Documentation

Jaynie Maya MSN, RN

Texas Administrative Code
Title 22 Texas Board of Nursing

- Standards Applicable to All Nurses.
  - Accurately and completely report and document:
    - Client's status including signs and symptoms
    - Nursing care rendered
    - Administration of medications and treatments
    - Client's response(s): and
    - Contacts with other health care team members concerning significant events regarding client's status

ANA Standards for Documentation

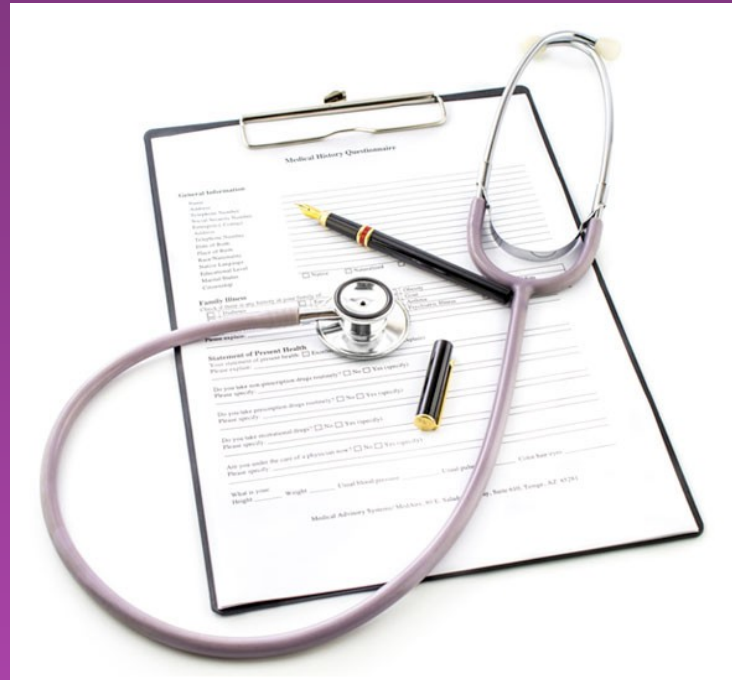
- **Relevant data** accurately and in a manner accessible to the interprofessional team.
- **Diagnoses, problems**, and **issues** in a manner that facilitates the determination of the expected outcomes and plan.
- **Expected outcomes as measurable goals.**
- The plan using **standardized language or recognized terminology**
- **Implementation** and any **modifications**, including changes or omissions, of the identified plan
- The **coordination** of care.
- The results of the **evaluation.**
- Nursing practice in a manner that supports **quality and performance improvement initiatives**.

Records Contain

- Patient identification and demographic data
- Informed consent for treatment and procedures
- Admission data
- Nursing diagnoses or problems
- Care plans
- Record of nursing care treatment and evaluation
- Medical history
- Medical diagnosis
- Therapeutic orders
- Progress notes
- Physical assessment findings
- Diagnostic study results
- Patient education
- Summary of operations
- Discharge plan and summary

Purpose of Records

- Includes
  - Communication
  - Legal document
  - Reimbursement compliance
  - Education
  - Research
  - Auditing and monitoring



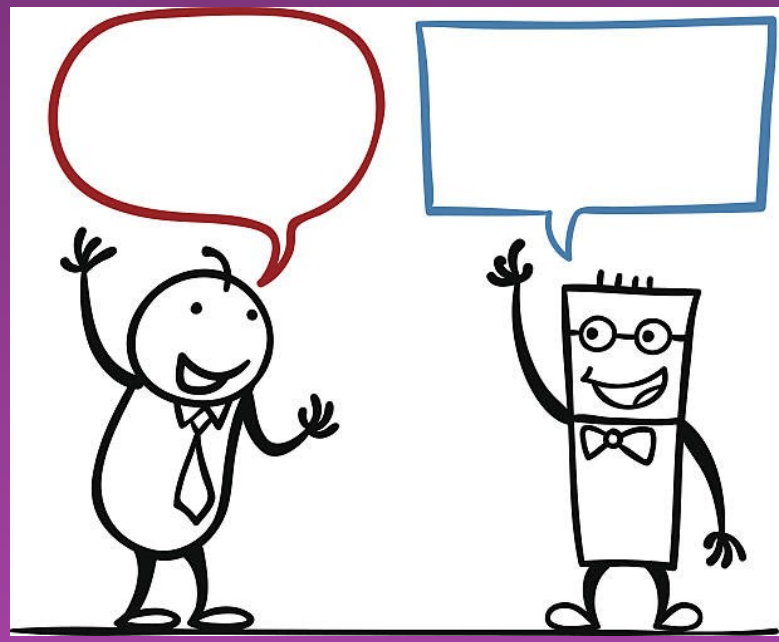
Purpose of Documentation

- Document the *care* given to the patient
- *Communication* to all members of the health care team
- Documents and supports *continuity of care* form one professional to another
- Supports *compliance* with standards of care
- Legal document

***The chart is a very persuasive witness because it is the description of the facts at the time**

Communication

- Multi-Disciplinary
- Critical for Continuity and Risk Reduction
  - current status/ needs
  - progress
  - therapies
  - consultations
  - education
  - discharge planning

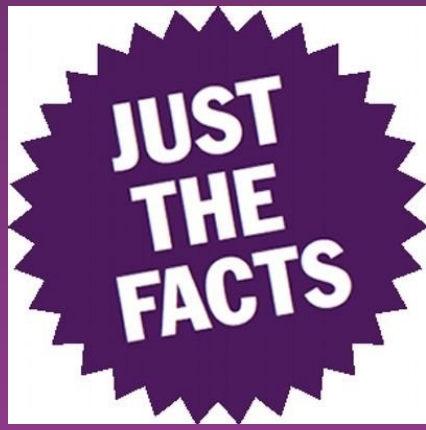


Documentation

- Factual
- Accurate
- Complete
- Current
- Organized

Documentation

- Factual
  - Objective
  - Descriptive
  - Subjective (quotes)



NO ASSUMPTIONS OR OPINIONS

No Assumptions!

- Example:
  - Don’t record a patient fell out of bed unless you actually see him/her fall.
  - If you find the patient on the floor. Record that
  - If the patient tells you that he fell on the floor. Record that.
  - If you heard a thud and went to the room found the patient on the floor, record that.

Documentation

- Accurate
  - Exact measurements
  - Clear
  - Understandable
  - Standard Abbreviations only
  - *Timed, dated with signature and title*
  - Correct spelling

