Charting and Documentation:
Know Your Professional Responsibility While Keeping Your Nursing License Safe

NYSNA Continuing Education

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How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

   Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. At this point, you should print the certificate and keep it for your records.

Course Introduction

How many times have you heard, “If it’s not charted, it didn’t happen?” Since our earliest days as student nurses we have been told by instructors and later by nursing supervisors and our facility’s risk management departments and attorneys that documentation in the medical/health record is critical, both for good patient care and for liability reduction.

Nursing documentation has come under greater scrutiny as more groups use these records for reimbursement, malpractice evidence, quality assurance, professional review audits and nursing research. Would your documentation withstand scrutiny?

Course Objectives

At the completion of this learning activity the learner will be able to:

- Discuss the purpose of documentation in the patient record.
- Describe factors that impact on documentation.
- Identify regulatory agencies that determine documentation requirements.
- Apply the American Nurses Association's Principles of Documentation.
- Discuss the "who, what, when, where, why and how" of nursing documentation.

About the Author

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What is the Purpose of Healthcare Documentation?

Why all this emphasis on documentation? Why can't we, as nurses, just provide care for our patients without having the burden of "paperwork"? We often think that if we had less documentation to complete, we would have more time for nursing care. While there may be considerable truth to that thought, and documentation may be able to be reduced, we also recognize the need for a record of the care that has been accomplished (the burden of paperwork will be discussed in a later section of this course).

There are a number of purposes that the medical record or the healthcare record serves. It:

- Provides a complete and accurate record of the planning of care and the treatment provided to a particular patient.
- Provides a means of communication between the treatment team members for planning and orchestrating care.
- Meets criteria for facility/agency accreditation by federal, state and private credentialing groups.
- Serves as a vital component of assessment activities.
- Provides documentation which can support reimbursement to the facility/agency for the patient's care.
- Constitutes an important legal document that may be used as evidence in a lawsuit.
- Provides information to those involved in multiple other activities such as credentialing, education, research, worker's compensation, etc.
- Provides information that can be used during an investigation by the New York State Education Department, Office of Professional Discipline in any charge of professional misconduct.
- Provides information that can be used during an investigation by the New York State Department of Health in any charges of patient harm/questionable practice in facilities they oversee.

NOTE: Throughout this course, New York State laws/regulations and entities governing licensees and facilities are discussed. This course is intended for users from any location. New York is used as an example, but your state/country has similar governing bodies, laws and regulations that you may wish to review.

Certainly, in today's fast-paced, hectic, and often chaotic, healthcare workplace there just does not seem to be enough time to provide the care needed, let alone the documentation of that care. However, it is important not to lose sight of why documentation is important.

Each patient is a unique individual, with unique needs. Meeting those needs requires the use of the nursing process:

- Assessment - collecting the data.
- Diagnosis - identifying the problems and needs.
- Planning - identification of what is needed to resolve the patient's problems or meet the patient's needs.
- Intervention – identifying what specifically is being done for, and to the patient to meet the needs.
- Evaluation – identifying/evaluating patient outcomes.

It is important for nurses, regardless of the state of the healthcare system, to remember that each patient requires and deserves the full benefit of nursing care; this includes documentation. The Joint Commission Resources (2002) refers to clinicians as the architects and the documentation, as the "blueprints." Nurses must remember, that in providing good nursing care to patients, the entire story of that patient's care must be told in the medical/health record. Implementation and documentation of the nursing process allows for a complete patient "story," or "blueprint" to be recorded.

Common Documentation Problems

The following are identified as the most frequent documentation problems in hospitals (JCR, 2002):

- Written policies are not followed in practice.
- Practice is not documented.
- Practice is not documented correctly.
- Multiple policies regarding the same issue contradict each other and lead to confusion in practice.
- Staff does not receive adequate instruction about new policies, procedures and forms.
- All new policies and documentation forms are not disseminated to applicable settings for implementation.
- Out of date forms are still used in some areas of the facility.
- Handwritten documentation (for example, entries in medical records, medication orders) is illegible or incomplete.
- Abbreviations and corrections used in documentation do not conform to hospital policy (this will be addressed in detail below).
- Clinicians use forms from other facilities that do not correspond to the hospital's documentation requirements.
- Multiple charting methods are used with no instructions or labels.

Although the above relates to documentation problems in hospitals, many of these documentation problems occur in multiple practice settings.

Problem Abbreviations, Symbols and Acronyms

In 2005, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) affirmed its "do not use" list of abbreviations. This list was originally created in 2004 as one of their National Patient Safety Goals. Goal 2B required facilities to, "Standardize a list of abbreviations, acronyms and symbols that are not be used throughout the organization" (JCAHO, 2006).

This can be difficult for healthcare providers due to long traditions in healthcare documentation of the use of these items. These new documentation guidelines apply to all clinical documentation related to a specific patient, including progress notes, consultation reports, operative reports, order forms and documentation.

The following abbreviations in Table 1 should not be used in any of their forms. Upper and lower case formats and specific punctuation are not relevant in these new guidelines; this new list should be used. This "minimum" list includes those abbreviations, symbols and acronyms that JCAHO has determined to be entirely unacceptable.

Table 1. JCAHO's Abbreviations, Symbols and Acronyms That Should NEVER Be Used

Abbreviation/Acronym/Symbol	Potential problem	Solution
"U" (unit)	Can be mistaken as a zero or the number "4" or "cc".	Write out "unit"
IU (for International unit)	Can be mistaken for "IV" (Intravenous) or the number "10"	Write out "International Unit"
Q.D. or Q.O.D	Mistaken for each other; the "O" or the	Write out "daily" or "every other day"

	period can be mistaken for an "I", making it "QID" (four times daily)	
X.0 mg (trailing zero) or .X mg (lack of leading zero)	The decimal point can be overlooked.	Always use a zero before a decimal point (0.X mg); never write a single zero after a decimal point (X mg)
MS, MSO_4, $MgSO_4$	Mistaken for one another; can mean morphine sulfate or magnesium sulfate	Write out "morphine sulfate" or "magnesium sulfate"

