DOCUMENTATION BEST PRACTICES

DON Bootcamp

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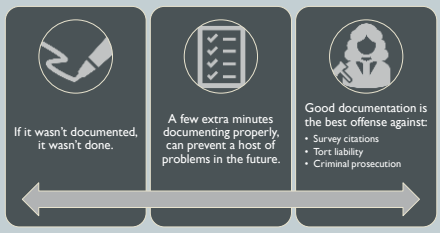
PRINCIPLES TO LIVE BY



DOCUMENTATION

Documentation Dos:

- Date, time and sign every entry with ink
- Document facts and observations, not opinions or interpretation of behaviors
- Use approved abbreviations only – if you are not sure write out the word
- Document clearly and legibly
- Document contemporaneously

Documentation Problems:

- Summary charting
- Lack of follow-up
- Failure to document PRN meds and tx
- Failure to document resident refusal of meds
- Failure to document interventions in response to refusals
- Failure to document non-pharmacological interventions
- Documenting on events that were not witnessed or that occur when you are not present in the facility
- Documentation that conflicts with facility policy or other documentation
- Blaming others in the medical record
- Extraneous documentation that is not directly related to the resident's care

EXAMPLES

"8am: CNA notified nurses upon entering the room, patient noted to be cold and unresponsive. Vital signs absent. RN supervisor paged to station stat. Dr. paged at this time. Dr. made aware that patient expired at 7:15 am."

EXAMPLES

1. "Duricef noted to be expired. It was noted that out of 16 days, only 5 doses were given."
2. "Upon checking medication cart, this nurse found wrong medication sent by pharmacy. Three doses were given."
3. "Incident report completed."

EXAMPLES

- "Resident's daughter complained that wheels on resident's bed not locked three times this week to the DON".
- RT Note – "Resident worried that nurses may not come fast enough when she pushes the call bell. Instructed resident to disconnect herself from the ventilator if they do not come fast enough because staff will respond to the ventilator alarm faster."

EXAMPLES

- "personal alarm AAT"
- q,d,
- MS (for morphine sulfate)
- "Flush TLC"
- "resident pale and lupy"

NEVER FALSIFY OR DESTROY RECORDS

- Medicaid fraud
- Violation of criminal statutes relating to drug documentation
- Criminal prosecution of nurses for neglect
- Tampering with evidence/obstruction of justice
- Civil Tort Suits (negligence) – Punitive damages

PROTECT AGAINST FALSIFICATION

- Never alter a resident's medical record
- Never remove/delete pages, documents or entries from a medical record
- Never obliterate completely with ink, white-out or erase
- Correct Mistakes/Errors in Documentation
  - Cross out with a single line, write "error" and then date, time and initial
  - Document correct entry below, if applicable
  - Changes in electronic documentation

LATE ENTRY

- Identify as "late entry"
- Enter date and time entry was made then identify the date and time the event took place
- Use if documentation was omitted
- Never use to contradict an earlier entry

ADDENDUM

- Same as late entry
- Enter date and time note is actually written
- Identify as "addendum" to note written on X date at X time
- Only use when adding more detail/follow-up to a note already written
- Electronic – be sure that initial note is note removed or hidden

NOTIFICATION

FAXES

- If information is faxed to the physician – you must confirm she/he received it.

Always document that the physician was notified of a change in condition (paging and leaving messages is not notification.)

Follow appropriate chain of command.

ELECTRONIC MEDICAL RECORDS

Proof of "wrongdoing" is more easily identified.	Metadata	Audit Trails
• Inappropriate Corrections • Tampering • Data Destruction • Electronic Data Stamps • Unauthorized Access • Incorrect Data Entry	• Metadata is commonly defined as "data about data"	• "An audit trail is a record of who, when, where, how and sometimes why a person used a computer program or accessed a patient's medical record."

ELECTRONIC MEDICAL RECORDS

"Pop-up" Can be a warning, alert, or reminder. System metadata can show the EMR program warned the nurse.

"Preliminary questions" and checkboxes (similar to pop-ups) contained in the records also contain metadata. These types of preliminary questions and checkboxes can establish whether nurse considered certain types of information, can be used to establish negligence if they go unanswered.

Most EHRs are not designed to be printed. What is seen in the printout may not be what the physician/nurse saw on the computer screen when treatment/service to the resident on a particular day.

Worse still, it may not be possible to print a patient's electronic record relevant to a case. In this case, the Facility will have to allow litigators access to the computer system running the EHR.

If nurses take shortcuts or use automated features to complete patient data quickly, a court of law may consider it as slipshod, impersonal patient care. When the copy-paste functionality is excessively used by providers and results in extensive documentation, there is a chance of judging it as impersonal care or a lack of concern for the patients' well-being.

QA DOCUMENTATION

KEEP QA DOCUMENTS CONFIDENTIAL

- Clearly mark as QA
- Share/circulate only with others on QA Committee
- Keep separate from clinical record
- Keep separate from mandatory investigations

NEVER – Reference a QA document (e.g., incident report) in any part of the record.

Guiding Principles for Drafting Work Emails and Texts

REMEMBER: Your email/text is FOREVER.	Even if you delete messages, they are never really gone and are accessible to government agencies, plaintiff attorneys, and law enforcement with a subpoena.
Take a moment before drafting an email or text and ask yourself if it is an appropriate medium for the discussion/message.	Consider whether the discussion would be better had in person, by phone, or using a different company process for conveying your message
Never put anything in writing that you would not want to see	* On the front page of the paper, or * Blown up in front of a jury, or * In the hands of law enforcement/government agent.
Always avoid the use of texting for anything substantive.	Texting has too many opportunities for typos and is often conveying incomplete or out of context thoughts.
Fill in email addresses **AFTER** you have drafted the email.	This reduces the risk of sending an incomplete email and gives you an additional moment to consider your audience, along with your message.

Consider each email/text as a stand-alone message.	Rest assured that any email/text that is used as evidence will be taken out of context. With every email, reply, or text, try to give the message a frame of reference.
REMEMBER: If your words can be perceived in different ways, they'll be understood in the way which does the most harm.	Much like the need to give each message context, it is important to be intentional with your words, and to avoid inflammatory language. Consider whether your words would "trigger" a government agent or plaintiff attorney.
CONSIDER: "Now" is often the wrong time to say what just popped into your head.	Before sending an email/text, take a moment or two (a day) to consider if your message is driven by facts or emotion. Knee-jerk emails/texts are often the most regrettable.
Get a second opinion.	If you are sending a consequential email (we avoid consequential texts) consider a second set of eyes to help evaluate the substance, the context, the tone, and the language.
Use a clear, concise, subject line	Most emails are searched by their subject line.

QUESTIONS?