Documentation

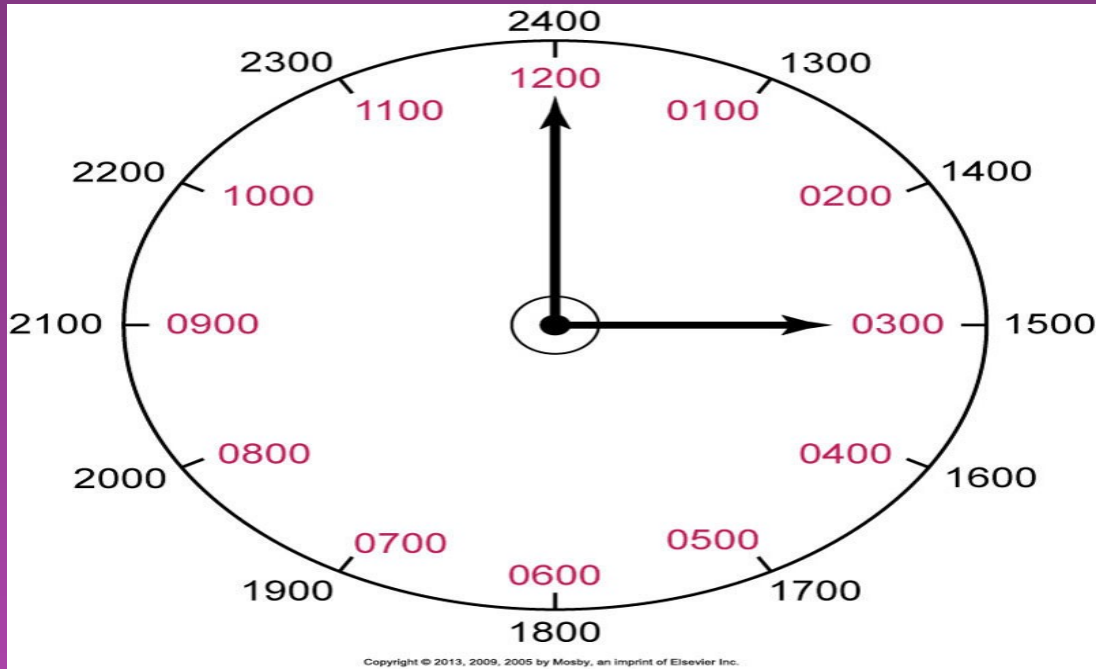
- Complete
  - Condition change
    - Onset, duration, location, description, precipitating factors, behaviors ….
  - Do not leave blanks. Use N/A
  - Communication with patient and family

Documentation

- Current
  - As soon as possible
  - **Time of occurrence**
  - Military clock
  - Never pre-time,

  Pre-date, pre-chart.

  (this is illegal falsification of the record)



Documentation

- Organized
  - **Chronological order**
  - Concise
  - Clear
  - To the Point
  - Complete sentences not needed

Avoid These Terms

- Accidentally
- Apparently
- Appears
- Assume
- Confusing
- Could be
- May be
- Miscalculated
- Mistake
- Somehow
- Unintentionally

Documentation “Don’ts”

- Don’t document a symptom without charting what you did about it.
- Don’t alter a patient’s record – this is a crime.
- Don’t write imprecise descriptions, such as bed soaked or large amount.
- Don’t chart what someone else heard, felt or smelled unless information is critical. Use quotations and attribute remarks appropriately.
- Don’t chart care ahead of time. It’s fraud.

Common Formats

- **Narrative –**
  - written in order of patient experience happens.
  - Provides details of patient's care, status, activities, nursing interventions, psychosocial context and response to treatment.
- **Problem-Intervention-Evaluation (PIE)**
  - Nursing focused instead of medical focused and eliminates need for separate care plan
- **SOAP/SOAPIE/SOAPIER**
  - Subjective data, objective data, assessment, plan, intervention, evaluation, revision.
- **DAR**
  - Data, action, response

Forms

- Nursing admission data forms
- Discharge summary
- **Flow sheets and graphic sheets**
  - Check list - assessment
  - Vital signs
  - Intake and Output
- Medication Administration Records
  - Scheduled meds, unscheduled meds, drug allergies, single order medications
- **Kardex**
  - Not a permanent record. A summary of patient needs and care.

Documentation

- Paper Charts
  - Print or Script
  - BLUE or BLACK Ink
  - NEVER Use White-Out
  - NEVER Use Erasable Ink
  - NEVER Obliterate
  - NEVER erase – NO Pencils

Kardex

- A summary worksheet reference of basic information that traditionally is not part of the record. Usually contains:
  - Patient’s data (name, age, marital status, religious preference, physician, family contact).
  - Medical diagnoses: listed by priority.
  - Allergies.
  - Medical orders (diet, IV therapy, etc.).
  - Activities permitted.

SICU REPORT

SITUATION:
DIAGNOSIS
Ht Wt
BACKGROUND:
HISTORY:

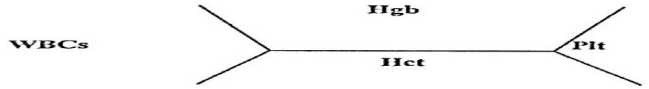
ALLERGIES:

ASSESSMENT:

IVs SC IJ R / L DATE:
PICC: date:
peripheral: date:
A-Line: date:
PA @ cm date:
AV graft/fistula
last dialysis #
IVF & GTTS

DTV PROTOCOL SCD/Plexi/TEDS

FOLEY SIZE: INSERT DATE:
PT/INR

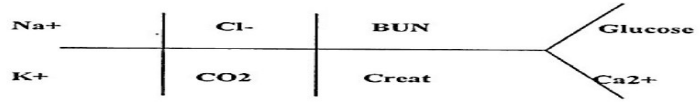


HEART RHYTHM: TMP/PPM
Influenza Vacc Date Pneum Vacc Date
ACCUCHECKS Q
COVERAGE SSI
DIET:
TF @ CC/HR
GOAL VIA

CONTACT INFORMATION:
1
2
3

CODE STATUS: FULL DNR MEDS ONLY
ADMITTING PHYSICIAN:
CONSULTANTS:

ADMIT DATE: ADMIT TO SICU:
PROCEDURES:

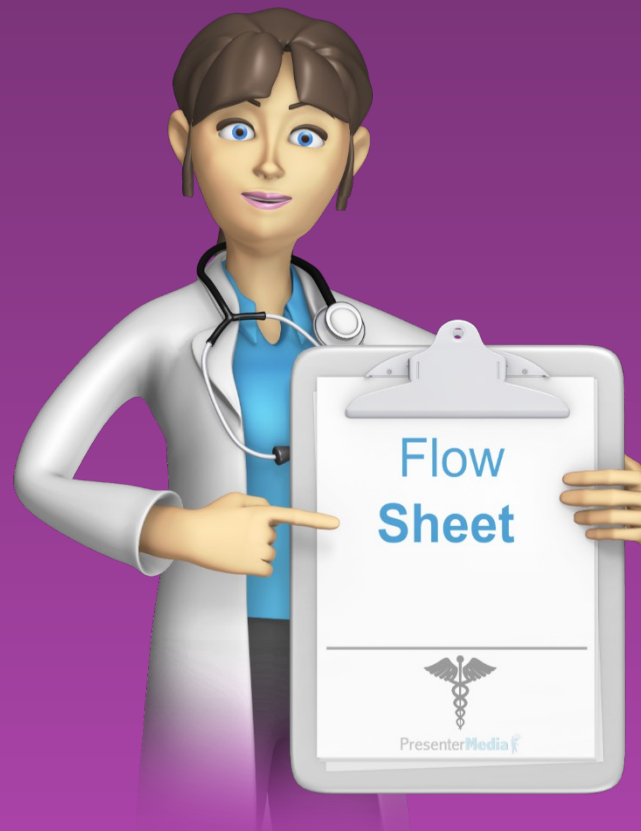


NEURO Q LOC GCS \ /
O2 L/NC VM NRB BiPAP
VENT
@ CM SHILEY
VT FiO2 RATE PEEP PS
SKIN BREAKDOWN STAGE: LOCATION:
DATE ADQUIRED:
ACQUIRED: HOME SICU ER OR FLOOR
INCISIONS:

CT	J-TUBE	EVD/ICP
CT	G-TUBE	NG/OG
JP	OSTOMY	HEMOVAC

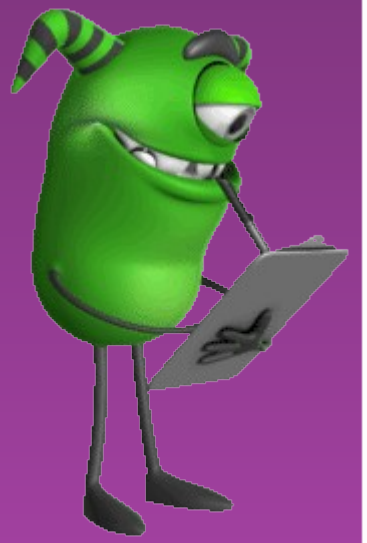
Flow Sheets/Forms

- Vertical or horizontal columns for recording dates and times and related assessment and intervention information:
  - Vital Signs
  - Intake and Output
  - Assessment



Nurse’s Progress Notes

- Narrative note:
  - Patient’s condition, problems, and complaints.
  - Interventions.
  - Patient’s response to interventions.
  - Achievement of outcomes.
  - Additional assessment



As a STUDENT in Clinical

- Confidentiality and compliance with HIPPA are part of your practice
  - **Do not** share information with classmates unless in clinical conference
  - **Do not** access medical records of other patients
  - Electronic health records are traceable through login
  - CAN cause disciplinary action by employers and *dismissal from work or nursing school*

Student Clinical (cont'd)

- Students paper work in clinical practice should not include patient identifiers
  - Ex. Room number, DOB, demographic information, name
  - ✓ **NEVER print material from electronic medical record for personal use**

Legal Guidelines for Recording

- Correct all errors promptly, using the correct method.
- Record all facts; do not enter personal opinions.
- Do not leave blank spaces in nurses' notes.
- Write legibly in permanent black/blue ink.
- If an order was questioned, record that clarification was sought.
- Chart only for yourself, not for others.
- Avoid generalizations.
- Begin each entry with the date/time and end with your signature and title.
- Keep your computer password secure.

Legal Documentation

- Accurate documentation is the best defense for legal claims
  - Must describe exactly what happened to patient and how nurse followed agency standards
  - Try to chart immediately following care provided
  - **IN A COURT OF LAW… " CARE NOT DOCUMENTED IS CARE THAT WAS NOT PROVIDED"**

Components of Good Documentation

- Who
- What
  - Assessment findings?
  - Patient's complaint
  - Care you provided
- When
  - The time when you provided care
- Where
  - Where did event take place
  - Where was the treatment given or medication administered
- How
  - How was treatment completed?
  - How did the resident tolerate the procedure/treatment
- Outcome
  - Outcome of the procedure/treatment

Components (con’t)

- Follow-up
  - What type of follow-up needed (retaking BP. Pain level…)
- Accuracy
  - Exact measurements (don’t use about or approximately)
- Objective vs. Subjective

Notifying Provider

- Include the full name of the provider. •
- Note the exact time that you notified the provider.
- State the specific laboratory result, symptom, or other assessment data that you reported.
- Record the provider’s response, using exact words if possible. •
- Include any orders which the provider gives. If the provider gives no orders, note this - especially if you anticipated an order. For example, “Dr. Sara Jones informed of oral temperature of 104o F. No orders received.”
- In your complete note of the event, include the patient’s other vital signs, relevant observations and any nursing interventions you performed. •

- Include the commitment for necessary follow-up by provider, such as, “Will visit patient at 0600.” •
- Include symptoms and parameters such as changes in vital signs, level of consciousness, or pain that the provider defines as indicators for nurses to use in deciding to call the provider again. •
- It is essential that you document your own actions to assist the patient in addition to documenting your contacts with the provider. •
- If a provider fails to respond to a page, a telephone message, or fails to order an intervention and thereby creates a risk for the patient, pursue the chain-of-command and notify your direct supervisor.
- Document your actions.

How to Fix

Incorrect

1. "Appears confused"
2. “Medicated for pain” (30 minutes later): “Reports relief”
3. "Voiding qs"
4. “Pedal pulses present”
5. “Taking oral fluids well”
6. "Nervous"

Correct

1. “Patient found in lobby, stated he thought he was at the airport.”
2. “Patient states incisional pain at a level 7, on a 1-10 scale. Patient medicated. 1/2 hour later, patient states pain at a level 2.”
3. “Voided 300 mL clear yellow urine”
4. “Peripheral pulses in both legs 2+/4+
5. "(1200) “Drank 1,000 mL since 0700
6. “Asked several times about length of hospitalization, expected discomfort, and time off work.”

Specific Aspects of Care

- Critical diagnostic results •
- Fall reduction •
- Infection prevention •
- Medications and reconciliation of medications •
- Non-conforming patient behavior •
- Pain assessment and management •
- Patient and family role in safety •
- Restraints •
- Skin care •
- Suicide

Common Mistakes = Legal Action

1. **Failing** to record health information/drugs
2. **Failing** to record nursing actions
3. **Failing** to record medications that was given
4. **Failing** to record drug reactions/ or change in patient condition
5. Writing illegible or incomplete
6. **Failing** to document discontinued/refusal medication

Common Mistakes = Legal Action (cont'd)

7. **Failing** to notify Dr., nurse, family and recording exact conversation
8. **Failing** to record a late entry correctly
9. **Failing** to record referrals
10. **Failing** to record patient teaching

Correcting Errors

- A single line through entry errors and your initials **(no erasing, “white out”- do not write error or mistake)**
- **Make sure you have the right chart!!**

Late Entry

- Add the entry to the first available line, and label it “late entry” to indicate that its out of sequence, according to facility policy
- Record the date and time of the entry and, in the body of the entry, record the date and time it should have been made
- EMR – change date and time and then document. However…

Patient Care System - (SJHS/SJHS.TEST5.66/TEXAS.TEST5.66) - Thomas, Cathy W RN

Wound Images | Iatric Systems | Windows

Oesmith, Will

DOB: 10/11/1972 41 M
MA0000165115 / MU00012015
CMC South 9 TCM962S-01 ADM IN

Allergy/AdvReac: No Known Allergies

CMC South 9 - My Location

Room-Bed	Diagnosis	Med	Age-Sex	Pulse	Resp	Isolatio...	Diets	Last BM	PN
Patient Name	Attending	Orders	Temp F	SBP	02 Sat	Skin Risk	Fluid Re...	Lang	Inf
CONFIDENTIAL	Admit Date	Results	Temp C	DBP	Transf	Fall Risk	Pharm ...	Pt Activity	DC
TCM962S-01	STAGE FRIGHT		41/M	86	16		Regular ...	08/20/20...	
OESMITH,WILL	Skinner,Dere..		98.7	144	92			English	
	07/30/2014		37.1	85			0 New/ 0...		
TCM963S-01	IMPARED GO...		36/M						
OEWOODS,TIGER	Skinner,Dere..							English	
VIP	07/30/2014						0 New/ 0...		
TCM964S-01	LASAGNA OV...		38/M						
OEARBUCKLE,GARFIE...	Skinner,Dere..							English	
Conf	07/30/2014						0 New/ 0...		
TCM965S-01	SORE THROAT		47/M	70	18		Regular ...	07/23/20...	
OEMCGRAW,TIM	Dihenia,Chan..		98.6	132	97			English	
	07/08/2014		37.0	83			0 New/ 0...		
TCM966S-01	COMPULSIVE...		64/F	89	15		Regular ...	08/05/20...	
OEBOOP,BETTY	Skinner,Dere..				93			English	
	07/08/2014						0 New/ 0...		
TCM967S-01	BAD ACTING						Regular ...	08/05/20...	
OEPITT,BRAD	Skinner,Dere..							English	
	07/08/2014						0 New/ 0...		
TCM968S-01	UNCONTROL						Regular ...	08/05/20...	
OEPOTTER,HARRY	Skinner,Dere								
	07/18/2014						0 New/ 0...		
TCM969S-01	WRITER'S BL...						Regular ...	08/20/20...	
OEROWLING,J K	Skinner,Dere..								