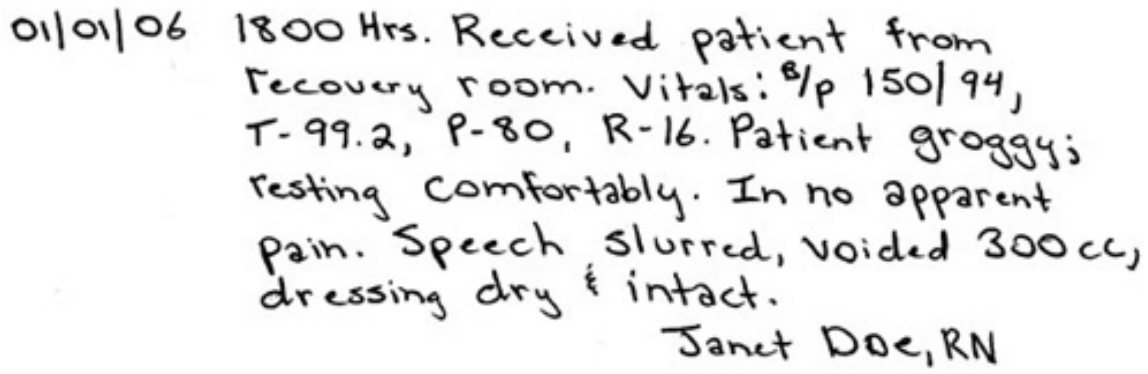
Table 2. JCAHO's "Do Not Use" List (JCAHO, 2004)

Abbreviation/Acronym/Symbol	Potential Problem	Preferred Term/Solution
µg (for micrograms)	Can be mistaken for "mg" (milligrams) leading to a critical overdose	Write "mcg"
H.S. (for half-strength or the Latin abbreviation for hour of sleep)	Can be mistaken for one another; Q HS can be mistaken for "every hour"	Write out "half-strength" or "hour of sleep" or "bedtime"
T.I.W. (for three times weekly)	Can be mistaken for "three times a day", or "twice weekly"	Write out "3 times weekly" or "Three times weekly"
S.C or S.Q. (for subcutaneous)	Can be mistaken for "SL" (sublingual); or "5 every"	Write "Sub-Q", "subQ" or "subcutaneously"
D/C (for discharge)	Can be mistaken for "discontinue …". (including the medications that follow, as in discharge medications)	Write out "discharge"
c.c. (for cubic centimeter)	Can be mistaken for "U" (units)	Write "ml" for milliliters
A.S., A.D, A.U. (Latin abbreviations for left ear, right ear and both ears); O.S., O.D., O.U. (Latin abbreviation for left eye, right eye and both eyes)	Mistaken for each other	Write out "left ear", "right ear", "both ears", "left eye", "right eye" or "both eyes" as applicable

Impact of Poor Documentation

Imagine being charged with negligence in a case that occurred five years ago. You try to think about the identified patient and the situation and you cannot recall the patient or this situation at all!

The only information available to you is the patient's medical/health record. Your note indicates that the surgery, a cholecystectomy, proceeded well, but the patient was having a slow recovery from anesthesia. Imagine that you are being sued for negligence because you did not recognize that instead of a slow recovery from anesthesia, this patient had actually suffered a cerebrovascular accident (CVA). The suit alleges that you were negligent in failing to recognize and to report significant changes in the patient's condition. Your progress note reads as follows.


01/01/06 1800 Hrs. Received patient from recovery room. Vitals: B/P 150/94, T-99.2, P-80, R-16. Patient groggy; resting comfortably. In no apparent pain. Speech slurred, voided 300 cc, dressing dry & intact.
Janet Doe, RN

Could you defend yourself given the limited information in this record?

The impact of poor documentation can be profound. Most of us don't remember all the details of one day, let alone what occurred five years ago! The medical/health record is often thought of as a "witness" to the delivery of patient care. An incomplete record reflects incomplete care.

Clearly there are legal ramifications of poor documentation. A registered nurse can be charged with professional misconduct by the Licensing Department in the state in which s/he is licensed. In New York State, the New York State Education Department, Office of Professional Discipline would investigate any charge of professional misconduct. One area of the investigation is review of the nurse's documentation.

Recent reports in the media have focused on the high incidence of medical errors that occur in healthcare settings. A frequent contributor to medical errors is poor documentation. Illegible writing leads to misinterpretation and confusion. High among medical errors are errors related to medication administration and documentation.

Additionally, a malpractice suit, charging the nurse with negligence can be filed by the patient's attorney. A well documented medical/health record can influence the plaintiff's attorney not to pursue a case; a medical/health record in which the documentation is lacking, conflictual, inaccurately corrected, or otherwise not complete can fuel a malpractice suit. Can your documentation stand up to such scrutiny?

Factors that Impact Documentation

Despite the importance of documentation, nursing documentation can fail to represent the care delivered or the patient's actual health status accurately (Taylor, 2003). Some factors that contribute to making documentation difficult for nurses are:

- The shortage of nurses at the bedside that requires nurses to work mandatory overtime;
- Longer hours subsequently limiting nurses by fatigue;
- The need for nurses to care for higher numbers of patients, making for hurried care and hurried documentation;
- Short lengths of stay resulting in more frequent admissions and discharges, thus resulting in more frequent assessments and paperwork;
- The overall high volume of documentation required by various regulatory and reimbursement agencies;
- Nurses' apathy toward documentation (Taylor, 2003);
- Discrepancies between nurse/patient and nurse/nurse interpretation of the significance of an event (Taylor, 2003);
- The nurses' literacy skills (Taylor, 2003).

The well-documented nursing shortage has placed a high stress on nurses at the bedside. This shortage of nurses relative to the number of patients, as well as the long hours worked, often on a mandatory basis, contributes to documentation shortcomings. Nurses are stressed by the amount of work, fatigued and overburdened with paperwork.

No one disputes the fact that documentation of a patient's condition, medications and treatments, nursing care and patient education are necessary. Requirements for paperwork documentation, even with computer technology, continue to grow. Often federal and state agencies require the same information to be collected on different forms. Also, when governmental or accrediting agencies identify shortfalls in care, often the solution is to require specific documentation to make sure that the care problem is addressed.

Professional nurses want to use their time to deliver patient care, not paperwork. It is estimated that 25% of acute care nurses' time is spent on paperwork (Smeltzer, 1996). In home care, as much as 60% of the nurses' time is spent in attending to paperwork, not patients (Braunstein, 1993). Nurses' time is money. If the average nurse's salary is $30,000/year, then $7,500 to $15,000 dollars per nurse per year is spent on documentation and paperwork. If nurses were not required to "shuffle paper", more time (2 to 4 hours per shift) could be spent on delivering patient care. A reduction in paperwork requirements would result in better quality of care through the efficiency gained and higher staff morale (Schneider, 1995).

