Documentation Do's and Don'ts in the Senior Care Setting

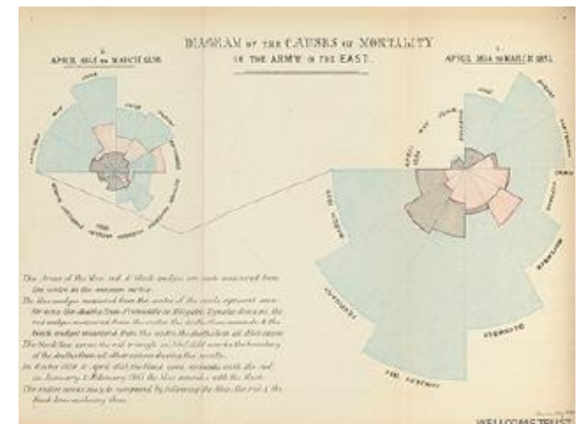
Zita Hans, RN

Avera eCARE®

Feb 4th 2020

History

- Florence Nightingale
- War times
- Nursing Process
- Paper charting to Electronic Medical Records



Purpose and Objectives

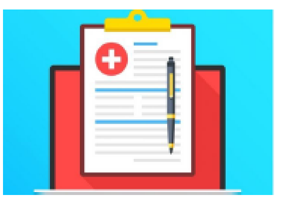
1. Identify three (3) purposes of documentation in the patient record.
2. Explain, in an organized form, how to document patient issues in a narrative type note.
3. Explain how to correct errors in documentation.
4. Describe the audit trail that occurs in the EMR.
5. Compare and contract paper charting with electronic charting.

Purposes of Documentation

1. Conveys patient information to other providers.
2. Used for legal and billing purposes.
3. Contributes to research and quality improvement projects
4. May be evaluated by review boards

Training

- Begins in nursing school
- Technical training in documentation up to facility
  - Comply with organizational related policies
- Proficient use of EMR
  - Finding and retrieving data
  - Documentation in template form and narrative form
  - Training should be ongoing
- Nurses should always be involved in the development and evaluation of charting systems
- Training should always include HIPPA guidelines



Training

When I eat too much dessert, I don't post about it on Facebook.

Because if it isn't charted, it didn't happen.

Life Coaching for Nurses

Documentation 101

- Ensure you have correct patient, DOB/medical record number, date, time, correct title
- Know facility policy regarding use of initials
- Write legibly, use correct spelling
- Document all you do
- Document significant events - status change, falls, injuries, abuse AMA
- Document admissions & discharges
- Pertinent facts – loss of important items, vital signs, physical assessment
- Document education & understanding of education

Documentation 101 Example

Document any change in patient condition

“11/11/19 12:15
Resident vomited 3 times, dark brown/green color, no food particles noted. Bowel sounds present in all 4 quadrants. Remains nauseous after episodes of vomiting. Zofran 4mg given at 13:00 which was effective in providing relief.” – NNRN

Followed up with charting on **11/12/19 13:00**
“No episodes of vomiting today but still complains of nausea. Declines medication for nausea. Taking sips of liquids, doesn’t want anything “heavy” to eat.” – NNRN

11/14/19 14:00
“Resident complaints of nausea and vomiting have resolved. Patient eating full diet without symptoms.” - STRN

Facts vs Judgements

Document Facts not Judgements

Judgement

- Disruptive and agitated behavior
- Client appears to be in pain
- Client is non-compliant
- Wound is infected
- Client is a fall risk
- Client appears to be hemorrhaging

Fact

- Client is yelling and pacing in hallway
- Client grimaces when moved from back to side
- Client said he does not want to take his medication as it makes him feel nauseous
- Skin around wound is red, warm to touch with purulent discharge, client complains of increased pain over the past two days
- Client stumbles when walking and shuffles feet
- Client has saturated 2 peri pads in 1 hour

Documentation 101 Example

- *Document in your own words – avoid copy/paste or drag chart*
- *Document all communications with pertinent people*
- *Know the policy for late entries*

“5/7/5555 08:00 – **Late entry.** On 5/5/5555 at 10:30 resident was assisted by this writer to the bathroom. After sitting on toilet she became light headed and said the room was spinning. Had resident put head between knees and take, slow deep breaths and applied cool washcloth to back of the neck. Symptoms subsided and she was returned back to bed. Orthostatic vitals were taken:
Lying 142/78, sitting 118/70 and standing 108/70. Notified team leader, Julie Nurse RN, she will notify doctor. Your Signature, RN.”

Addendum
“5/6/5555, 08:00, addendum – on 5/5/5555, 10:00 lungs sounds had rales bilaterally in bases.”

Know the policy for **Clarifications**
“5/6/5555 08:00 Clarificatoin on 5/5/5555 10:30, open wound on shin was on lower left extremity. N Nurse, RN”

Avoid the Following in Documentation

- Abbreviations
- Do not chart for someone else
  - "At 16:00, 8/31/2019, Suzy Nurse RN calls stating she gave Tylenol 650mg on */31/2019 at 11:00 to Mr. D for left ankle pain 8/10. At 12:00pm, Mr. D rated his pain at 2/10. Nurse Nancy, RN"

- Don't Use Judgement Comments
- "9/5/1919 18:30 is angry because her room tray was removed too early. She threw her newspaper on the floor."

