Nursing Documentation

LTC Resources LLC

Documentation

- Proof that care was given
- GAPS or lack of follow-up leads to questions of creditability and or accuracy
- Must be **legible**
- LTC Documentation is unique
  - Documentation by Exception
  - Specific State of Iowa (Chapter 58) requirements
  - PRN’s must state dose, why given and response

Why Document?
More documentation is not necessarily better!

Purpose of Documentation

- What is the purpose of this entry?
- Have I communicated clearly to other team members?
- Does this note satisfy its intended purpose?
- Not just resident status and clinical findings

Your Responsibility

- To prove that you have met the professional responsibilities as a nurse or long term care staff member
- To document what you did and did not do for a resident
Before you start!

- Gather information and be prepared to chart.
- Never chart just because you think you need to write something.
- Read the previous entry before charting.
- Remember this is a legal document.

Documentation should include

- All components of the nursing process
- The resident’s own words
- What your senses tell you
- Professional judgment
- Verbal and clinical responses
- Limit use of abbreviations and know your facility approved list

Requirements

- Adherence to Nurse Practice Acts
  - Iowa Administrative Code 655, Chapter 6
- Accountability
  - Proper nursing documentation provides evidence that the nurse has acted as required or ordered. Must demonstrate accountability by complying with the documentation requirements established by the health care facility, professional organizations, and state law.
Accountability

- Iowa Board of Nursing
  - Governing agency
  - Rules require RN or LPN to clearly identify to direct patient care their licensure
- Professional Nurses are accountable to:
  - “Obligated to answer for one’s acts, including the act of supervision”
  - Public
  - Other professionals

Minimum Standards—RN

Iowa Administrative Code 655
Chapter 6 6.1(152)

- Minimum standards
- Utilize the nursing process
  - Nursing assessment about health status
  - Formulation of nursing diagnosis
  - Planning of care
  - Interventions implemented to implement plan of care
  - Evaluation

- Respect rights
- Respect confidentiality
- Legal implications of accountability
  - Perform or supervise functions as RN
  - Assign staff
  - Using professional judgment
- Supervising
  - Supervising, overall responsibility, delegation, and determination that care provided is adequate and delivered appropriately.
- Executing regimen prescribed by physician
- Wearing identification which identifies you as RN—NAME TAG
Accountability includes but need not be limited to the following:

- Performing and supervising persons performing those activities and functions which require the knowledge and skill level currently ascribed to the nurse and seeking assistance when activities and functions are beyond the licensee’s scope of preparation.

What should be charted?

- Don’t need to write down everything
- Skillfully choose words and phrases to describe an event
- Strive for the best description possible
- **NO recognized standard for documentation**

Things to DO

- Chart in chronological order
  - Tell what the resident’s needs were, the care and services provided and the outcome
- Write so others can read your entry
  - Useless if others cannot read what you wrote
- Time and date all entries
  - Key is time frame between observations and assessment of a problem and the interventions
› Use only truthful, accurate information
  ◦ Factual data from observation, assessment, medical history, physician’s progress notes, and other sources
  ◦ Only subjective info—What the resident says

› Use only standard abbreviations
  ◦ Facility must have a printed, approved copy

› Document, immediately after the observation, assessment, treatment or event
  ◦ Limit late entries, use only when necessary

FORMAT

Not one perfect FORMAT!

› Select what is best for your facility
› Become comfortable with the style
› Limit subjective information to what the resident says

Things Not to DO

› Avoid assumptions or your personal opinions
  ◦ Very self centered and very prejudice
› Do not chart for others
  ◦ Your signature certified that you actually assessed, observed, and delivered
› Do not use chart to assign blame or settle disputes
Not a place for staff issues
- Follow chain of command to address staffing issues or incompetence of staff
- Do not refer to risk management efforts
  - “Incident report completed”
- Do not try to cover up anything
- Do not leave blanks to fill in later
- Do not leave space for someone else

Do not back date
- Do not add to previously written notes
- Do not write over dates
- Do not wait until the end of the shift when everything has to be done from memory

Difficult situations?
Ask for assistance:
- Get input from others that were present at the time
- Consult with your Director of Nursing
- Follow specific policies of your facility
Critical Thinking

- Be sure that your critical thinking gets from the bedside to the chart
- "Resident complains of pain in R shoulder, No visible signs of injury. Will monitor pain intensity after medication. Motrin 800 mg given per order for shoulder pain. T, P R, BP.
  - Doesn’t address:
    - How much pain
    - Any limitations to ROM

Characteristics of Critical Thinking

- Purposeful, outcome directed thinking
- Driven by resident needs
- Based on principles of nursing process
- Requires specific knowledge, skills, and experience
- Guided by professional standards
- Is constantly reevaluating, self-correcting, and striving to improve

Falls

- Most frequent adverse event in long term care
- Nursing home placement doesn’t guarantee that people will not fall
- Documentation is key here
Falls Documentation

- Less is often best
- Tell the whole story
- Be concise
- Limited to the event
- State facts objectively
- DO NOT try to rationalize or explain why the event occurred
- Avoid an opinion on the outcome

Examples

Poor documentation
- Resident fell out of bed, probably trying to turn on the TV by herself. Vitals ok, ROM done, no injury

Improved documentation
- Resident observed on floor by bed, upright sitting position. Stated did not know what happened. Stated she was not in any pain. ROM in all extremities w/o complaint of discomfort. T 98.8, BP 128-62, R 86, R 22. No visible signs of injury. Pupils equal, reactive to light. Nightlight on in room, call light attached to bed. Daughter Sally notified, and physician notified of assessment data and no visible signs of injury. Dr. Jones states “No orders at this time.”