A survey commissioned by the American Hospital Association (AHA) (2001) confirmed what nurses already know about the burden of paperwork. Researchers found that for every hour of nursing care in either inpatient or outpatient settings, between 30 to 60 minutes of mandatory paperwork are generated. The burden of paperwork varies depending on the healthcare setting:

- In emergency departments every hour of care generated 60 minutes of mandatory paperwork;
- In home health care every hour of care generated 48 minutes of mandatory paperwork;
- In surgical settings every hour of care generated 36 minutes of mandatory paperwork;
- In inpatient acute care settings every hour of care generated 36 minutes of mandatory paperwork;
- In a skilled nursing facility every hour of care generated 30 minutes of mandatory paperwork (Price Waterhouse Cooper, 2001).

In order to address this increasingly burdensome documentation situation, The American Nurses Association's (ANA) House of Delegates, in 2001, acting on a proposal by the New York State Nurses Association (NYSNA), requested that the ANA begin to examine and address ways to eliminate the documentation requirements that burden nurses and keep them from being able to provide direct patient

care. Activities are being suggested to identify, to legislators and regulators, the magnitude of the problem, to study and make recommendations regarding appropriate paperwork and to collaborate with federal and state government agencies and accrediting organizations to reduce unnecessary or duplicative documentation and paperwork.

The focus of documentation tends to be on the patient's physical body; it is reductionist in nature (Taylor, 2003). It does not necessarily reflect the care provided by nurses. Although nursing literature and education focus on the value of holistic nursing care, the non-physical care provided by nurses is often omitted when documenting. Taylor (2003) identifies the following areas that are sometimes omitted in the patient's record:

- Emotional needs;
- Expression of sexuality;
- Spiritual needs;
- Social needs;
- Communication difficulties, both verbal and non-verbal;
- Maintenance of dignity;
- Promotion of self.

In today's hectic healthcare environment, when human resources and time are scarce, documentation may not reflect the holistic care provided, but rather the documentation can be narrowly focused on the presenting problem. While nursing care is often about meeting the needs and providing the care listed above, it frequently is not documented in the record.

In a review of the nursing literature, Taylor (2003) examined nurses' attitudes toward documentation that may impair the quality of documentation. Some studies (Tapp, 1990; Korst, et al., 2003; Martin, et al., 1999) have found that nurses do not value the documentation process. They may view documentation as a separate distinct activity, and not part of the nursing process. Some of the research has also indicated that despite the perceived amount of time nurses spent in documenting, the actual quality of that documentation is less than comprehensive (Taylor, 2003).

Despite these multiple limitations on nurses' ability to document, as licensed professionals, nurses still have the legal responsibility to document. What and how you document can also help or hinder the safety of your nursing license.

Laws and Regulations That Impact Documentation

A number of regulatory groups have requirements for documentation. Some of these requirements are consistent among groups; others differ. Some of the agencies that regulate documentation are: New York State Department of Health (NYSDOH), The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and The Centers for Medicare/Medicaid Services (CMS) formerly the Healthcare Financing Administration (HCFA).

The Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit organization that sets standards and accredits healthcare organizations. JCAHO evaluates and accredits nearly 19,000 healthcare organizations and programs in the United States. JCAHO requires that care be based on a documented assessment of the patient's needs and that the assessment is a systematic collection and review of patient specific data gathered from all appropriate and available sources. Because the accreditation of a healthcare organization rests with its ability to meet JCAHO standards, and accreditation is closely tied to reimbursement for services, healthcare facilities must comply.

JCAHO's expectation is that the permanent nursing documentation in the medical/health record will include:

- Initial assessments and reassessments of physical, psychological, social, environmental, self-care, education and discharge planning factors;
- Nursing diagnoses and/or patient care needs;
- Planned nursing interventions or nursing standards identified to meet the patient's nursing care needs;
- The nursing care provided;
- The patient's response to interventions and the outcomes of the care provided;
- Discharge planning activities, including the ability of the patient and/or significant other to manage continuing care needs after discharge.

The US Department of Health and Human Services, Centers for Medicare and Medicaid (CMS)

The use of the Outcome and Assessment Information Set (OASIS) form, intended to identify quality outcomes in homecare, and required for reimbursement, has added greatly to the burden of paperwork in home care agencies.

New York State Department of Health

New York State's Hospital Code (405) for Nursing Services states

> "…written nursing care plans shall be kept current. Such plans shall indicate what nursing care is needed, how it is to be provided and the methods, approaches and mechanisms for ongoing modifications necessary to ensure the most effective and beneficial results for the patient. Patient education and patient/family knowledge of the care requirements shall be included in the nursing care plan."

The Hospital Code (405) for Medical Records states that

> "…medical records hall be legibly and accurately written, complete, properly filed and retained and accessible. The hospital shall use a system of author identification and record maintenance that ensures that integrity of the authentication and protects the security of all record entries."

Furthermore, it states that

> "…the medical record shall contain information to justify admission and continued hospitalization, support the diagnosis and describe the patient's progress and response to medications and

services. Also, upon completion of ordering or providing or evaluating patient care services, each such action shall be recorded and promptly entered in the patient medical record."

All documentation entries must be legible and complete and must be authenticated by the person completing such action. Authentication may include signatures, written initials or computer entry.

> "The hospital shall allow patients and other qualified persons to obtain access to their medical records and to add brief written statements which challenge the accuracy of the medical record documentation to become a permanent part of the medical record."

New York State Department of Health Requirements for Medical Records in the Hospital Setting

New York State law requires that the permanent hospital medical record include:

- A physical examination and health history at the time of admission;
- An admitting diagnosis;
- The results of all consultations and referrals made during the admission;
- Documentation of all complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia;
- Consent forms for all procedures and treatments;
- All practitioners' diagnostic and therapeutic orders, nursing documentation and care plans, reports of treatment, medication records, radiology and laboratory reports, vital signs and other monitoring information;
- A discharge summary with outcome of hospitalization, disposition of case and provisions for follow-up care;
- A final diagnosis;
- A physician's attestation sheet which states that the physician certifies the accuracy of the narrative descriptions of the principal and secondary diagnoses and the major procedures to the best of the physician's knowledge.

New York State Department of Health Requirements for Medical Records in the Nursing Home Setting

NYSDOH requires that nursing homes maintain clinical records for each resident in accordance with accepted professional standards and practice. The records must be:

- Complete;
- Accurately documented;
- Readily accessible;
- Systemically organized.

Additionally, the nursing home is to permit each resident to inspect and obtain copies of his or her medical/health record.

