

Chart This, Not That!

The 7 Documentation Habits of Highly Effective
(Legally-Savvy) Nurses

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1. Tell Your Patient's Story...

- The medical record is a scientific *and* legal document which supports the delivery of the care provided
- Needs to tell the complete story of the patient's care
- Lawsuits take years before a claim sees the inside of a courtroom. Your documentation now will help you recall the “who, what, when, where and how” years later
 - ✓ Chart what you did and how you did it
 - ✓ Don't only chart by exception – explain! *Nurses' notes with few explanations, little description of key findings, or no mention of regular patient checks could be construed as negligence*
 - ✓ Always document the abnormal and what you did about it
 - ✓ Always important to note, “Assumed care of patient...” and “Shift report given to...”

4 C's of Documentation

1. Clear
2. Concise
3. Correct
4. Complete (closed loop)

“If another nurse had to step in and take over care of my patient, does my documentation provide sufficient information for the seamless delivery of safe, competent care?”

2. ...Don't Forget The Ending

- Essential to chart the *full* picture
- Anticipated vs. actual care
 - If patient was consented for a procedure, make sure the medical record explains what actually took place and what patient education you performed

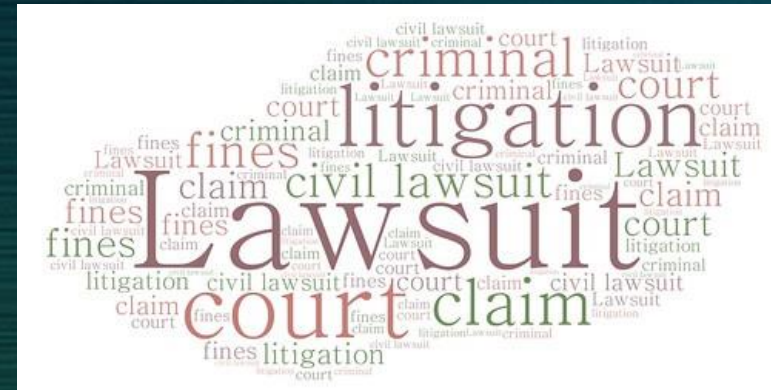
1. a. My preferred language is: English Spanish Other: _____
If needed, an interpreter will be provided at no cost to you.

b. Surgery/procedure I am having [include both the medical term and patient words]:
Lumbar four - five, Lumbar five - Sacral one
Transforaminal Lumbar Interbody Fusion (TLIF)

c. The body part is [write and mark on diagram]: _____ Left Right Middle
 Other: _____

- Don't dismiss the discharge
 - Help ensure discharge instructions, follow-up appointments, medications, etc., are complete, updated in the medical record and provided to the patient

IF IT WASN'T DOCUMENTED, IT WASN'T DONE



And if ever in court: if you didn't do it, were you negligent?

3. Escalate and Advocate



- Monitor closely for acute (even minute) changes – in mental status, vital signs, wound progression, pupillary response, bleeding, etc.
- Escalate early and often
- If you're not getting a prompt response, escalate again
 - Involve charge nurse, ED attending to troubleshoot
 - Escalate to next higher resident >> attending in specialty area
 - Chart EVERY time you notify a doctor or use the chain of command

- Document your escalation efforts carefully (who – full name, initial call time, response, when at bedside, and what plan/new orders)
- Beware of SecureChat – Always escalate using pager and phone
- (While tempting), avoid blaming or criticizing others in the medical record. RNs have a duty to advocate and take action on their patient's behalf

4. If You See It, Say So

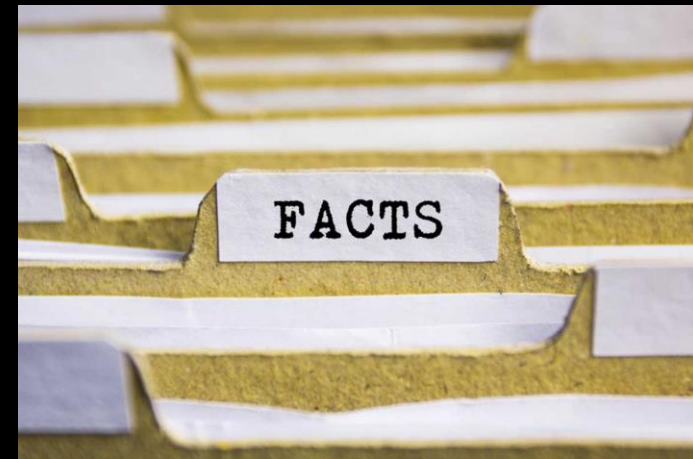
- Describe what you observe and what you do
- ED/Trauma RNs first to assess patients directly off the street: prime opportunity to begin charting any pre-existing wounds, conditions, etc.
- Do chart normal findings – important for establishing baseline
 - How closely were you monitoring your patient when a change occurred?
 - How quickly did you pick up on what was happening?
 - For ex, “0300am patient sleeping in bed, breathing unlabored, NAD.”