When you open the status board this is what you will see. The patient that is highlighted will be the patient you will be viewing.

Status Board
Interventions
Outcomes
eMAR
IV Spreadshee
Transfusions
Special Panel
Assign Care Pr
Notes
Process Plans
Schedule
EMR
Orders
Allergies
Oncology
Reconcile Meds
Patient Instruc
Pt Ed
Discharge
Exit PCS

My List | Locations | Find Patient | Acknowledge | Messages | Select | Add To | Add To | Print | Return

smith, Will

DOB: 10/11/1972 41 M
MA0000165115 / MU00012015
CMC South 9 TCM962S-01 ADM IN

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CMC South 9 - My Location

Room-Bed	Diagnosis	Med	Age-Sex	Pulse	Resp	Isolatio...	Diets	Last BM	PN
Patient Name	Attending	Orders	Temp F	SBP	02 Sat	Skin Risk	Fluid Re...	Lang	Inf
CONFIDENTIAL	Admit Date	Results	Temp C	DBP	Transf	Fall Ris			
TCM962S-01	STAGE FRIGHT		41/M	86	16		Regular ...	08/20/20...	
DESMITH,WILL	Skinner,Dere...		98.7	144	92			English	
	07/30/2014		37.1	85			0 New/ 0...		
TCM963S-01	IMPARED GO...		36/M						
DEWOODS,TIGER	Skinner,Dere...							English	
VIP	07/30/2014						0 New/ 0...		
TCM964S-01	LASAGNA OV...		38/M						
DEARBUCKLE,GARFIE...	Skinner,Dere...							English	
Conf	07/30/2014						0 New/ 0...		
TCM965S-01	SORE THROAT		47/M	70	18		Regular ...	07/23/20...	
DEMCGRAW,TIM	Dihenia,Chan...		98.6	132	97			English	
	07/08/2014		37.0	83			0 New/ 0...		
TCM966S-01	COMPULSIVE...		64/F	89	15		Regular ...	08/05/20...	
DEBOOP,BETTY	Skinner,Dere...			142	93			English	
	07/08/20						0 New/ 0...		
TCM967S-01	BAD				20		Regular ...	08/05/20...	
DEPITT,BRAD	S				9			English	
							0 New/ 0...		
TCM968S-01							Regular ...	08/05/20...	
DEPOTTER,HARRY									
	07/						0 New/ 0...		
TCM969S-01	WRITE				16		Regular ...	08/20/20...	
DEROWLING,J K	Skinner,Dere...			144	92				

The interventions is where you will go to chart your vital signs, intake and out put, patient care.

Status Board
Interventions
Outcomes
eMAR
IV Spreadsheet
Transfusions
Special Panel
Assign Care Provide
Notes
Process Plans
Schedule
EMR
Orders
Allergies
Oncology
Reconcile Meds
Patient Instructions
Pt Ed
Discharge
Exit PCS

My List | Locations | Find Patient | Acknowledge | Messages | Select Status Board | Add To User List | Add To My List | Print

Return | Save

Oesmith, Will

DOB: 10/11/1972 41 M
MA0000165115 / MU00012015
CMC South 9 TCM962S-01 ADM IN

Allergy/AdvReac: No Known Allergies

Interventions

Real Time
Wed, Aug 27, 2014 0945
Thomas,Cathy W

Intervention	Text/ Ord	Status	Src	Frequency	History	Next Scheduled	Prtcl	Assoc Data
* Patient Rounding		A	PS	Q1HR	6 days	08/25 0100		
* Change Dressing		A		AILY		08/25 0900		
* Pneumococcal Vaccine Assessment		A		N		08/26 1115		
* ADM Malnutrition Screen						08/26 1115		
* Diet Intake						08/26 1200		
* Patient Rounding						08/26 1200		
* Pain Assessment						08/26 1200		
* Vital Signs						08/26 1200		
* Patient Safety and Positioning						08/26 1200		
* Ambulation Assessment						08/26 1200		
* Intake And Output						08/26 1800		
* Chart Check						08/26 1800		
* Physical Assessment Med/Surg					rs	08/26 1900		
* Sepsis Screening						08/26 1900		
* Lift Team Assessment						08/26 1900		
* Fall Risk						08/26 1900		
* Braden Skin Risk						08/26 1900		
* Isolation Care Precautions						08/26 1900		
* IV/Invasive Line Assessment		A				08/26 1900		
* Patient Care		A		07,19		08/26 1900		
* Care Plan/Outcome Updated		A	SC	07,19		08/26 1900		
* Education General Medical		A	CP	08,20		08/26 2000		
* VTE Risk Assessment		A	SC	09		0900		

The things that need to be address will be highlighted in pink. The green highlighted intervention when you click on it will be what you are charting on.

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Allergies
Oncology
Reconcile Meds
Patient Instruc
Pt Ed
Discharge
Exit PCS

Document | Document | Link | Edit | Select | Add | Delete | Undo | Return

Oesmith, Will

DOB: 10/11/1972 41 M
MA0000165115 / MU00012015
CMC South 9 TCM962S-01 ADM IN

Allergy/AdvReac: No Known Allergies

Document Patient Rounding

Wed, Aug 27, 2014 0946 by Thomas,Cathy W Real Time

Rounding

4 P'S Addressed With Patient	○ Yes ○ No Comment 4 P's are Pain, Positioning, Potty (offered toileting), and Placement (Call bell, phone, water pitcher, trash can within reach)

Patient Off Unit

Patient Off Unit	○ Cardiac Cath Lab ○ Endo ○ Radiation Oncology ○ Surgery ○ Cardiology ○ Interventional Radiology ○ Radiology ○ Therapy ○ Dialysis ○ Nuclear Medicine ○ Stress Test ○ Ultrasound ○ Other

Rounding Comment

Rounding Comments	

This is patient rounding . The click boxes makes it easy to chart and not forget what you need to address.