NYSDOH also requires that clinical records contain:

- Sufficient information to identify the resident;
- A record of the resident's comprehensive assessments;
- The plan of care and services provided;
- The results of any preadmission screening conducted by the state;
- Progress notes by all practitioners and professional staff caring for the resident;
- Reports of all diagnostic tests and results of treatments and procedures ordered for the resident.

New York State Department of Health Requirements for Home Care Agencies

Home care agencies (Article 36) are required to have a plan of care for the patient. The care the patient receives must be in accordance with a comprehensive plan of care developed by all appropriate disciplines, the patient, the patient's family and the patient's physician.

The patient record in home care agencies must include:

- Identifying data;
- Physician's orders;
- Nursing assessments conducted to provide services;
- A plan of care revised as necessary to reflect changing care needs;
- Signed and dated progress notes following each patient visit or telephone contact, including a summary of patient status and response to plan of care and any contacts with family;
- Informal supports and other community resources;
- Supervisory reports of the registered professional nurse or the therapist and if applicable, home health aide/personal care aide;
- Observations and reports made to professional staff by aides;
- Documentation of accidents and incidents;
- Documentation of the patient's receipt of information regarding rights;
- A discharge summary and recommendations and referral for any follow-up care.

The Nurse Practice Act

Each state licenses nurses to practice based on the laws of that state. The laws related to the practice of nursing in New York State are found in New York State Education Law, Article 139. Included in this section of the law is the requirement for documentation. It is considered unprofessional conduct if a nurse fails to maintain a record for each patient that accurately reflects the evaluation and treatment of the patient. A nurse can be charged with professional misconduct because of documentation failures and an investigation from the State Education Department's Office of Professional Discipline can result.

Additionally, all patient records must be retained for at least six years and obstetrical records and records of minor children for at least six years or until one year after the minor patient reaches the age of 21.

In New York State, the legal signature is the one that appears on the registered professional nurse license/registration.

The Health Insurance Portability and Accountability Act

The federal government instituted the Health Insurance Portability and Accountability Act (HIPAA) in 2003. The law was intended to insure that protected health information remains private. HIPAA privacy regulations are minimum standards; they do not override any other federal or state laws that are more restrictive, for example laws related to the disclosure of Human Immunodeficiency Virus (HIV) or mental health issues.

HIPAA requires that protected health information, such as all individually identifiable health information related to a person's past, present or future physical or mental health condition, provision of healthcare to the person, or payment for healthcare for the person, not be disclosed without the patient's consent. Protected health information includes information maintained in oral, written, or electronic form, including names, social security numbers, birth date as well as medical condition.

Healthcare organizations such as hospitals, are bound by this law. Nurses employed by a hospital would be obligated to follow that institution's policy. Even nurses not directly employed by the institution, such as agency nurses, would likely be required by contract to abide by the policies of the institution in which they are working.

Standards Related to Documentation

In an ideal world, universal standards of documentation would be developed, nurses would learn these standards, apply them consistently in their practice, and every healthcare facility and organization would honor these same standards. Unfortunately, such universal standards do not exist. Additionally, specific documentation formats vary as well. However, despite the variety, there are commonalities among the various standards and formats related to documentation. (Documentation formats will be covered in a later section of this course).

American Nurses Association

The American Nurses Association (ANA), the national professional association for registered nurses, also addresses the issue of documentation. The ANA has several documents that directly provide guidance for nursing documentation: the *Nursing: Scope and Standards of Practice* (2004), *Code of Ethics for Nurses With Interpretive Statements* (2001b), and the ANA *Principles for Documentation* (2005).

The ANA *Nursing: Scope and Standards of Practice* (2004) includes the following relative to documentation:

- Relevant data are documented in a retrievable form;
- Diagnoses are documented in a manner that facilitates the determination of expected outcomes and plan of care;
- Outcomes are documented as measurable goals;
- The nursing plan of care is documented;
- Interventions and the patient's responses are documented;
- Revisions in diagnoses, outcomes and the plan of care are documented.

The ANA's *Code of Ethics for Nurses With Interpretive Statements* (2001b) states that:

> "The standard of nursing practice and the nurse's responsibility to provide quality care require that relevant data be shared with those members of the health care team who have a need to know" (ANA, p. 12).

The driving force for ANA *Principles for Documentation* (2005) is the following policy statements:

- The registered nurse is responsible and accountable for documentation.
- The *Nursing: Scope and Standards of Practice* (2004) should guide the nurse in addressing issues of documentation.
- Relevant clinical data should be collected in an efficient and retrievable format with every effort made to decrease unnecessary and duplicative paperwork.
- The promotion of efficient documentation systems is just one critical effort to improving the work environment. Efforts to reduce duplicative paperwork, while important, should not supercede other strategies that are critical in improving the work environment.
- Staff nurse involvement in decision making is crucial to preventing duplicate documentation, while ensuring quality of care and clinical documentation.

The *ANA Principles for Documentation* (2005) supports statements in the *Nursing: Scope and Standards of Practice (2004)* and the *ANA Code of Ethics for Nurses With Interpretive Statements* (2001b); it identifies documentation as an essential component of nursing practice. The Principles are:

1. Unique patient identification must be assured within and across paper-based and electronic healthcare documentation systems.

2. Documentation systems must assure the security and confidentiality of patient information.

3. Documentation must be:

    - Accurate and consistent;
    - Clear, concise and complete, reflecting patient response and outcomes related to nursing care received;
    - Timely and sequential;
    - Retrievable on a permanent basis in a nursing-specific manner;
    - Able to be audited.

4. Documentation must meet existing standards such as those promulgated by state and federal regulatory agencies (to include HIPAA, the Healthcare Insurance Portability Act as enforced through the Department of Justice), The Centers for Medicare and Medicaid Services (CMS), and through accrediting organization such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA).

5. Entries into the medical record (including orders) must be legible, complete and authenticated and dated by the person responsible for ordering, providing, or evaluating the care provided.

6. Abbreviations, acronyms, and symbols utilized in documentation must be standardized.

7. The nurse must be familiar with organizational policies and/or procedures related to documentation.

8. Several terminologies have been recognized by ANA which specify the domain of nursing and contain terms used in the planning, delivery, and evaluation of the nursing care of the patient or client in diverse settings. An ANA-recognized terminology should be employed in documentation so that data can be aggregated. However, in instances where clinicians are using electronic information systems and structured data linked to a reference terminology, the use of an ANA recognized terminology at the interface may be unnecessary.

Reimbursement for Nursing Services

In order for facilities/agencies/practices to be reimbursed for nursing services, certain criteria must be met. Insurance companies, managed care entities and CMS require that their own criteria be met in order for there to be reimbursement for care. These documentation criteria vary from organization to organization and can change over time.

