this self-study packet and if you have any questions you may contact our office at 1-888-658-6641.

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WrittEn PrOgram RegistRatIOn Form

Date: ____________________

Name & Title: ________________________________________________________________

Address: _____________________________________________________________________

City: __________________ State: ____ Zip: ________________________________

License No. (Required for Florida): ____________________________________________

Email: _____________________________________________________________________

Employer: __________________________________________________________________

(W) # __________________ (H) # ___________________ (F) # ____________________

Have you registered with us before? _____ Yes ______ No

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Total: $36.95

Paying By: _____ Check_____ Credit Card _____ Money Order _________ Cash

Credit Card Number: ___________________________ Exp. Date___________

Cardholders Name: ____________________________ Sec. Code___________