



Risk Management Quarterly News

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Special points of interest:

- Documentation
- Defending Your Documentation

Documentation

A "medical chart" is a legal document and record of a patient's clinical status, care, history, and caregiver involvement. Depending on the clinical setting – hospital, physician's office, outpatient center, skilled nursing facility or assisted living facility – the medical record can take on different forms of organization and types of documentation. However, no matter what form of charting your facility uses – SOAP, PIE, Narrative Notes, Charting By Exception (CBE) – there are basic do's and don'ts for healthcare documentation.

Following is a summary of the basics that we must all (RN's LPN's and NP's) be in compliance with in order to 1. Ensure good communication between care providers 2. Provide a continuity of care 3. Establish a complete and accurate picture of the patient's condition and the care provided, and 4. Provide legal protection.

First, the medical record should always be stored in a pre-designated, secure area. It should only be discussed in appropriate and private clinical areas. Be cautious never to leave a chart lying around where others can view it. A proper medical record is clearly labeled with the patient's name and demographic information. It should have an allergy label on the front cover. DNR orders should be prominently displayed on large colored stickers on the front of the record. The information in the chart should be organized utilizing tabs or dividers to allow for quick location of information.

Second, Nurse Practitioners have additional requirements for their charting. The OIG (Office of Inspector General) states that NP's must be sure their documentation includes the following:

- **Presenting Complaint/Symptoms**
- **History and Physical**
- **Progress Notes**
- **Treatment Plan**
- **Referrals and Consultations**
- **Patient Education- both discussed and material provided**
- **Recommended Follow-Up Care**
- **Documented rationale for services**
- **Documentation supporting medical necessity**

- **Test Results**
- **Relevant health risk factors**
- **Prescriptions**
- **Completeness:** does the information flow logically, are there any information gaps, are there abnormal test results without explanatory documentation, is there conflicting documentation in the patient record, and are there any required reports that are missing?
- **Timeliness:** certain documents need to be in the patient's record within 24-48 hours to provide the quality of care by all clinicians involved.
- **Authentication:** physician signature is required not only for their work, but the need to co-sign and often document more detailed information for other clinicians whose work they are responsible for. It is not acceptable to document "discussed with resident", or "agree with the above" and then provide a signature.
- **Informed Consent:** Remember that a signed consent form is NOT informed consent. A narrative note from the Physician or NP should include; the name of the procedure or treatment proposed, the reason for the procedure/treatment, the inherent risks and complications, the expected benefits or results of the procedure/treatment, alternatives to the procedure and their inherent risks and complications, the consequences of not undergoing the procedure/treatment, the relative costs considerations of proposed plan and its alternatives, answering patient questions and confirming patient understanding, and supplemental education if necessary for further decision making.

Third, it is vital that the information in the chart be clear and concise. In order to ensure that the medical record notes are as well written as possible, the following do's and don'ts should be followed regardless of what form of charting you utilize or whether you are a nurse or nurse practitioner:

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Documentation Continued

DO'S:

All pages of the medical record should be clearly marked with the patient's name and identifying information.

Each entry should be clearly dated and timed.

Each entry should be signed by the writer using their first initial, last name, and title.

Use blue or black ink only

Keep records in chronological order. This includes note entry. If additional information needs to be added, the entry should be marked "late entry".

Correct errors properly. Do not use white out or obliterate the entry. The correct way is to draw a single line through the entry, write "error" above the entry, and sign your initials.

Use clear sentences and proper English.

Write legibly.

Use only commonly used, facility approved, abbreviations.

When charting what a patient stated, always use quotation marks.

Provide objective rather than subjective information. For example, do not chart "the patient appears to be in pain". An acceptable entry would be "the patient stated the pain in her right hand is a rated a 9 out of 10".

Always chart all occurrences or incidents, **but do not write** that an incident report was completed.

DONT'S:

There should never be gaps in charting. At the very least, one entry should be made by each primary staff member each shift.

Charting should be frequent enough and lengthy enough to tell the whole story.

Never chart a symptom, such as complaints of pain, without also charting what you did about it.

Never alter a medical record.

Do not give excuses as to why care was omitted or delayed.

Do not include information regarding staffing issues or conflicts.

Never chart your opinion. i.e. "The patient's daughter is controlling and manipulative." You may however chart direct quotes made by the daughter, precisely as she stated them, in quotation marks. i.e. Daughter stated "Mom, I make all your healthcare decisions."

Never chart ahead – all charting should be done in real time, as soon as possible. Do not wait until the end of a shift to document care provided.

Avoid vague or general descriptions. Statements such as "a large amount of blood" are open to interpretation. Instead, chart with accuracy and precision, stating "30 cc's of blood".