Employer Requirements for Documentation

Healthcare facilities and healthcare employers also have documentation requirements. These requirements are laid out in each organization's specific policies. Policies regarding documentation should state:

- Who may document;
- What must be documented;
- Frequency of documentation;
- Format for documentation;
- Permitted abbreviations;
- Specific forms that must be utilized.

These policies insure that there is internal consistency regarding the format of documentation. Nurses must be familiar with the policies of the organization in which they are employed. Failure to comply with facility policies can put the nurse's employment in that facility in jeopardy.

Documentation Formats

Styles of documentation change over time and vary from agency to agency. A variety of different formats are possible. Although the formats vary, they should all be consistent with the ANA *Principles for Documentation*, as well as the standards of the previously mentioned ANA *Principles of Documentation*. Specific formats should:

- Establish common terminology and abbreviations across all forms;
- Not duplicate information from form to form;
- Be consistent, without contradiction;
- Promote current, timely charting.

A variety of documentation formats exist. Among them are:

- Flow Charts. These generally include information that is monitored over time. It provides a quick method for evaluating the patient's status at one point in time compared to another point in time. This can include records that document intake and output, weights, vital signs, what care has been provided, etc.

- Computerized records. The computer is used to generate an assessment of the patient, add to the database, develop plans of care and record the interventions as well as patient responses to the interventions. This documentation can all occur at the bedside; this method has become increasingly more popular.

- Narrative notes. These are notes in narrative form that address routine care, normal findings as well as the status of identified problems, interventions and the patient's responses. These notes are generally written in chronological order.

- Problem Oriented Medical Record. Developed by Dr. Lawrence Weed in the 1960s, this approach organizes the record, the planning of care and the progress of the care around a multidisciplinary problem list; narrative notes then address specific problems on the list. This approach utilizes the SOAP format for documentation in the progress notes; S= subjective data, O=objective data, A=assessment and P=plan.

- PIE (Problem-Intervention-Evaluation) Charting. This system does not develop a separate plan of care; rather it is incorporated into the progress notes. Each patient is assessed each shift, problems that are identified in the assessment are identified by number and are addressed in the note.

- Multi-disciplinary team notes. The narrative notes are continuous in a chronological fashion, with all disciplines charting on the same progress notes.

- Source-oriented record. Each discipline has its own section within the chart. Nurses, physicians, laboratory personnel each document, generally in a narrative fashion, but it can also be in a flow chart, in their respective section of the medical record.

- Charting by Exception. Well-defined standards of practice are utilized to plan care. Written standards identify basic nursing care and provide protocols for intervening. Generally multiple flow charts are used to track trends. Only significant finding or exceptions are documented in narrative notes. This format is considered to decrease charting time; the emphasis of documentation is on significant data. Charting can be accomplished at the bedside, resulting in more timely, frequent, better communication among various healthcare disciplines and lower costs. This type of documentation requires significant adjustment for nurses who are used to documenting routine care; comprehensive training on the standards of practice and protocols is needed (Simpson-Brooke, 2004).

Documentation Principles

The principles of charting have not changed much over the years. Eggland (1993) identified three critical documentation points:

- Be accurate
- Be concise
- Be complete

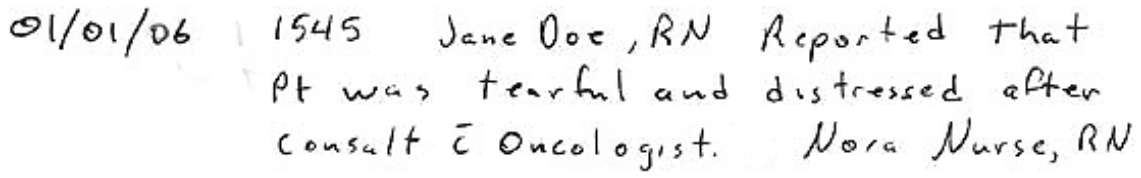
These principles are consistent with the ANA *Principles of Documentation* #3: "Documentation must be accurate and consistent; clear, concise and complete, reflecting patient response and outcomes related to nursing care received; timely and sequential; retrievable on a permanent basis in a nursing-specific manner; and able to be audited".

Documenting in the healthcare record requires that the nurse utilize the "rules" of any good written material. This includes:

- Who
- What
- When
- Where
- Why
- How

<u>Who</u>

The ANA *Principles of Documentation* #5: "Entries into the medical record (including orders) must be legible, complete and authenticated and dated by the person responsible for ordering, providing or evaluating the care provided" is relevant to the "Who" aspect of documentation. The licensed individual, who is observing ordering, providing, and evaluating the care of the patient, should document. Never document or complete notes for another nurse or other healthcare provider. Delegation of charting destroys the credibility and value of the record both in the facility and in court. If necessary, the nurse who received information from another healthcare provider, can document as follows:

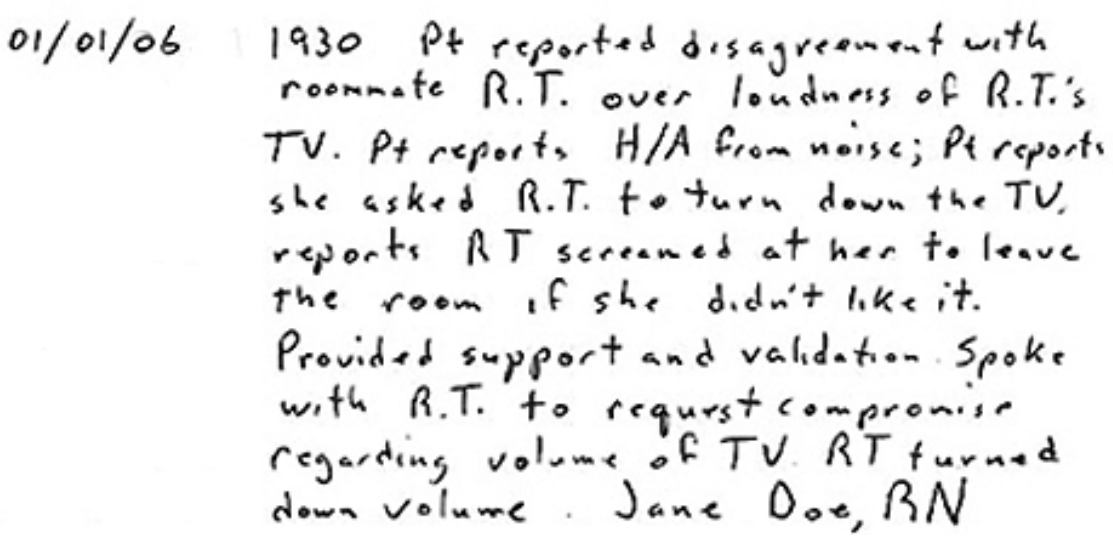


In some facilities, nurse aides are permitted to chart. Generally this occurs after education relative to documentation and only within the nurse aide role and responsibilities. Make sure to know and follow the facility policies and procedures relative to who is allowed to chart, and in which section of the record, if applicable. The ANA *Principles of Documentation* #7: "The nurse must be familiar with organizational policies and/or procedures related to documentation" is relevant to the above.