…Vs…

- "9/5/2019 18:30. Resident put her call light on. Upon entering the room noticed she was shaking and face was red. She spoke loudly to me "someone took my tray before I could them they could. Resident threw her newspaper to the floor after that comment. ST, RN"

- Don't release copies of records

Avoid the Following in Documentation

- Don’t forget about the real patient
- When a patient feels unimportant they often become disgruntled

Avoid the Following in Documentation

- Don’t use words such as incident, error, accident
- Use issue, occasion, notification

➢ “10/10/2019 16:00 Notified Dr. Soso of medication issue – resident received Hydrocodone 10/325 on 5/5/5555 at 14:00. Resident is breathing easy and even, has no complaints at this time. S. Nurse, RN”

Copyright ©2013 R.J. Romero

EMR System prompt: "You caused an error that we never thought of. Click any key and see what happens."

EMR Nuances

- Use both drop down and narrative charting
- Protect passwords
- Logout when not using computer
- Protect screen so unauthorized personnel cannot view
- Audit trail
- Plan for downtime

Charting Tips

- Developing your personal system of charting
- Write notes

Cheat Sheet

RM	name	vitals	lungs	bowels	dressings/wounds
301					
302					
303					
304					
305					
306					
307					
308					
309					
310					

Name	Name	Name	Name
Meds	Meds	Meds	Meds
T P R BP Sat	T P R BP Sat	T P R BP Sat	T P R BP Sat
CBC	CBC CMP	K+	UA

Charting Tips

- Chart as you go
- Chart everything you can
    - Every notification of a provider
    - Direct quotes
    - Times
- Review expert nurse charting

References

Cohen, Bernard. March 1984. Florence Nightingale, Scientific American 250(3): 128-137.

Peterson, Elizabeth. (2004). Long Term Care Pocket Guide to Nursing Documentation. Marblehed, MA: HCPro, Inc.

Griffin, Ashley L.,(9/15/2015). Legal Implications of Electronic Medical Records (EMR) Documentation for Nurses: “Charting “a Better Course, http://www.trclaw.com/article/legal-implications-of-electronic-medical-records-emrdocumentation-for-nurses-charting-a-better-course/ Accessed 8/30/2019.

Karp, Eva; Freeman, Rebecca; Simpson, Kit; Simpson, Annie N.; May 2019.CIN: Computers, Informatics, Nursing: Changes in Efficiency and Quality of Nursing Electronic Health Record Documentation After Implementation of an Admission Patient History Essential Data Set, 37(5), p 260-265.

Kelly, Will. MSN, Top 6 Charting Tips for Newbie Nurses. https:// healthandwillness.org/top-6-charting-tips-for-newbie-nurses/, accessed 11/29/2019.

Kroll, Maureen. Medical Charting Rules What were you thinking? Charting rules to Keep you Legally Safe. https://www.maureenkroll.com/articles/medical-charting-rules-tokeep-you-legally-safe.aspx, accessed 8/30/2019.

ANA’s Principles for Nursing Documentation: Guidance for Registered Nurses. 2010, Nurses books.org http://www.nursingworld.org/-4af4f2/globalassets/docs/ana/ethics/principles -of-nursing-documentation.pdf accessed 11/3/2019.

Technology Informatics Guiding Educational Reform (TIGER). 2009 TIGER Informatics Competencies Collaborative TICC final report. https://tigercompetencies.pbworks.com/f/ TICC_Final.pdf accessed 11/3/2019.

Post Test

1. Reasons for thorough documentation include:
   A. Billing and research purposes
   B. To show your Director of Nursing that you are a good nurse
   C. Practice Typing Skills

2. When is it helpful to use a narrative note?
   A. To better explain further an event that needs better clarification
   B. To provide duplicate documentation
   C. To explain in great detail normal assessment findings

3. Narrative notes should always contain:
   A. Grammatically correct sentence structure
   B. Name of facility and facility administrator, name/date/birth of patient and nurse name
   C. Name and date of birth of patient, name of nurse and nurse credentials

4. When documenting a late entry:
   A. Do NOT write late entry in the note
   B. Identify that it is a late entry and include the date & time of the actual finding, and the date & time the finding is being documented
   C. Get the permission of the nurse supervisor before doing so

Post Test

5. When documenting a medication error:

A. Just document what medication was given, what time it was given and evaluation of response to medication given

B. Do not document medication errors

C. Identify clearly that entry is regarding a medication error

6. When using electronic charting, nurses should be taught:

A. To only do the template charting

B. Narrative and template charting, how to fix wrong entries, how to retrieve diagnostic results and other notes from providers of care

C. How to create software for nursing documentation

7. To avoid charting judgment, nurses should:

A. Chart only using the template

B. Write only narrative notes

C. Chart factual observations

Post Test

8. To chart effectively, nurses should:

A. Chart at the end of the shift

B. Chart only with narrative notes

C. Chart as they go, documenting significant findings first then normal findings

9. Electronic charting makes it easier to:

A. Provide an audit trail to see who's been in the patient's chart and what they did

B. Get your charting done on time

10. To promote good patient relations:

A. Make sure you get all your charting done first, then attend to patient need

B. Allow the patient to enter their own medical history into the computer

C. Take breaks during documentation, make eye contact with the patient and significant others

THANK YOU

Follow us LinkedIn

Discover the possibilities at AveraeCARE.org