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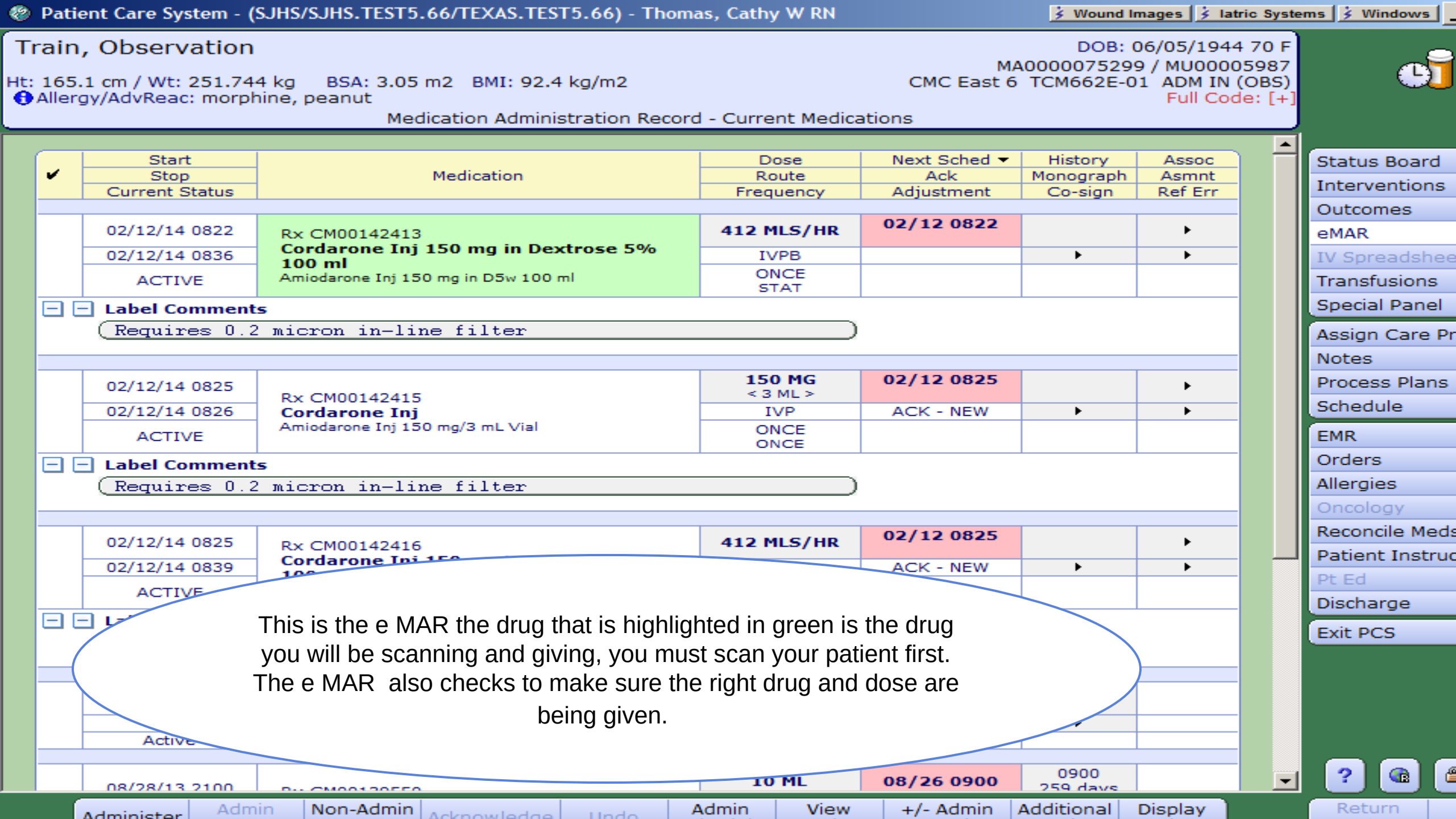
Patient Care System - (SJHS/SJHS.TEST5.66/TEXAS.TEST5.66) - Thomas, Cathy W RN
Wound Images
Iatric Systems
Windows
Train, Observation
DOB: 06/05/1944 70 F
MA0000075299 / MU00005987
Ht: 165.1 cm / Wt: 251.744 kg BSA: 3.05 m2 BMI: 92.4 kg/m2
CMC East 6 TCM662E-01 ADM IN (OBS)
Allergy/AdvReac: morphine, peanut
Full Code: [+]
Medication Administration Record - Current Medications
Start
Stop
Current Status
Medication
Dose
Route
Frequency
Next Sched
Ack
Adjustment
History
Monograph
Co-sign
Assoc
Asmnt
Ref Err
02/12/14 0822
02/12/14 0836
ACTIVE
Rx CM00142413
Cordarone Inj 150 mg in Dextrose 5% 100 ml
Amiodarone Inj 150 mg in D5w 100 ml
412 MLS/HR
IVPB
ONCE
STAT
02/12/14 0822
Label Comments
Requires 0.2 micron in-line filter
02/12/14 0825
02/12/14 0826
ACTIVE
Rx CM00142415
Cordarone Inj