At 0305am, patient is found on the floor. How long had the patient been there? How do you prove this? What if they claim patient was lying on the floor in agony with a broken hip since dinner the night before and no one did anything?



5. Be Objective

- State only the facts and information you see, hear and collect
 - Avoid charting opinions, speculation or assumptions
 - Never vent anger or assign blame
- False or inaccurate information, even if unintended, can provide the basis for criminal or regulatory action
- Describe, don't label
 - Instead of drunk = Pt smells of alcohol, unsteady gait
 - Instead of violent = Pt seen striking the wall
- Preferred statements of fact
 - Good appetite = Ate 100% of meal
 - Breath sounds normal = Lungs CTA bilaterally
 - Pulses present = Peripheral pulses 3+ in BLE



6. Timeliness Matters

- Document as close to “IRL” (i.e. real time) as you can
 - Complete your documentation before leaving the hospital each day/night
- Correct assessment and proper charting should occur before the fact, as a matter of routine
- Charting defensively, post-incident, raises red flags – telegraphing the message that you believe you might be at fault
- Avoid back-dating. If necessary, chart a late entry instead

Late entry example

Late entry 1/01 0300 (EHR not available on 12/31 at 0015):

On 12/31 at 0015 pt states she felt faint when getting out of the chair & fell to the floor. States did not injure self. No bruises, lacerations noted. No LOC. Denies pain. Dr. [INSERT full name] notified. Awaiting additional orders.

A. Nurse, RN

- Identify the new entry as "late entry"
- Enter the current date and time. Do not try to give the appearance that the entry was made on a previous date or time.
- Identify or refer to the date and incident for which the late entry is written
- Document as soon as possible. The more time that passes, the less reliable the entry becomes

7. Know Your Audience – How/Where to Chart Adverse Events

- Do not confuse incident reports (SIs) with patient charting
- Report your observations, facts and patient care in the medical record, for example:

After finishing report I noted that patient's call light was on, went to check in on her to see what she needed, before entering room I noted that pt's bed was empty and she could not be readily seen, I went into her room and noted that she was in a sitting position next to the wall closest to her room door, when asked what happened patient stated that she had needed to use the restroom. I was assisted by another nurse and nursing student to safely get the patient back up, she was checked for obvious injuries to her person, once check was done pt was assisted to the bed where the assessment continued, MD was paged and they were made aware of her fall as well as the pt reporting that she had hit her head. Vital signs were stable and her neuro had no changes as she remained at AO3 without being able to name where she was, she was assisted to the bedside commode then back to bed, bed alarm and camera in place after return to bed. Family was called and updated on her fall.

- What goes to quality review may be highly critical of how an incident transpired, but it is confidential and stays within quality review
- What is documented in the patient's chart is guaranteed to come out in court

7. Know Your Audience – How/Where to Chart Adverse Events

- Avoid charting or mentioning:

- “By mistake”
- “Somehow”
- “Unintentionally”
- “Miscalculated”
- “My fault”
- “Incident report completed”
- “Risk or Legal notified”



- If ever in doubt, call Risk Management for counsel and advice

A good chart
defends itself
and
also those who
wrote in it.



Risk Management at Denver Health

- Part of the Legal Department
- All clinical/former RNs
- Train, educate and seek to prevent loss
- Investigate and manage claims, key areas of risk
 - Liability
 - Malpractice
 - Property
 - Workers' Compensation
 - Auto
- Purchase, administer and oversee insurance programs

Required State (CDPHE)-Reportable Events:

Unexplained or suspicious deaths	<i>Alleged</i> physical, sexual or verbal abuse of a patient by another patient, staff or visitor
Brain or spinal cord injury	Neglect
Life-threatening anesthesia or transfusion reactions	Misappropriated Property
Missing “At-Risk” or AWOL patient	Diverted Drugs
Burns	Malfunction of Equipment

- Must be reported to Denver Health Risk Management AND the SI System ASAP
- Must be reported to the ***State*** within one (1) business day



Risk Management: Your Phone-A-Friend

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Thank You
For Taking Exceptional
Care of Patients!!