Do not use negative language about your patient. Words such as stubborn, weird, nasty, etc. suggest a negative attitude on your part.



Finally, a frequently asked question is "what should I chart about"? The following is a list of the minimum reasons an entry should be made in the nurse's notes, medication record, flow sheets, or assessment forms:

- All medications, including the time, date, route, and patient's response.
- Any patient refusal of care, medications, meals, etc. Be sure to chart that you contacted the physician and any new orders obtained.
- Chart all precautions and preventive measures used, such as bed rails.
- Record every phone call to and from the physician.
- Chart all procedures including what was done, by whom, how it was performed, all findings, and how it was tolerated.
- Record all vital signs, I&O, blood sugar readings, etc. as ordered by the physician.
- Any change in condition – physical or mental. Include who you notified and any new orders obtained.
- All incidents, injuries, falls, or occurrences. Provide a clear and objective account of the incident, who was notified, and all treatment provided. Again, do not chart that an incident or adverse report was completed.
- Complete admission and all periodic assessments timely and completely. If using a form, be sure to write in every blank provided, even if the entry is "N/A". Leaving a blank can be taken as though you overlooked that question.

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Defending Your Documentation

In this litigious society that we live in, nurses must be able to defend their care with their documentation. Every patient, family member and visitor is a potential plaintiff, but you will not know who will file a suit until a couple of years after they have left your care. Try to remember all the names of all the patients you treated two years ago, a nearly impossible task. It makes you realize how important your charting is to your career. Many patients are growing increasingly frustrated by the healthcare system. When patient needs aren't met, many feel that their only recourse is to sue. As a result, nurses are being pulled into the legal arena more often than ever before. Patient-related reports and clinical records are legal documents that can be used as evidence in courts of law and provide another reflection of how well nurses perform professionally. A study, published in the November 2004 edition of Applied Nursing Research, showed that 11.9% of nursing errors were documentation errors.

Charting by exception is being used more frequently, but attorneys still use the adage, "If it wasn't charted it wasn't done", and jurors agree. If you have a patient that is hypertensive and you chart the abnormal blood pressure, take the time and chart the pulse, temperature and respirations. This will give a more thorough picture of what is

happening and help at any potential deposition. You may be able to testify that your patient was hypertensive, but will you be able to testify if they were tachycardia or bradycardic?

When performing tracheotomy or gastrostomy site care, chart the solution used to clean the site and describe the site. Many times nurses only chart "trach care done." But, if that tracheotomy becomes infected in the future you may be asked to testify if the site was infected when you provided care. Unless your observation of the site was documented this may be difficult.

The abbreviations you use should only be what your employer designates as acceptable abbreviations. Many nurses will use the abbreviation B.S. However, this abbreviation could represent breath sounds, bowel sounds, blood sugar, bed side, blind spot or brain stem. M.S. could be medical student, morphine, mitral stenosis, musculoskeletal, and multiple sclerosis. P.T. could be patient, pint, prothrombin time, posterior tibial (pulse), or physical therapy. Every time you use an abbreviation, stop and

think what else that abbreviation could represent. If you can come up with another medical term, write the word out in its entirety.

Family visits should be documented and the patient's reaction to the visit. Many family members will testify that they were with the patient every day and all day. Their next statement usually is they never saw a doctor or another healthcare professional in the patient's room. If it is clearly documented in the chart when the family was at the bedside and when they left, it is easier to find the error in the family member's statement.

Medical malpractice is not the only time a nurse may be called to testify. In cases of abuse, the nurse may be asked about the interactions between the patient and the alleged abuser. A co-worker was glad that she accurately documented what medications a pediatric patient was being discharged on and the family education. A couple of months later, she was called and asked for this information specifically, and her documentation saved a child's life. The parents were trying to get a refill on Phenobarbital, and said the child was discharged on this medication. When the facts came out about no Phenobarbital and the frequent apnea spells the child was suffering, Munchhausen's was suspected and the child removed from the dangerous home.

Kathy Massing, RN, Risk Consultant



Red flags in charts that will cause problems in the future:

- telephone orders not dated and timed
- medication missed, not given...not signed for
 - patient allergies not recorded
 - skin breakdown – no further documentation
 - nursing notes not written in chronological order
 - incident reports



Documentation Gigglers:

- She slipped on the ice and apparently her legs went in separate directions in early December.
- She has no rigors or chills but her husband says she was very hot in bed last night.
- client was alert and unresponsive
- client has left his white blood cells at another hospital
- no c/o voiced or distress note
- On the second day the knee was better and on the third day it had completely disappeared.
- When she fainted her eyes rolled around the room.
- She stated that she had been constipated for most of her life until 1989 when she got a divorce

