Documentation

It is important

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Why..

- The purpose of complete and accurate patient record documentation is to create a means of communication and continuity of care between staff about the health status, treatment, planning and care received. This will help eliminate mistakes made when there are transfers of care.

Purpose of Documentation

- Effective Communication
- Patient care
- Auditing Health Agencies
- Research/Education
- Reimbursement
- Legal Document

Paint a story

- What brought patient to the ED.
- Vital Signs
- What does the patient look like
- Subjective vs Objective
- Be factual

Treatments/Interventions

- Meds
  - Pain meds
  - Nebs
  - Cardiac-Diltiazem, adenosine, Pressors, Nitroglycerine
  - Med given for fever

Procedures

  - Cath
  - Lumbar Puncture
  - Splinting/reduction/fractures
  - Laceration repair
  - Moderate Sedation

Flow Sheets

- Graphic Records
  - Vital Signs
  - Intake and Output
- e-MAR or MAR
- Trauma
- Code Blue
- Assessment: Basic/Critical
- IV spreadsheets

eMAR/MAR

- Medications
  - Name of med, dose, route, time given
  - IV fluids- Continuous
  - 1345 – Normal Saline 100cc/hr IV via L)AC
  - IV fluids – Boluses (start/stop time)
    - 1245: Normal Saline 999cc/hr IV L)AC
    - 1345 : Fluid Bolus complete

eMAR/MAR cont'd

- IV Therapeutic Meds: Need start and stop times
  - Dopamine, Levophed, Heparin, Potassium, Amiodarone, TPA, Antibiotics

- *Ex: 1310- Heparin drip 1000 Units/hr IV via L)AC*
- *Ex: 1330- Dopamine 20mcg/kg/min IV via R)FA*

eMAR/MAR cont'd

- Pediatric fluids:
  - Usually are ordered 20ml/kg IV
- Need to be specific when documenting

- *Ex: Normal Saline 320cc fluid bolus to infuse @ 200cc/hr IV (need amount infusing & rate)*

- **The documented rate does <u>NOT</u> mean it is the same as the volume infusing.**

Research/Education

- QI projects
  - Code Blue
  - Trauma
  - Chest Pain Study/STEMI's
  - Falls risk
  - Sepsis Study
  - Stroke Protocol
  - Intubations

Code Blue

- This can be used as your orders from your provider & documenting for meds.
- So do not need to go back to e-mar, unless it is a therapeutic drug or hydration (NS,LR)
- Responsible parties for signing code blue sheet: primary RN, Provider and scribing RN/LPN

As long as your physician has signed the code blue sheet

Trauma

- Need to be specific for trauma registry
- Date/Time of Event
- Mechanism of injury
- Pre-hospital information
- VS (serial always include temp)
- GCS with VS
- Assessment & Findings
  - Basic vs Critical (hourly)

Chest Pain

- Time of arrival
- Symptoms/Chief complaint
- EKG within 10 minutes of arrival to ED
- Did patient take Aspirin or receive ASA in ED.
- STEMI
  - Do they meet TNK critieria
- Transfer out/Cath lab

Sepsis

- Sepsis screening done on every patient

Sepsis Screening	
Infection Screening	○ No Infection Suspected ○ Known/Suspected Infection
	Known or Suspected infection as evidenced by any of the following: * Fever/Chills * Weakness * Cough/Shortness of Breath * On Antibiotic Therapy * Abdominal Pain * Altered Mental Status * Cellulitis/New Purulent Wound Drainage * Recent Procedure
Sepsis Screening	☐ Screening Criteria WNL ☐ RR > 20 ☐ Temp < 96.8, > 100.9 ☐ MAP < 65 ☐ Pulse > 90 ☐ Lactic Acid >2 ☐ SBP < 90 ☐ WBC < 4,000, > 12,000 ☐ O2 Sat < 90
	If there is a Suspected or Documented infection and 2 or more of the above are present the screening is POSITIVE.