Amiodarone Inj 150 mg/3 mL Vial
150 MG
< 3 ML >
IVP
ONCE
ONCE
02/12/14 0825
ACK - NEW
Label Comments
Requires 0.2 micron in-line filter
02/12/14 0825
02/12/14 0839
ACTIVE
Rx CM00142416
412 MLS/HR
02/12/14 0825
ACK - NEW
Active
08/28/13 2100
10 ML
08/26 0900
0900
Status Board
Interventions
Outcomes
eMAR
IV Spreadshee
Transfusions
Special Panel
Assign Care Pr
Notes
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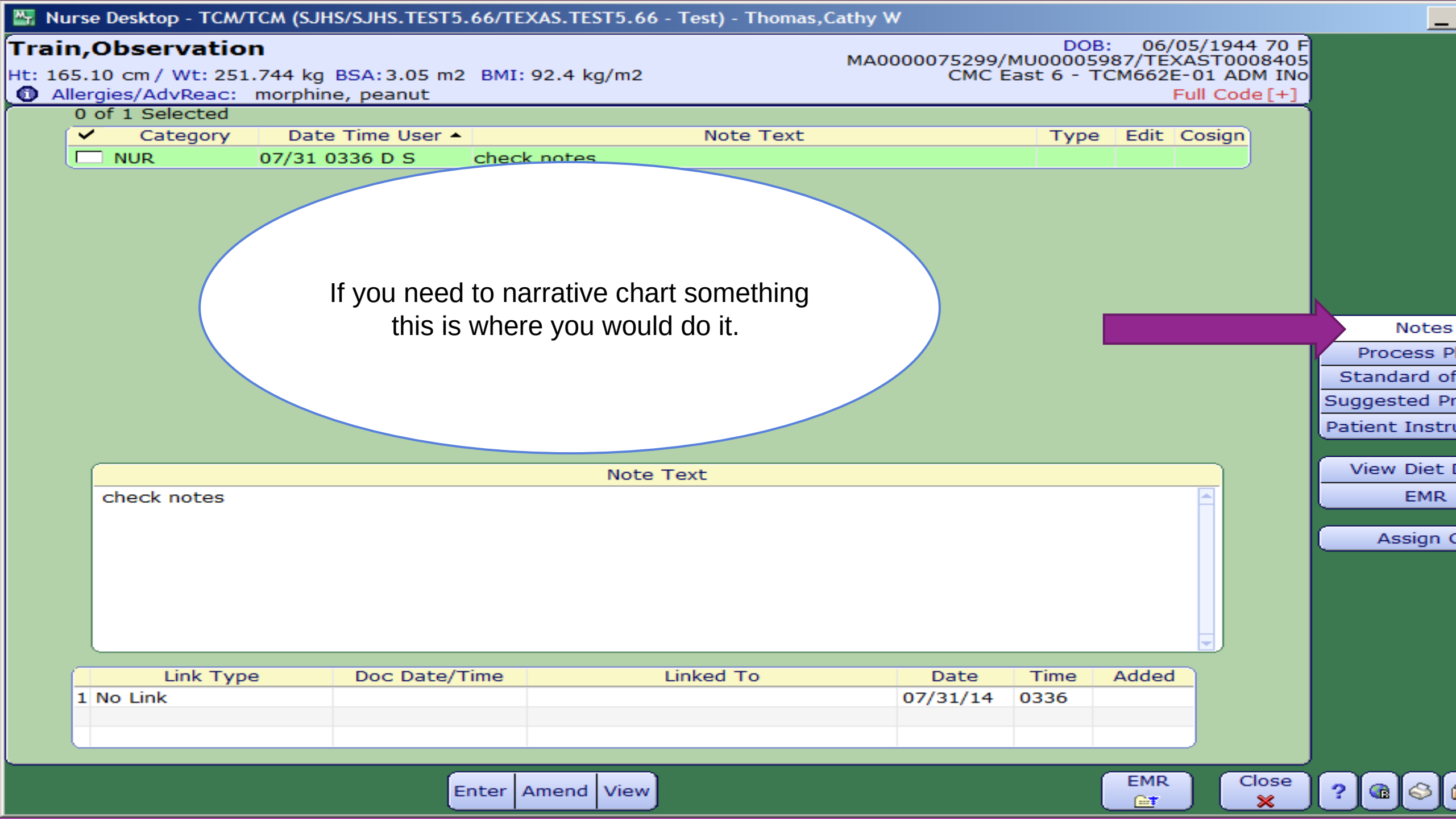
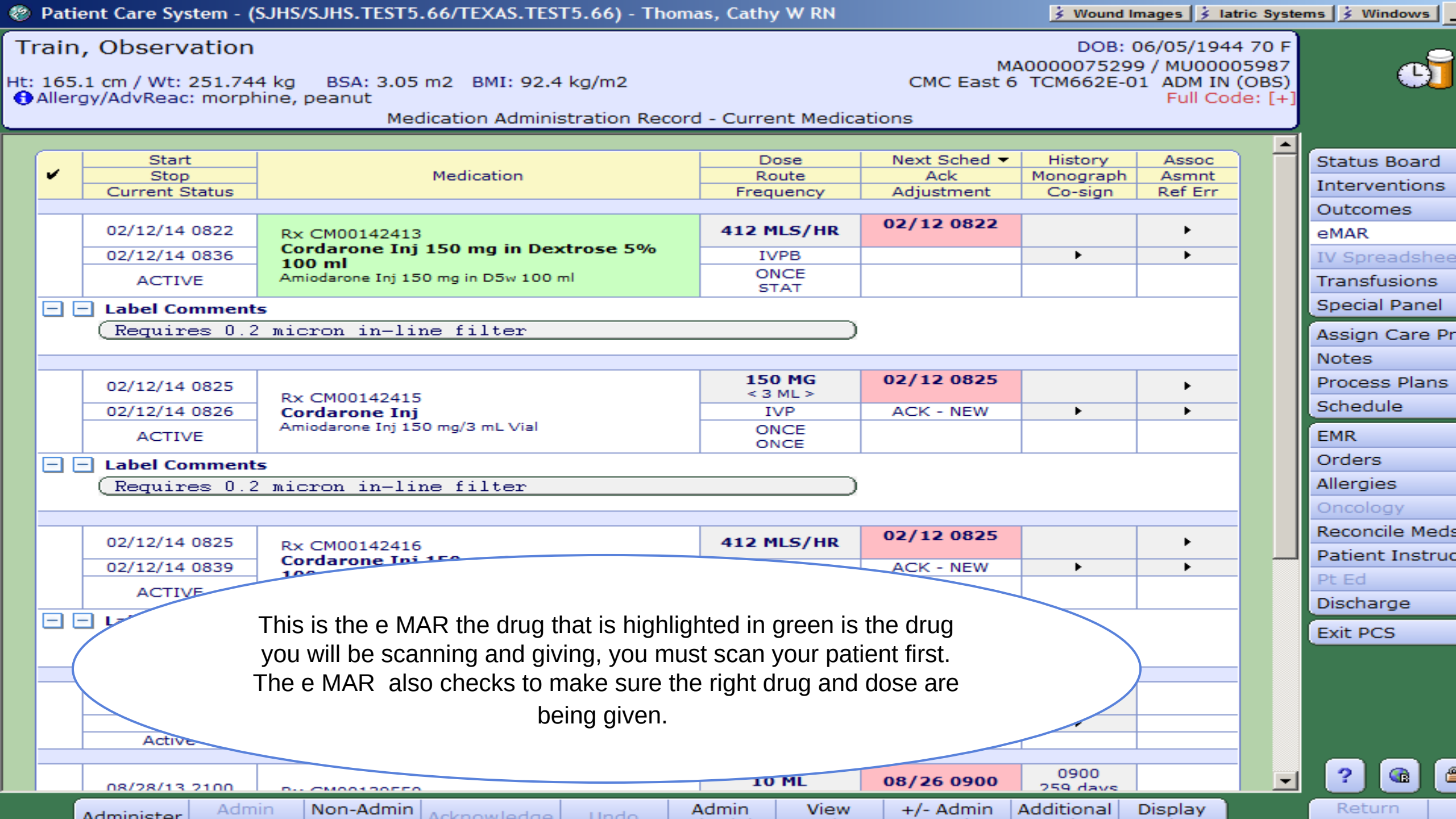
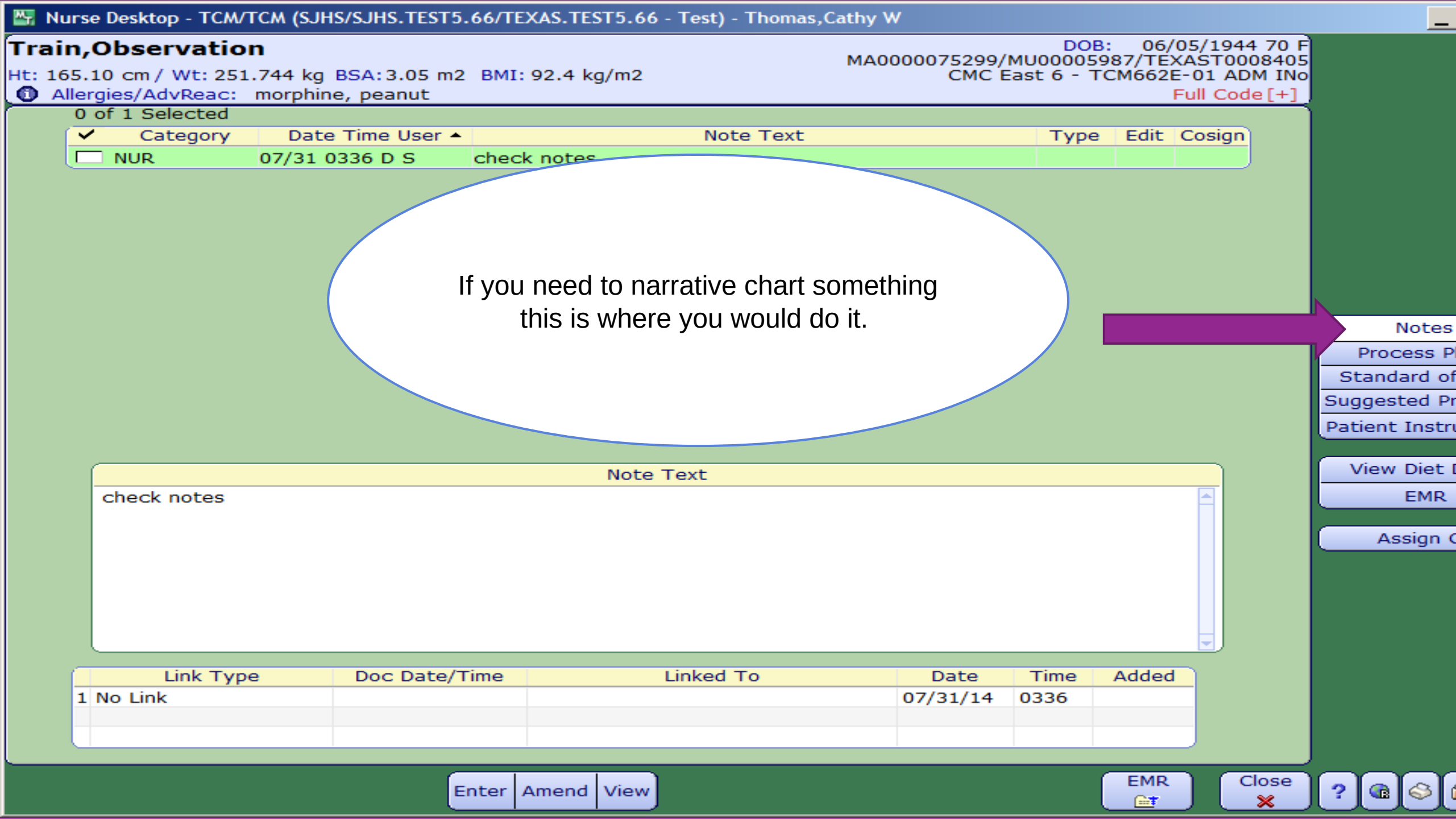
Reconcile Meds
Patient Instruc
Pt Ed
Discharge
Exit PCS
This is the e MAR the drug that is highlighted in green is the drug you will be scanning and giving, you must scan your patient first. The e MAR also checks to make sure the right drug and dose are being given.
Administer
Admin
Non-Admin
Acknowledge
Undo
Admin
View
+/- Admin
Additional
Display
Return


