Medical Record Documentation and Legal Aspects Appropriate to Nursing Assistants
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2 In-Service Hours

Course Objectives:

1. Describe four forms commonly used in documentation

2. Understand legal aspects of documentation

3. Define documentation and identify its importance

4. Understand reasons for careful documentation

5. Describe guidelines for documentation
Introduction

It is important to remember the basics for good documentation to protect yourself legally and to be able to provide good care to your patients. Cover all your bases, and think about the policies that are lined up to protect your facility the patient and yourself, your daily routines. Remember that what you write today can save you and your career in the future, should the record end up in a court room. You won’t have anything to worry about because you covered yourself.

Keep in mind, whether your facility uses narrative charting or the more modern documentation systems on a computer, you need to document your actions expertly. By following these tips and guidelines, you will be well on your way to protecting yourself legally and provide the best possible care to your patients.

What Is Documentation?

Documentation material provides officials information or that serves as a record. Documentation is the written account of observations, the information the client, resident or family relates or states, the data you collect during the care you provide to the patient.

A medical record is a collection of information about the person you are caring for. It is a legal and confidential record with important information related to the care provided.
We have heard it said over and over again, “If you did not document it, it was not done”.

A medical record is the patient’s history, of all care that is provided. If it is not recorded, it did not happen. If it is recorded incorrectly it happened incorrectly. As a health official you don’t want to be the indivial trying to explain something that didn’t happen. This is why it is so important to be accurate when documenting.

Four most commonly used forms with particular importance are:

1. Nurse’s progress notes
2. Graphic sheet for vital signs
3. Care plans
4. Activities of daily living sheets by CNA’s

The most important data is collected through these forms. There is no room for error on these documents. This is not to say that the rest of the chart is not equally as important, as the whole record is vital. These forms are particularly important because the information they contain history that lead up to what was done (or not done) for the patient.
Legal Implications

Documentation provides important legal protection. Admissible in court, the patient's medical record must be documented in an accurate, complete, systematic, logical, concise, and timely manner. Courts will view the documentation in the medical record as proof and verification to patient care. By showing that the individual under your care received quality, an equal care, a well documented record can, and will most likely protect you legally.

The medical record is a legal document. It is also regarded as highly confidential, especially in light of the new HIPAA regulations. In the event of a medical malpractice case, the medical record may be used to provide the court with evidence about a patient’s condition and treatments. In a malpractice case, the jurors usually see the medical record as the best evidence of what really happened. For this reason, all documentation should be neatly written. Not legible handwriting is handwriting that cannot be read or understood by others. This would account for sloppy writing, and often misspelled words and poor grammar. Not legible or poorly written documentation makes you look careless and distracted. Take the time to write neat and clear. Avoid words that are unnecessary or very long. If you don’t know the definition to a word dont write it. When you abbreviate, make sure it is a standard abbreviation, not one that you invented with no possibility of having more than one meaning.
Don’t whit out anything on a medical chart. Draw one line through it and indicate “error”, and make sure you initial it.

NOTE: if you didn’t write on the chart, you didn’t do it. Also, do not document care provided by someone else. If there is a problem, you will be held liable.

**Proper charting**

1. Check to be sure you have the correct chart before you begin writing
2. Make sure your documentation reflects the nursing process and your professional capabilities.
3. Write LEGIBLY
4. Use a permanent black ink pen (other colors do not Xerox well) there not professional
5. Chart completely
6. Be concise and accurate
7. Give yourself enough time to chart each entry
9. Chart precautions or preventative measures, (Such as use of side rails)
10. Include the following for procedures: what was done, when it was done, who did it, how it was done, how the client tolerated it, adverse reactions, if any. Paint a clear picture of what happens.
11. Record each phone call to or from a physician, including exact time,
message, and response. Protect your self

12. Chart when a doctor makes a visit, and if there are any new orders.

13. Chart as soon as possible after providing care. For best accuracy

14. Chart a client’s refusal of treatment or medications.

15. Chart client’s subjective data (What he says and how he says it) use quotations if necessary.

16. If you remember something important after you have completed your documentation, write “late entry” and make the note. Be very accurate

17. If information on a flow sheet does not pertain to your patient, write N/A for not applicable, leaving it blank appears that it was not addressed or an oversight.

18. Make sure that each page has the patients name on it. Just last name is not acceptable, as it could become misplaced, and posted on the wrong chart of someone else with the same last name. The caregiver becomes liable for that

These good rules of charting are a good start to successful documentation.

The do not of charting are very important also:

1. Don’t chart a symptom such as “c/o Pain” without also writing what you did about it. Without out it looks like you left them in pain, didn’t help them.

2. Don’t alter a chart, this is a criminal offense. Consequences are severe
3. Don’t add information at a later date without indicating that you did so.

4. Don’t date the entry so that it appears to have been written at an earlier time, that will be considered forgery.

5. Don’t use shorthand or abbreviations that are not standard.

6. Don’t write short descriptions that don’t explain much, such as “large amount of drainage”

7. Don’t make excuses, such as “meds not given because not available.” make caregiver look incompetent

8. Don’t chart what someone else says unless you use quotations and state who said it.

9. Don’t chart an opinion. Facts are only allowed.

10. Don’t use words that suggest a negative attitude, such as “weird” or “nasty”

11. Don’t chart ahead of time. If something happens it will look bad to go back and make that correction. Looks like something illegal happen. Or there is some kind of cover up

12. Misspelled words and bad grammar are as bad as illegible handwriting. If another caregiver can’t understand it can progress to a bigger problem.

