What do nurses document? (What do we “put in writing”?)

- Patient information
- Nursing care delivered
- Outcomes of care
- Policies & procedures
- Administrative records

How do nurses document?

- Electronically
- Paper/pen
- Dictation/transcription
- Some combination of above
Where do nurses document?

- “Nurses notes” or a nursing care section versus an integrated record.
- Patients with cancer may have multiple records.

Why do nurses document?

- Provides an account of the care delivered.
- Promotes continuity of care.
- Reduces redundancy in care delivered.
- Supports charges/billing.
- May be your best defense—or your worst enemy—in the event of legal action.

Why do patients sue?

- To obtain compensation for perceived harm/injury
- To obtain information
- To retaliate, vent anger or frustration
- To “prevent this from happening to anyone else”
- (Family) To advocate on behalf of injured or deceased relative
Elements needed to support allegations of negligence

- Duty exists.
- Duty was breached.
- Breach in care caused or contributed to patient harm.

Allegations of negligence

Failure to--

- inform the patient of the risks and benefits of [treatment/drug].
- properly assess the patient prior to treatment.
- properly administer [treatment].
- monitor the patient.
- identify [adverse event, error].
- properly document the event.
- communicate the incident.

What kinds of documentation may be reviewed in a malpractice case?

- Patient’s medical record
- “Off the record” documentation
- Policies and procedures
- Personnel and administrative records
- Photographs
- Other
Legal considerations

- MDs, RNs, and pharmacists are independently licensed.
- The multidisciplinary “team” often falls apart when litigation is initiated.

“Defensive” and “Offensive” Charting

- “Every man for himself.”
- Objectivity decreases; subjectivity and opinion increase.
- Often includes details that otherwise would not be included.
- Attempts are made to absolve self/others or incriminate others.

- Patient is 6 feet 3 inches tall.

__________ inches
- Patient is 6’ 3” tall
- Nurse erroneously converts to 63” instead of 75” and records 63” in the medical record
- Miscalculated BSA = 2.01
- Correct BSA = 2.2
- Patient under-dosed 11%
- Patient has testicular cancer and wins a jury verdict of $500,000

Treatment plan (progress notes)

Chemotherapy orders document that a “double check” was done by the nurses
Patient developed ventricular tachycardia and died 12 hours post paclitaxel overdose.

Overdose detected the following day by the oncology CNS.

Case settled out of court for $1 million.

- If you are documenting a “double check,” what are you verifying?
  - In medical record or P & Ps (preferably both), clearly state what is being verified.
  - ONS: “multiple checks and balances that include dose verification by at least two healthcare professionals.”
  - ASCO: “systematic method of drug verification by at least two individuals.”
Double-checks (Joint Commission, 2007)

- One person performs a review or calculation twice
- Least reliable double-check method

Second type of double-check

- Second person looks at calculation to confirm “(‘eyeballs it’)”

Third type of double-check

- Second person recalculates after watching first calculation or knowing calculation
Fourth type of double-check
- Second person recalculates without having seen the first person’s calculation (independent double-check). Most reliable.

Realities of documentation
- "If it wasn't charted, it wasn’t done."
- "The palest ink is better than the best memory."
- Considered by some authors to be the 6th right of medication administration.

"If you cannot acquire the habit of documentation one way or other, you had better give up being a nurse, for it is not your calling, however kind you may be."
Barriers to timely and complete documentation

- "not enough time"
- "keep getting interrupted or distracted"
- "hard to keep all the patients straight"
- "not humanly possible to chart the way we were taught in nursing school"

Notations made on charts.....

- Patient denies chills but husband says she was hot in bed last night.
- The patient has been depressed since she started seeing me in 2002.
- The skin is moist and dry.
- Both breasts are equal and reactive to light and accommodation.
- Examination of the genitalia reveals that he is circus sized.

Documentation Pointers

- Document only what YOU see, hear, and do.
- Do not document in advance.
- Include dates and times.
- Make sure you have the correct chart or electronic record.
- Be as objective as possible (include patient's quotes, measurable data, etc.)
Accurate documentation is dependent upon:

- A thorough physical assessment
- Use of standardized measures (e.g. pain scale)
- Promptly recording findings and interventions

Chemotherapy documentation

- Complete information about agents administered
- Evidence of double checking (and what you are double checking—BSA? Labs? Drug/dose?)
- Peripheral administration: site, device, attempts, blood return, site condition upon completion
- Port/CVC administration: device, size/gauge of non-coring needle, blood return, skin assessment
- Monitoring: blood return frequency
- Patient teaching: vesicant precautions, general chemotherapy information

Corrections & Late Entries

- Draw single line through incorrect words, write “void” (not “error”), initial/sign and date/time.
- Do not use liquid paper (“white out”)---it can be x-rayed.
- State that an entry is late, state date/time at the time the entry is made.
Flowsheets & Electronic Documentation

- Beware of the process of “check, check, check” or “click, click, click.”
- Why is the patient here?
- What has been done?
- What is the patient’s response?
- Look for redundancies.
- Ensure individualization of entries.

“What is of most concern to you right now?”

Commonly misspelled words

- Antecubital
- Conscience and conscious
- Dysphagia and dysphasia
- Loose and lose
- Mucus and mucous
- Regimen and regime
- Vesical and vesicle
Commonly confused words

- Proximal and distal
- Abduct and adduct
- Contralateral and ipsilateral

Abbreviations

- WNL
- LOC
- Joint Commission: introduced “do not use” list of abbreviations in 2004
- U and IU: spell out unit and international unit
- qd, qod, etc.: spell out
- No trailing zero (e.g. 2.0 mg)
- Use leading zero (e.g. 0.8 mg)
- MS and MS04: spell out morphine and magnesium

Ambiguous & literal wording

- Incident report: “Patient started falling and states that mother tried to catch her but hit head on bathroom door.”
- P & P: “Check for blood return.”
Best practice

- Have a routine
- Tell patients/families what you’re doing and what you’re finding
- Reinforce information
- Document truthfully

Now it’s up to you……

- Proactively examine your clinical practices.
- Take a look at your policies and procedures.
- Streamline your documentation tools or systems.
- Share what you’ve learned with your colleagues.