

The Best Defense is Good Documentation



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The Do's

- Check that you have the correct patient's chart before you begin documenting. Make sure each page has a label.
- Use permanent black ink pen **ONLY**-other colors do not Xerox well.
- Write legibly-if penmanship is poor-**PRINT**. (You should be able to read your entire name, title and any credentials after it each and every time you write or print your name)
- Chart completely, concisely and accurately (Tell it like it is)
 - ✓ Write clear sentences that get right to the point.
 - ✓ Use simple, precise words.

Chart only what you see, hear, feel, measure and count...NOT what you suppose, infer, conclude or think.

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The Do's (Continued)

- Chart precautions or preventive measures used, such as SCD's, warming and or cooling blankets, ace wraps, padded side rails. **(If a checklist is part of chart, you MUST check off each item utilized or it WAS NOT done)**
- Medication charting-**document what given, time, route and response to pain medication. This must be done after each and every dose of any medication given.**
- Chart as soon as possible after giving care...**DO NOT wait until end of the day, or after the patient is discharged.**
- Include the date and time you charted the entry. Date should include year. **DO NOT CHART IN BLOCKS OF TIME-IE. 0700-1500.**
- **✓ Check off forms are great as they save documentation time, but if you do no check off items as required, it means that legally the care was not done.**
- Document client's history (including unhealthy conditions, or risky health habits such as smoking, failure to take prescribed medication)

You must chart (what you hear/subjective) and (what you see/objective)

See attachment.

- Document patient's pain, observe and document objectively (what you see) and subjectively (what you hear). Use appropriate pain scale to document severity and location of pain.

IE: 1/29/2010 0900 Patient complains of # 10/10 severity pain of right ankle incision. 0905: Patient appears comfortable, VSS BP 110/65, HR 60, RR 16, is able to move right ankle and toes, right toe nail beds pink, denies any sensation of right toes or ankle. Patient received regional block/general anesthesia during procedure. 09:20 Went over pain scale with patient and again questioned patient about his incisional pain. 09:23 Patient now states pain is # 3/10 severity. Nancy Nurse, RN.

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- Document the patient's, family members or significant others response (verbal or non-verbal) to any aspect of care provided. **(Verbal responses should be recorded using quotation marks)**
- Document a patient's refusal to allow a treatment or take a medication and document the reason why the patient refused.
- If you forgot to document something after you completed your documentation, chart the information as "late entry."
- Flow sheets: If there is information on the form that does not apply to your patient, then write NA (not applicable) in the space provided.
- Chart often to tell the whole story.
- Use only approved abbreviations and symbols.

The Don'ts

- Do not 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" if used would indicate a mistake in care, not documentation was made. Write in the the correct entry as close to the mistaken entry as possible and sign with your first initial, last name and title.
- Do not use blue or red ink. It does not Xerox well.
- No empty lines or spaces. Fill in empty line or space with a single line to prevent charting by someone else.
- No writing in the margins.
- Do not mention any incident or accident report in the medical record. You can document the facts of an incident, but NEVER write "incident report filed."

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The Don'ts (Continued)

- Do not use words associated with errors or ones that suggest that the patient's safety was in danger.
"by mistake, accidentally, unintentionally, miscalculated, confusing"
- Do not name a second patient..doing so violates the patient's confidentiality. If you must refer to a second patient, use the word "roommate".
- **Charting care that you haven't done is considered fraud..likewise charting events or care before it is done is also fraud.**
- Don't record staffing problems.
- Don't record staff conflicts.
- Don't chart a symptom such as "c/o pain," without also charting what actions you took.
- **Don't alter a client's record . . . THIS IS A CRIMINAL OFFENSE.**

4 DON'TS OR RED FLAGS OF CHART ALTERING

- **Do not add information at a later date without indicating that you did so.**
- **Do not date the entry so that it appears to have been written at an earlier time.**
- **Don't add inaccurate information.**
- **Don't destroy records.**
- Do not use shorthand or abbreviations that are not widely accepted. If you can not remember the acceptable abbreviation, then write out the term.
- Do not give excuses such as "medicine not given because not available."
- Do not chart your opinions.
- Do not use language that suggests a negative attitude towards your patient such as stubborn, drunk, weird, loony, nasty.

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The Don'ts (Continued)

- **Do not chart ahead of time, something may happen and you may not be able to give the care you have already charted...charting care that you have not given is considered fraud.**
- **Notes filled with misspelled words and incorrect grammar are as bad as those that are illegible.**

References

1. **Charting Made Incredibly Easy. 2nd Edition. Lippincott Williams & Wilkins: Philadelphia, Pennsylvania, 2002.**
2. **Feutz-Harter, Sheryl. "Nursing Case Law Update: Faulty Documentation." Journal of Nursing Law, Vol.2 Issue 4**

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IS YOUR DOCUMENTATION SATISFACTORY?

Periodically, review and evaluate your documentation.

- Chronological
 - Comprehensive
 - Complete
 - Concise
 - Descriptive
 - Factual
 - Legally aware
 - Legible
 - Relevant
 - Standard abbreviations, symbols, and terms
 - Thorough
 - Timely
- How you chart is as important as what you chart.
- Chart only what you see, feel, measure and count...NOT what you suppose, infer, conclude or think.
- "If it's not documented in the medical record, it was not done!"
- Complete and accurate documentation is required to justify reimbursement from private insurance carriers, Medicare and Medicaid.

IE: PMH: HTN and nicotine abuse

Subjective:

1/29/2010 07:15

**Pt stated that "he did not take his blood pressure medications the last 2 months".
Nancy Smith, RN.**

When quoting patient, put what they say in "".

Objective:

1/29/2010 07:30 VS BP RT arm 196/96, BP LT 210/120. 07:40 Notified surgeon and anesthesiologist of patient's blood pressure. 07:50 Both Drs. Jones and Smith at bedside. BP RT arm 200/96. Discussed cancelling patients elective surgery with Dr. Jones and Dr. Smith. 08:10 No order's received. 08:20 Patient taken to OR on cart, hand off communication to J. Jones, RN regarding BP 200/96, no orders received. Nancy Smith, RN

Document any actions that you did in response to any of your observations and response to your actions.

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The Best Defense is Good Documentation – Post test

Name: _____

Date: _____

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 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 a box on a flow sheet next to the words, home instructions explained, understood, signed and received, then legally

- A. The patient did not receive home discharge instructions.**
- B. The patient received them, but did not sign for them.**
- C. The patient received them, signed for them, but they did not understand them.**

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Post-test - Page 2.

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

- A. Forget about it since you 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 the next day using "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.**

7. Falsifying information in the medical record is not a criminal offense.

True

False

8. When a patient refuses care, you do not have to document anything because you did not give any care.

True

False

9. 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.

True

False

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

True

False