13. Don’t record staffing problems.
14. Don’t document that an incident report was completed.

15. Don’t record staff conflicts, staff problems are facility issues not patients.

Charting care that was not given is fraud. It is punishable by the Board Of Nursing and can land you in court, or put your license in jeopardy.

If you mistake just draw a line through it and place proper wording. Happy faces and childish words are unprofessional look inappropriate and health official can get in trouble for it. This is unprofessional and inappropriate.

Don’t leave any blank spaces. Never save a space for a colleague who forgot to chart. You might just be trying to protect them, but it will lead to you in trouble.

To avoid litigation, healthcare professionals must document according to State and Federal Legislation. Remember it’s the law.

Nurses are also mandated by their state’s nurse practice act to document appropriately.

Avoid block charting, such as 0700-1500, this makes it very difficult to pinpoint a time that anything was done on the shift.
Types of charting

Regardless of the system of charting you use, it must include the nursing process as a guideline.
1. Assessment
2. Planning
3. Implementation
4. Evaluation

Assessment includes watching the patient for signs and symptoms that may indicate actual or potential problems.

Planning includes putting together a plan of care directed at preventing, or resolving identified client problems or issues.

Implementation (or intervention) of the plan that has been developed includes the specific action that the nurse needs to take to accomplish the plan.

Evaluation shows whether or not the goal was met in identifying if the plan of care was effective in preventing, or resolving the problem.
Narrative charting

The nurse documents in chronological order the events that took place throughout the shift. Narrative charting takes a lot of time so make certain your notes are legible and clear to understand by all who reads them. A note should be made at least every two hours.

SOAP Notes

This method is preferred by many nurses. It stands for Subjective data, Objective data, Assessment, and Plan. Sometimes it can be referred to as SOAPIE or SOAPIER, in which the “I” indicates implementation and “E” indicated Evaluation. When an “R” is included, this indicates Revision.

APIE

More commonly known as “Pie Charting”

Assessment, Plan, Intervention (or implementation), and Evaluation, It is more concise in the aspect that the nurse will indicate subjective and objective data in the assessment section, what will be done in the plan, the intervention and the outcome. As it follows through in A, P, I, E format.

Flow Sheets

Flow sheets also known as graphic sheets or graphic records. These are a quick way to document. They need to be used carefully, as some areas do not
apply to all patients. Avoid leaving any boxes unmarked, and individualize it to meet your patient’s needs.

**Focus Charting**

The term focus was developed to encourage the nurse to view the client's status from a positive perspective rather than a negative perspective. The system uses three columns to indicate date/time, focus, and progress note. The progress note portion includes DAR (date, time, response)

<table>
<thead>
<tr>
<th>Date/time</th>
<th>focus</th>
<th>progress note</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date:
Action:
Response:

**Charting by exception**

Charting by exception also known as CBE is a system of charting in which only significant information, findings, or exceptions are documented.

No matter which method you prefer, or your facility uses, make sure that the content is addressing the proper dos and don’ts for charting.
Care Plans

Most care plan formats have three columns, one for the nursing diagnosis, one for the interventions, and one for the expected outcome. The nurse must develop a care plan for each client usually within a specified period of time after the client arrives to the facility. They are generally initiated upon admission.

Standardized care plans are preprinted care plans to help save time for the nurse. They must be individualized to fit the needs of each patient separately and individually.

Critical pathways or health care maps are usually preprinted care plans. They include nursing actions for a client with a specific medical diagnosis. The specify care that should be given on a daily basis including, but not limited to diet, medications, activity, treatments, ect. Pathways are popular with managed care becoming about more and more.

Kardexes

Kardexes are useful, but need to be looked at and up to date to be of any value. The card system is available to all staff that needs information at a glance to what is important with the patient. The cards are written in pencil so they can be updated appropriately and easily.
Things to Remember

We have learned a lot about proper documentation. Here are a few other things to consider:

The following mistakes can cause legal problems:

- Accuracy of documentation
- Documentation not fully completed
- Failure to record prevention efforts
- Particularly falls, side rails, call bells in reach, restraints (if used), smoking and any other potential for injury
- Failure to record treatments and care
- Failure to record refusal of care
- Failure to record families refusal to accept care provided to patient
- Incomplete incident reports (do not note incident reports in a chart)
- Meddling with a medical record
- Failure to record client’s failure to follow orders, noncompliance

Reimbursement

Another very important aspect of charting is related to reimbursement. In health care, sometimes private insurance and Medicare will deny payment if documentation is not satisfactory or is not done at all. This means that Insurance Companies, Medicare, and Medicaid pay the facility in reimbursement for care provided, which in turn pays salaries and supply
costs. Payment can be denied if documentation is missing or incomplete
from the chart. The importance of good documentation, charting vital
information, and patient status is essential for reimbursement in many cases.

**Reasons for Careful Documentation**

1. Documentation gives written evidence of care given, the patient’s
   response, and the effect of the care.
2. Documentation plans for the future care and changes in plan of care so
   all members can be kept current.
3. Documentation serves as a communication tool. When you document,
   remember that you're responsible for noting what was done, and
   observed.
4. Documentation is legal, and reimbursement is often dependant on the
   notes that are written. If it can’t be understand, no reimbursement
5. Documentation allows for continuity of care and focuses on clients
   needs and goals from all those involved in their care.
6. If the chart goes to court, you will most likely go to court too.

References:
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