Sometimes, nurses receive information about the patient from a source other than the patient or other healthcare providers. Always make sure to identify the sources of information, such as the patient's significant other, spouse or child.

When documenting in a patient's record, never identify another patient by name. Naming another patient violates that patient's confidentiality. ANA *Principles of Documentation* #2 states that "Documentation systems must assure the security and confidentiality of patient information". If it is necessary to make a reference to the other patient, refer to that patient as "roommate", or utilize initials, or room and bed

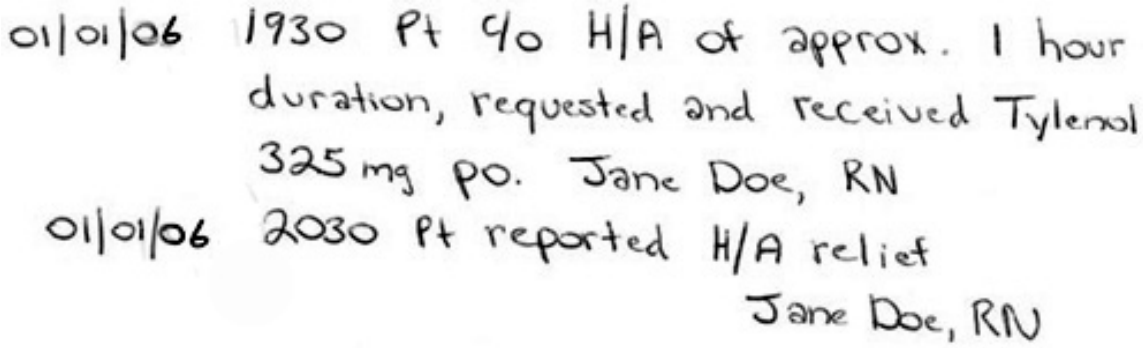
number, if necessary. For example, if the patient and the roommate got into a verbal argument that escalated and you, as the RN, intervened you might document as follows:



What

Document the patient's needs, concerns and chief complaint. Observations and changes in condition must be recorded; any significant events or situations. Based on the New York State Nurse Practice Act, it is the registered nurse who completes assessments; licensed practical nurses contribute by collecting data. Interventions provided, actions taken, care given, instructions and education provided must be documented. The patient's response to these interventions must also be documented. All appropriate blanks on a record must be filled in; boxes must be checked. Blanks give the impression that the care was not delivered. The ANA *Principles of Documentation* #5 states that "Entries into the medical record (including orders) must be legible, complete, and authenticated and dated by the person responsible for ordering, providing or evaluating the care provided."

For example: As above, Ms. K complains of a headache. You, as the registered nurse, ask about the nature and duration of the pain, then check her record to make sure that something has been ordered by the physician or nurse practitioner. She has been ordered Tylenol 325 mg q 4-6 hours PRN for pain. You give her the Tylenol and sign for the medication in the medication record. After approximately ½ hour, you return to the patient to follow-up on the status of her pain. She tells you that it's been relieved. Your documentation in the patient's healthcare record might be as follows:



Another important "**What**" relates to the content of what is documented. As above, documentation should be related to the patient's condition or chief complaint. An important component of **"What**" is documentation of any evidence of patient non-adherence to, or refusals of treatment recommendations.

The ANA *Principles of Documentation* #3 states that “Documentation must be accurate and consistent; clear, concise and complete, reflecting patient response and outcomes related to nursing care received; timely and sequential; retrievable on a permanent basis in a nursing-specific manner; able to be audited”. The above example illustrates this principle.

Should patients or family members have concerns or complaints, these should be documented as well. All follow-up actions, that the nurse or other healthcare provider takes, must be documented.

It is not appropriate to record staff conflicts in the patient record. Disputes among staff, questions about another’s actions or behaviors are not legitimate patient care concerns and do not belong in the patient record.

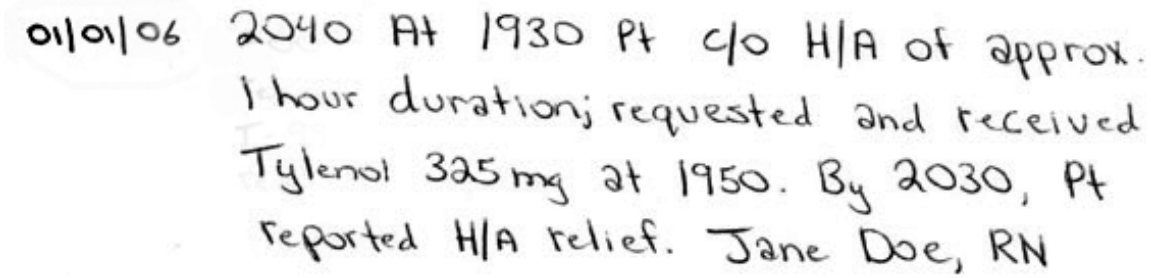
Staffing problems also do not belong in the patient record. Utilize your facility's policy for handling staffing concerns. Frequently, the nurse is required to put her or his protest and objections about working short-staffed in writing. You can document your concerns in a memo or utilize a "Protest of Assignment Form" (this is an example of such a form, utilized in facilities where NYSNA represents nurses for collective bargaining). See Appendix A for a copy of this form.

While documenting in a patient record, do not mention an incident or event report. Facilities have special forms or methods for documenting incidents. These reports are confidential and are handled differently than the medical record. The incident/event report is an internal document and is used by the facility administration to correct, improve and/or defend practices.

<u>When</u>

The general rule of thumb is to document as soon as possible after the event. While this is not always possible, the closer to the time of occurrence, the greater is your ability to recollect the situation accurately. The frequency for some types of documentation is generally dictated by facility policy/procedures or protocols. The ANA *Principles of Documentation* #3 addresses timeliness and the sequential nature of documentation. Timeliness of entries is a major issue in malpractice suits, so document as soon as possible after an observation or action is taken. It is important **never** to document in advance.