Sepsis cont'd

Screening Results	
Sepsis Risk Level	If Sepsis Screening Result is POSITIVE - notify the Physicians Immediately. *Anticipate the following diagnostics: Lactic Acid, CBC, CMP, BC x2, U/A, Urine Culture, Chest X-ray. *Anticipate the following Medications: Initial IV Fluid Resuscitation, Antibiotic Therapy within 1 hour. *Consider more frequent vital signs based on condition
Physician Notified of Results?	○ Yes ○ No **Comment**
	Document the name of the Physician notified in the comment box. Consider activating eEmergency for additional support
Time Physician Notified	

Stroke

- Symptoms
  - Sudden numbness or weakness of face, arm or leg
  - Sudden confusion,trouble speaking or understanding speech
  - Vision changes
  - Trouble walking,dizziness,loss of balance or coordination
  - Sudden severe headache with no known cause.

- Last known well time
- Blood sugar
- NIH scale
- Door to CT time
- Time CT read by radiologist
- IF giving Alteplase – know your facilities protocol for monitoring patient.

Auditing Heath Agencies

- JACHO
  - Quality
- CMS Guidelines
  - Medicare & Medicaid

Behavioral Homicidal/Suicidal

- JCAHO and CMS are cracking down on the monitoring and assessment for patients with homicidal/suicidal ideation.
- Know your facilities policy on assessing patients
- Every patient should be screened for self harm assessment

Self-harm assessment

Initial Self Harm Screen-12+years	
Have You Felt Down, Depressed or Hopeless	○ Yes ○ No Within the Last 2 Weeks
Have You Felt Little Interest or Pleasure in Doing Things	○ Yes ○ No Within the Last 2 Weeks
Wished You Were Dead or Could go to Sleep & Not Wake Up	○ Yes ○ No Within the Last 4 Weeks
Have You Had Thoughts of Killing Yourself	○ Yes ○ No Within the Last 4 Weeks *** If response is YES, initiate the ED BH Assessment***

Behavioral Health assessment

Behavioral Health Assessment			
Behavior	☐ Cooperative ☐ Uncooperative ☐ Guarded ☐ Agitated ☐ Manipulative ☐ Tics	☐ Good eye contact ☐ Poor eye contact ☐ Slowed ☐ Hyperactive ☐ Depressed ☐ Intoxicated	☐ Apathetic ☐ Withdrawn ☐ Combative ☐ Intrusive ☐ Tearful/ crying
Cognition	☐ Able to follow directions ☐ Alert ☐ Appropriate ☐ Confused ☐ Delusional ☐ Disconnected ☐ Disorganized ☐ Disorientated	☐ Frequent redirection ☐ Hallucinations, auditory ☐ Hallucinations, command ☐ Hallucinations, tactile ☐ Hallucinations, visual ☐ Impaired memory ☐ Lacks insight ☐ Memory, long term	☐ Memory, poor ☐ Memory, short term ☐ Paranoid ☐ Poor concentration ☐ Pt unable to verbalize ☐ Racing thoughts ☐ Requires cues
Additional Behavior Information	☐ Text		

Behavioral Health Assessment cont'd

Additional Behavior Information	☐ Text
Suicide	
Suicide	☐ No thought/plan/intent ☐ Suicidal thoughts ☐ Suicidal plan ☐ Suicidal intent ☐ Current attempt ☐ Previous attempt ☐ Self harm behaviors
Search of patient and personal belongings completed?	○ Yes ○ No **Comment**
Suicide Precautions	○ Yes ○ No **Comment**
Additional Suicide Information	☐ Text
BHS Hold	
BHS HOLD	○ Yes ○ No **Comment** Agency and Badge Number
Safety/Weapons check performed by Agency	○ Yes ○ No **Comment**

Behavioral Health assessment cont'd

History			
Mental health tx	☐ No previous tx	☐ Outpatient	☐ Partial/IOP
	☐ Inpatient	☐ Residential	☐ Support group
Hx Psychosocial/ Behavioral	○ Yes ○ No **Comment**		
	If Yes Continue Assessment		
Hx Previous Suicide Attempt	○ Yes ○ No **Comment**		
Hx Depression	○ Yes ○ No **Comment**		
Hx of Self-Mutilation	○ Yes ○ No **Comment**		
Hx Anxiety	○ Yes ○ No **Comment**		
Hx Schizophrenia	○ Yes ○ No **Comment**		
Hx Bipolar Disorder	○ Yes ○ No **Comment**		