Nurse Desktop - TCM/TCM (SJHS/SJHS.TEST5.66/TEXAS.TEST5.66 - Test) - Thomas,Cathy W
Train,Observation
Ht: 165.10 cm / Wt: 251.744 kg BSA: 3.05 m2 BMI: 92.4 kg/m2
Allergies/AdvReac: morphine, peanut
DOB: 06/05/1944 70 F
MA0000075299/MU00005987/TEXAST0008405
CMC East 6 - TCM662E-01 ADM INo
Full Code [+]
0 of 1 Selected
Category
Date Time User
Note Text
Type
Edit
Cosign
NUR
07/31 0336 D S
check notes
If you need to narrative chart something this is where you would do it.
Notes
Process P
Standard of
Suggested Pr
Patient Instru
View Diet
EMR
Assign
Note Text
check notes
Link Type
Doc Date/Time
Linked To
Date
Time
Added
1 No Link
07/31/14
0336
Enter
Amend
View
EMR
Close


Patient Care System - (SJHS/SJHS.TEST5.66/TEXAS.TEST5.66) - Thomas, Cathy W RN
Wound Images
Iatric Systems
Windows
Train, Observation
DOB: 06/05/1944 70 F
MA0000075299 / MU00005987
Ht: 165.1 cm / Wt: 251.744 kg BSA: 3.05 m2 BMI: 92.4 kg/m2
CMC East 6 TCM662E-01 ADM IN (OBS)
Allergy/AdvReac: morphine, peanut
Full Code: [+]
Medication Administration Record - Current Medications
Start
Stop
Current Status
Medication
Dose
Route
Frequency
Next Sched
Ack
Adjustment
History
Monograph
Co-sign
Assoc
Asmnt
Ref Err
02/12/14 0822
02/12/14 0836
ACTIVE
Rx CM00142413
Cordarone Inj 150 mg in Dextrose 5% 100 ml
Amiodarone Inj 150 mg in D5w 100 ml
412 MLS/HR
IVPB
ONCE
STAT
02/12/14 0822
Label Comments
Requires 0.2 micron in-line filter
02/12/14 0825
02/12/14 0826
ACTIVE
Rx CM00142415
Cordarone Inj
Amiodarone Inj 150 mg/3 mL Vial
150 MG
< 3 ML >
IVP
ONCE
ONCE
02/12/14 0825
ACK - NEW
Label Comments
Requires 0.2 micron in-line filter
02/12/14 0825
02/12/14 0839
ACTIVE
Rx CM00142416
412 MLS/HR
02/12/14 0825
ACK - NEW
Active
08/28/13 2100
10 ML
08/26 0900
0900
Status Board
Interventions
Outcomes
eMAR
IV Spreadshee
Transfusions
Special Panel
Assign Care Pr
Notes
Process Plans
Schedule
EMR
Orders
Allergies
Oncology
Reconcile Meds
Patient Instruc
Pt Ed
Discharge
Exit PCS
This is the e MAR the drug that is highlighted in green is the drug you will be scanning and giving, you must scan your patient first. The e MAR also checks to make sure the right drug and dose are being given.
Administer
Admin
Non-Admin
Acknowledge
Undo
Admin
View
+/- Admin
Additional
Display
Return


Nurse Desktop - TCM/TCM (SJHS/SJHS.TEST5.66/TEXAS.TEST5.66 - Test) - Thomas,Cathy W
Train,Observation
DOB: 06/05/1944 70 F
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Ht: 165.10 cm / Wt: 251.744 kg BSA: 3.05 m2 BMI: 92.4 kg/m2
CMC East 6 - TCM662E-01 ADM INo
Allergies/AdvReac: morphine, peanut
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07/31/14
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EMR
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Train, Observation

DOB: 6/5/1944 70 F
MA0000075299 / MU00005987
CMC East 6 TCM662E-01 ADM IN (OBS)
Full Code: [+]

Ht: 165.1 cm / Wt: 251.744 kg BSA: 3.05 m2 BMI: 92.4 kg/m2
Allergy/AdvReac: morphine, peanut

Orders

Order Date	Order Time	Service Date	Service Time	Ordered By	Category	Procedure	Status
7/31/14	16:02	7/31/14	16:01	Ranganath	PCS	* Discharge Patient (ONCE)	In Process
7/31/14	15:45	7/31/14	15:45	Ranganath	PHA	Lisinopril (Zestril) 10 MG PO ONCE ONE	Cancelled
7/31/14	15:44	7/31/14	15:45	Ranganath	PHA	Aspirin (Aspirin) 81 MG PO ONCE ONE	Cancelled
					PHA	Metoprolol Succinate... 25 MG PO DAILY SCH	Cancelled
7/31/14	15:42	7/31/14	15:34	Ranganath	LAB	CBC w/ Differential	Uncollected
7/31/14	15:42	7/31/14	22:00	Ranganath	LAB	Creatine Kinase (CK)...	Uncollected
7/31/14	15:42	8/1/14	06:00	Ranganath	LAB	Creatine Kinase (CK)...	Uncollected
7/31/14	15:42	8/1/14	14:00	Ranganath	LAB	Creatine Kinase (CK)...	Uncollected
7/31/14	15:42	7/31/14	15:35	Ranganath	PHA	Sodium Chloride IV SCH	Cancelled
7/31/14	15:33	7/31/14	15:24	Ranganath	CODE	Code/ Resuscitation ...	Active
					PCS	* Daily Weight (DAILY)	In Process
					PCS	* Tobacco Cessation (ADM...	In Process
					PCS	* Heart Healthy Educ (DIS...	In Process
					PCS	* Heart Failure Educ (ONC...	In Process
					PCS	* Anticoagulation Ed (ONC...	In Process
					PCS	Consult Dietitian Ed (ONC...	In Process
					PCS	* Intake And Output (Q1H...	In Process
					PCS	* Notify MD/ DO (.PRN)	In Process
					PCS	* Insert Saline Lock (ONCE)	In Process
					PCS	* Vital Signs Non Ro (Q4H...	In Process
7/31/14	15:33	7/31/14		Ranganath	DIET	Cardiac AHA Heart He...	Active
7/31/14	15:33	7/31/14	15:24	Ranganath	LAB	Magnesium Level, Mg	Uncollected
					LAB	Cardiac Panel	Uncollected
7/31/14	15:33	7/31/14	21:24	Ranganath	LAB	Cardiac Panel	Uncollected
7/31/14	15:33	8/1/14	03:24	Ranganath	LAB	Cardiac Panel	Uncollected
7/31/14	15:33	7/31/14	15:24	Ranganath	LAB	CBC w/ Differential	Uncollected
					LAB	B Type Natriuretic P...	Uncollected
					LAB	CMP Comp Metabolic P...	Uncollected
7/31/14	15:33	8/1/14	06:00	Ranganath	LAB	Lipid Profile	Uncollected
7/31/14	15:33	7/31/14	15:24	Ranganath	EKG	EKG/ ECG	Active
					PCS	Consult Case Managem (ONC...	In Process
					RC	RC Oxygen Oximetry A (AS ...	In Process
					PCS	* MD/ DO to Nurse Co (AS ...	In Process
					PCS	* Notify MD/ DO (ADMISSION)	In Process
					TAG	ZTAG-T-Cardiology-Adm	Active