Key Points on Falls

- Document the facts only
- Do not give your opinion as to how the event could have occurred
- Document your assessment in detail
- Include all interactions and resulting actions taken to care for the resident
- Document full conversions with the physicians on your assessment, your interactions, and any orders
- Document contacts with family and significant conversations
Skin Concerns

- Be clear on charting what type
  - Not all areas are pressure
- Visible assessment must be done on admission, return from hospital, and any time resident gone from facility more than several hours
- Include condition that predispose a resident to skin problems

Skin Flow Sheets

- Often helpful to follow progress of wound
- Be sure to follow facility policy
  - If your policy is weekly, must be done weekly
  - Standard of Practice—at least weekly
  - Medicare documentation—suggest each dressing change or at least daily if more frequent dressing changes
- Have ALL disciplines use that diagnosis in documentation

Skin Assessment

Isn’t limited to pressure or stasis ulcers
Include:
- Skin tears
- Bruises
- Surgical sites
- Lacerations
- Any area that is red
**Elopement**
Elopement and wandered are not interchangeable
- Have a definition of each
- Document using this definition consistently
- Elopement isn’t each time the door alarm sounds from the Wanderguard

**Change of Condition**
- Differs for day to day documentation and the MDS
  - MDS has specific criteria of what is a significant change of condition
- Document monitoring of change of condition without using the words “will monitor”
- Document baseline and the change
- Document physician notification of abnormal assessment findings

**Change of Condition**
Assessment should include:
- Vital signs
- Lung sounds
- Neuro check
- Cognitive Status
- Functional Status
- Pain/Discomfort
- Chart Review
Chart Review

Review medical record for the following:

- Abnormal lab values
- Medication changes
- Changes in daily routine
- Observations
- Recent change in weight

Family Notification

- Don’t just chart phone calls
- Include family visit and your exchange of information
- Document date, time, and whom notified
- Indicate what information you relayed and the response from the person notified
- Actual time family and physician called is key in relation to the event

Nurses

When charting:

- Is the information for other caregivers for continuity of care? If so, do they understand what you wrote.
- Does it call for you to take action?
- Does it require others to take action?
- Is it a special focus entry?
Words to Avoid

- Will monitor
- Will observe
- MD aware
- Will follow-up
- 7–3 will call MD
- Appears
- Reassured
- Routine, same, common
- Likely

Avoid value judgments in medical memos
  - You might not have all the information
  - Does my note imply negligence?
  - Does the note blame others?

No personal opinion of resident behavior
  - Prejudicial labeling
    - Acting nutty, mean and hateful

Opposing versions of an event
  - Often occurs when the previous entry isn’t read first

Elements of Sound Documentation

- Clarity
- Conciseness
- Consistency
LTC Documentation Guidelines

- When writing nursing summaries, be sure to address all specific resident problems noted in the plan of care.
- When writing progress notes, confirm that the resident’s progress is being evaluated and reevaluated continually in relation to the goals or outcomes defined in the plan of care. If goals aren’t met, also address. Any additional actions should be described and documented.
- Record transfer and discharges according to facility protocol.
- Be sure to report and document any change in resident’s condition to physician and family.
- Document any follow-up interventions or other measures in response to a reported change in condition.
- Keep a record in your notes of all visits and phone calls about the resident from family or friends.
- If an incident involving the resident occurs, such as fall or a treatment error, be sure to maintain follow-up documentation for at least 48 hours after the event.
- Ensure the records for newly admitted residents are maintained in a thorough and detailed manner. Frequency determined by facility. Most at least q shift 24–48 hours.
- Document in detail to support reimbursement–Medicare and Medicaid.
Be certain that your records accurately reflect any skilled service that the resident receives.
Always record a physician's verbal and telephone orders, and make sure that the physician countersigns these orders.
Record all physician visits as resident's required to be seen by physician every 60 days. Is q 30 days for first 90 days, and 60 days thereafter.

Medication Documentation

- Follow facility procedure
- Don't go through MAR's at end of shift to complete
  - Go through to look for GAPs
- Can't fill in GAPS without cassettes or bubble packs to validate
- Narcotic counts must be done with 2 staff members

Drug Administration

58.21(15) Drug administration

- b. An individual record shall be maintained for each Schedule II drug prescribed for each resident
- c. The health service supervisor shall be responsible for the supervision and direction of all personnel administering medication
Key Point!

- Some medications require special observation before administration
  - Be specific if Apical/radial pulse
- Self administration
  - Be demonstrate ability and care plan review
- Med errors
  - Must know how and when to report errors

References


Reference (Con't)


Questions

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