Suicide Precaution Intervention

Behavioral Health Assessment

Safety interventions	1:1
Pts Behavior Check Q15 Min	Cooperative; Apathetic; Poor eye contact; Agitated Manipulative; Intoxicated
Pts Mood Check Q15 Min	Agitated; Irritable; Angry
Pts Affect Check Q15 Min	Irritable
Pts Cognition Check Q15 Min	Frequent redirection; Alert; Lacks insight
Observed Behavior Q15 Min	Angry Affect; Good Eye Contact; Respirations Noted Commun Inappropriate*
Sucidial Q15 Min	Suicidal thoughts; Suicidal plan
Additional Behavior Comments	AVERA SECURITY IN ROOM.

Education

Occurrence #1

Topics	Suicide Precautions
Components	Depression
Recipient	Patient
Readiness to Learn	Ready
Teaching Method	Verbal explanation
Teaching Response	Education verbalized
Additional Education Information	

ED IV Discontinue

Restraints

- Restraint and seclusion is a hot spot with both CMS and the Joint Commission and a common area where hospitals are cited for being out of compliance.
- CMS says that restraint training must be on-going so you can't just provide training at orientation and forget about it.
- Any **physician or provider who orders restraint must be trained in the hospital's policy**
- Patient safety is at risk and patients have been injured or have died from improper restraint usage.

Restraints cont'd

- Non-violent or non self destructive behavior restraint
  - Is any physical restraint used to prevent inadvertent disruption of treatment: ETT, Pulling at lines, wound vacs,
  - Primary reason is to directly support medical care.
  - Order needed . A provider must see and evaluate the pt.
  - Assess every 2 hours
- Violent or self destructive behavior restraints
  - Is used for management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, self or others
  - Order needed. A provider must see and evaluate the patient
  - Assessment every 15 minutes
- Seclusion
  - Involuntary confinement of a patient alone in a room or any area where the patient is prevented from leaving
  - This is only used at the BHS hospital
- Forensic or correction restrictions
  - The use of handcuffs or other restrictive devices applied by law enforcement
  - Assess every 2 hours
  - No order needed

Restraints cont'd

- A provider must see and assess the patient at a minimum of every 24 hours before issuing a new order
- PRN or standing orders are not acceptable.

Legal Document

- Remember that the medical record is **permanent**.
- Chart/Report any abnormal findings
- Remember to do serial Exams/VS

If you did not document it, it did NOT happen!

Reimbursement

- Diagnoses
- Medications Used
- Diagnostic Testing
- Severity of Patient/Level of Care
- Procedures/Interventions

9 types of documentation errors

1. Sloppy or illegible handwriting
2. Failure to date, time and sign a medical entry
3. Lack of documentation for omitted medications and or treatments
4. Incomplete of missing documentation
5. Adding entries later on
6. Documenting subjective data
7. Not questioning incomprehensible orders
8. Using the wrong abbreviations
9. Entering information into the wrong chart.

Phrases you should not chart

- Dr. Smith and Dr. Foster at bedside to relocate the shoulder
  - *Dr. Smith and Dr. Foster at bedside to reduce shoulder*
- CT dye consumed by patient
  - *Oral contrast given to pt. per protocol*
- Nurse on unit notified I am ready for report, she will call when she is ready for report
  - *Attempted to call report, unsuccessful*
- Chief Complaint: Moto accident
  - *C/C Motor vehicle accident*
- Shoulder reduced just that easy.
- Influenza and Rapid Strep collected and sent to lab.
  - *Nasal and throat swab collected and sent to lab.*

Subjective phrase

- Complex family dynamic with male female family in room. He irritates her, she irritates him, they irritate the patient and they all irritate the nurse
- Chart objectively
- Put in quotes what patient states

Abbreviations

Unapproved

- Bc -because
- Ibu - ibuprofen
- Sba – stand by assist
- Succs – succinylcholine
- Prop - propofol

Use only approved abbreviations for your facility.

- PRN
- Amb.
- ASA
- AMA
- T.i.D

Questions?????