Return
Other Visit
Special Panels
24 Hour
Vital Signs
I & O
Notes
Medications
Order History
Laboratory
Microbiology
Blood Bank
Pathology
Imaging
Other Reports
Care Trends
Care Activity
History
Summary
Encounters
Referrals
Problem List
Discharge
Orders
Document
Reconcile Meds
Sign
Refresh

Documentation ABC

- **A**ccurate
- **B**ias-free
- **C**omplete
- **D**etailed
- **E**asy to read
- **F**actual
- **H**armless (legally)

Documentation

- Never use labels to describe a patient or patient's behavior
  - Obnoxious, belligerent, rude…
- Describe patient's behavior
- Document patient's refusal, reason for refusal and what you did about it.

Example

- 1300, received report and assumed care at 0700. Physical assessment attempted, pt rudely told me with her thick accent to leave and not come back until 0900. I went to first floor to smoke and returned promptly.

Example

10000, administered one hydrocodone.

1200, ate adequate amount of lunch.

1400, sitting on toilet grunting, exclaiming, I can’t have a bowel movement.

1600, report finally given to new nurse. She was late. JMaya

Example

- 1900 arrived to ER complaining of stomach pain. Claims to have drank 5-6 beers today. I would dare say more like 25-26 beers a day along with some cheap whiskey. Has wound on right lower leg, probably attained it trying to walk in a drunken state.
- 2000 pt still drunk.
- 2100 pt vomited atrocious smelling substance all over my new shoes.

Charting Errors

- Patient has chest pain if she lies on her left side for a year z
- The patient has no past history of suicides
- She is numb from her toes down
- She has had no chills, but her husband states she was very hot in bed last night.
- Vaginal packing out, Dr. Lee in.
- Patient has two teenage children but no other abnormalities.
- A 24-year-old woman oriented to person, space and time.
- Pt alive but hope to remedy situation by AM.
- Alert and organized x3

Charting Errors

- Cough with flame
- Patient has left white blood cells at the last hospital.
- Patient has hx of pickle cell anemia
- The skin was moist and dry
- The patient refused autopsy
- The lab test indicated abnormal lover function
- She was x-rated and sent home.
- Large brown stool ambulating in the hall.

Charting Errors

- Husband at bedside, patient easily aroused.
- The patient lives at home with his parents and pet turtle, who is presently enrolled in daycare three days per week.
- Cat in home wearing med alert pendant.
- Nonverbal, non-communicative and offers no complaints.
- Family at bedside attempted to urinate.
- This is a 981 YO female with a host of medical problems

State Board Nursing Disciplinary Actions

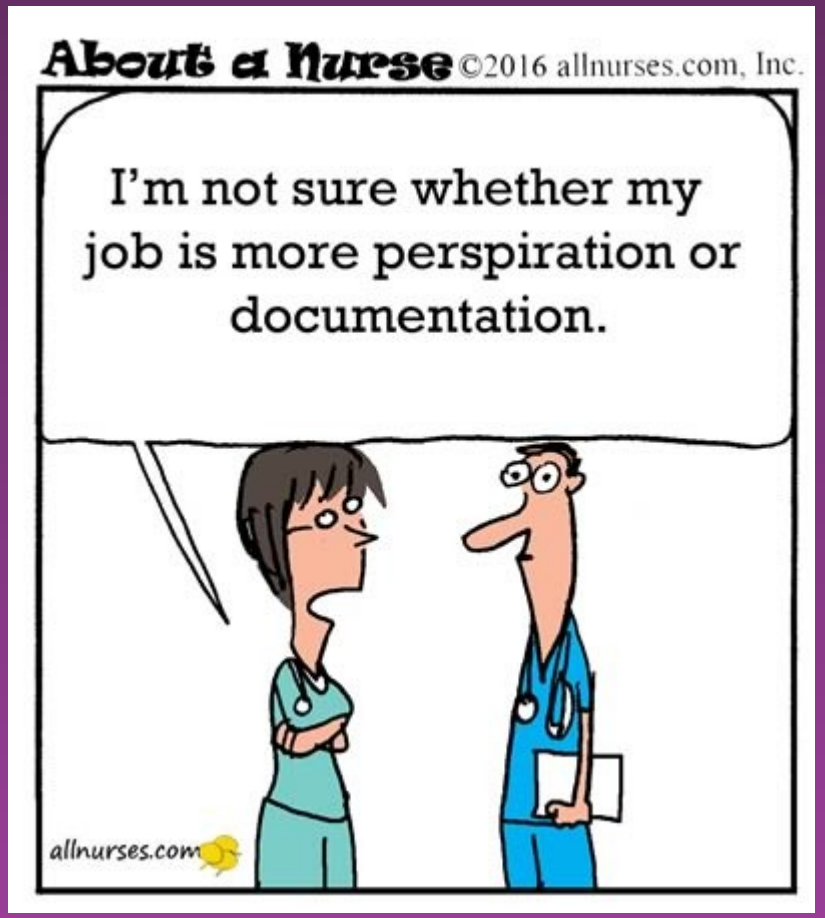
- Documented that she had received a physician's order and had read back and verified the order with the physician, when in actuality, ***the conversation never took place.***
- ***Failed*** to chart a restraint
- The patients glucometer levels in the machine ***did not match*** what the nurse had written in her documentation.
- Nurse ***failed*** to notify the primary care physician that her patient had an elevated temp it was documented in her notes, the patient died.
- ***Failed*** to document vital signs.
- Nurse called physician but call ***was not documented*** as well as transfer of a patient to a higher level of care ***was not documented***

State Board Nursing Disciplinary Actions

- ***Failed*** to actively and effectively chart.
- ***Failed*** to document medication administration.
- Nurse ***pre documented*** patients vital signs when the record showed the patient had passed away 3.5 hours earlier.
- Nurse ***falsified*** records.
- Documentation was ***not clear, descriptive, or thorough***.
- Nurse used and ***unapproved abbreviation*** and the meaning could not be ascertained.
- ***Failed*** to properly or timely document the assessment or interventions of her care of her patients.

Whose responsibility is it ? YOURS!!

- Two out of three most frequent allegations against nurses in medical liability claims deal with documentation.
  - Absence of documentation
    - Plaintiffs ***argue if it wasn't charted, it wasn't done.***
  - Timing of documentation (late entries)
    - Self serving
    - Different than would have been charted at the time of treatment.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I'm not sure whether my job is more perspiration or documentation.
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