For example: Utilizing the scenario above under "**What**", the entry may be dated and timed for 1/01/03 2035 but the text of both entries in the example above may be combined into a single entry.

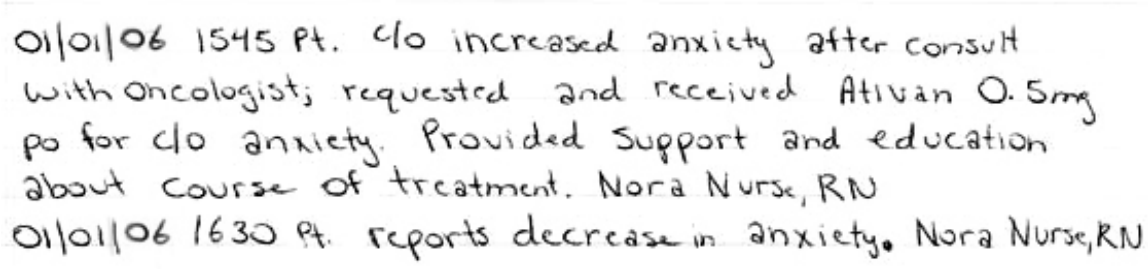

01/01/06 2040 At 1930 Pt c/o H/A of approx. 1 hour duration; requested and received Tylenol 325 mg at 1950. By 2030, Pt reported H/A relief. Jane Doe, RN

<u>Where</u>

Different forms and sections of the record contain differing information. Where to document the patient information is generally dictated by facility policy, or by regulatory bodies. For example, in many facilities vital signs are placed on a graphic record. Vital signs in the narrative notes generally occur only when they are not within normal limits and then are addressed because some intervention was taken. Another example is that in long-term care settings, the Minimum Data Set (MDS) is utilized to record and update specific patient information. The ANA *Principles of Documentation* #7, as stated previously, supports that “The nurse must be familiar with organizational policies and/or procedures related to documentation.”

Why

In a previous section of this course, the reasons why documentation is necessary were covered. In this section, the "**why**" relates to assessments or clinical judgments. This is consistent with the ANA *Principles of Documentation* #3 and #5 which have been identified and discussed previously.


01/01/06 1545 Pt. c/o increased anxiety after consult with oncologist; requested and received Ativan 0.5mg po for c/o anxiety. Provided support and education about course of treatment. Nora Nurse, RN
01/01/06 1630 Pt. reports decrease in anxiety. Nora Nurse, RN

How

This relates to the specifics of charting, including basic good documentation guidelines. Many of the guidelines presented here are consistent with the ANA *Principles of Documentation*, particularly those that relate to legibility of handwriting (#5), following facility policies and procedure (#7), documentation provided by those who are responsible for ordering, providing or evaluating the care provided to patients (#5), the permanence and retrievability of the medical record (#3), and use of abbreviations and symbols (#6):

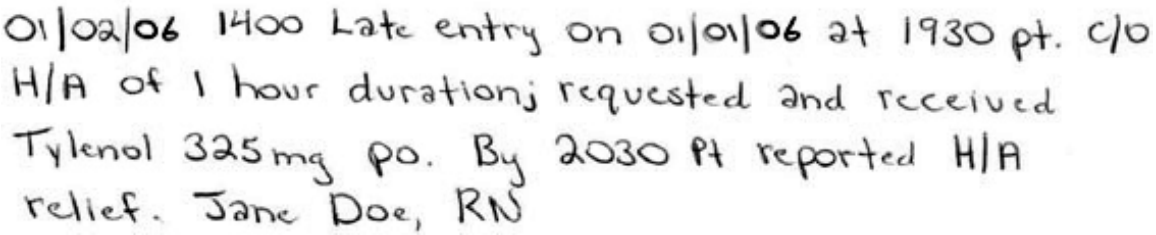
- Make sure that your handwriting is legible. Errors can occur because of misinterpretation of handwriting.
- Do not use the "dangerous" abbreviations that have been identified in JCAHO's 2004 Patient Safety Goals. They were discussed earlier in this course (see Tables 1 and 2). Utilize only approved abbreviations; know your facility's policies.
- Utilize blue or black ink. This is often dictated by facility policy or procedures. However, even if not dictated by policy, use of these colors allow for better quality of copies.
- Provide facts and supporting information for any assessments or clinical judgments.
- Document the range of care provided to patients, including emotional and spiritual care; do not focus solely on the physical care.
- When recording what a patient or family member has said, utilize quotation marks around their comments to identify that it is a quote.
- Avoid using defensive, argumentative, blaming and vague language. Be specific, but neutral in tone.
- Avoid labeling; instead describe the patient's behavior. Use neutral language; eliminate bias and confusion. For example, avoid the following "Patient agitated in a.m.". What does "agitated" mean? Why did this occur? Was there a precipitant? Agitation is a broad term that can easily be interpreted in multiple ways, depending on the perspective of the reader. Instead you might chart, "While turning the patient during am care, patient complained of pain and shouted, "Stop hurting me!" She was tearful and anxious and flailed her arms, striking out without making physical contact. Reassurance provided; after positioning, patient reported that she was comfortable."
- Keep the record intact. Don't leave space in order to chart later. Don't remove pages. Even if coffee is spilled on the page, let it dry; recopy only if no longer legible; explain the need for the recopying. Follow facility policy/procedure.
- Use correct grammar and spelling.

Although the ANA *Principles of Documentation* address the timeliness, sequential nature, accuracy, consistency, clarity, and completeness of documentation, there are occasions when documentation does not occur in this ideal way. An important "**How**" relates to additions, corrections, out of sequence, and

adverse incidents/events documentation. Most healthcare facilities have policies related to these situations. As is consistent with the ANA *Principles of Documentation*, be sure to check your facility's policies; however the following are generally acceptable procedures:

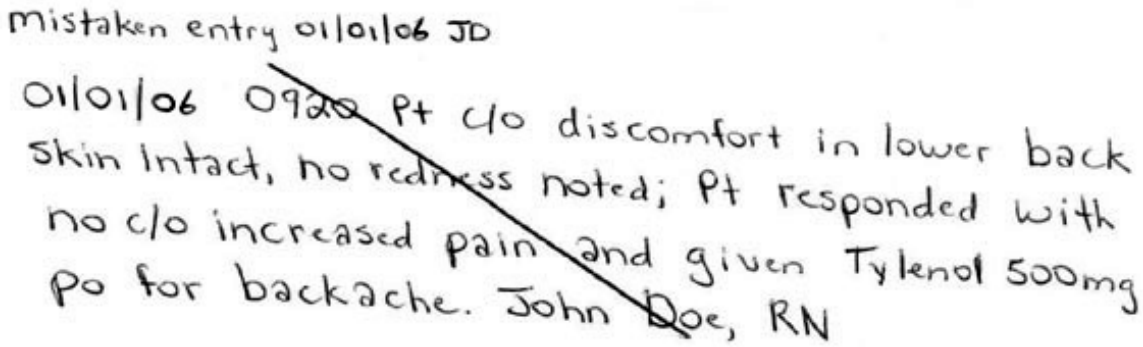
- Additions - Most facilities have a policy for inclusion of additional information; it is important to follow the policy and procedure at your facility. Rather than attempting to "squeeze" the information between lines, write "late entry" or "addendum" and the date on which you are documenting. In the body of your note you should indicate the date and time for which your are now documenting.

  Do not leave blank spaces. Draw a line through the empty space of write N/A (not applicable) on flow sheets when appropriate. Do not request that other nurses leave "space" in the chart for you to do your documentation at a later date.

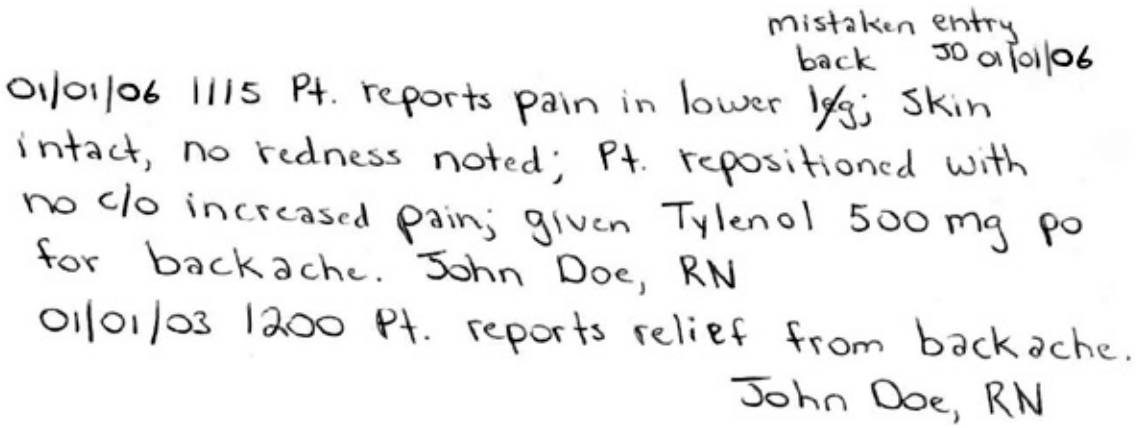


- Corrections – Correct mistakes promptly; never alter words or numbers after you've written them. Do not attempt to "squeeze" the information between lines or in margins.

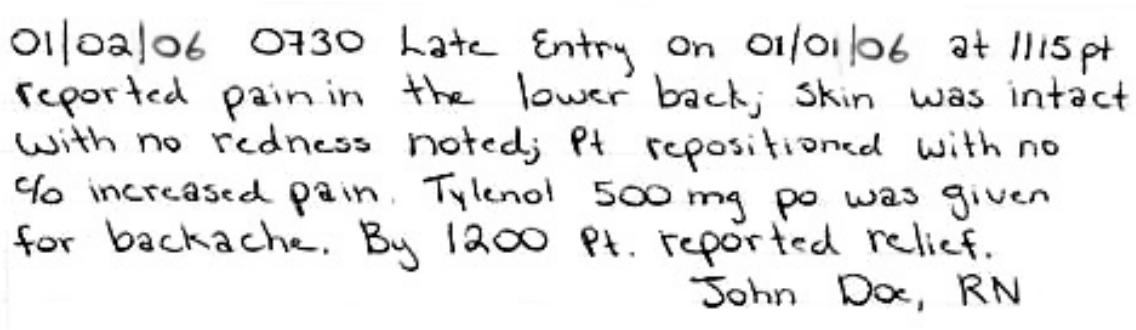
- Mistaken Entry or Wrong Chart – Incorrect information should be crossed out, generally using just a line across the information, so that the original information is still easily readable. Near the line, the nurse should provide the rationale for the correction. Write "mistaken entry" or "wrong patient entry" and include the date and her/his initials. Only the nurse who originally documented the erroneous information should correct the entry utilizing "mistaken entry" or "wrong patient entry". One should not alter another's documentation.



- Wrong information - Any erroneous information written in the correct chart needs to be identified as such. Do not obscure errors. It is never permissible to erase, "white-out" or thoroughly cross out so that the words cannot be read. Instead, the nurse should draw a line across the word or words that were written in error, again making sure that the words are still easily readable. In the past, the word "error" was written on the chart to indicate erroneous information. However, to avoid any misinterpretation of the word "error" as an error in the provision of care, the term "mistaken entry" is now more commonly used. The nurse should also add her/his initials and the date.



- Out of Sequence or Late Entries – At times the patient's record is unavailable for the nurse to chart; it may be with the patient at a diagnostic exam, for example. Or it may be that the nurse has merely forgotten to document on a particular patient, or that some part of the information was omitted when the note was originally charted. As soon as possible, add the late entry on the next available line of the progress notes; label it as "Late Entry" and then record the date and time that you are now documenting. Within the body of the note, indicate the date and time of the occurrence.



- Adverse Events/Incident Reporting – Use your facility's designated incident/event form to fully record the situation. These forms are usually dictated by the facility's malpractice insurance carrier. In the progress note section of the patient record indicate the date and time of the incident or event, then factually and specifically document the course of events. Only document what you personally witnessed or what the patient reported to you (use quotation marks when quoting another person). Be sure to include your clinical assessment, notification to physician or nursing supervisor, including the date, time, specific name and title of the person notified, any orders received, if none indicate that no new orders were received. Document notification to family members and include the date, time and names of persons notified. Do not indicate, in the progress notes, that an incident report was completed.

The Future of Documentation

As patient safety has become the forefront of discussions for facilities an effective continuum of care documentation model is being sought. Comprehensive treatment delivery systems that continuously monitor and assess outcomes improvement are being evaluated and incorporated into facilities across the world. According to Fernandez and Spragley (2004), this approach is possible with the following process changes:

- Strengthening the continuum: Educating the health care team regarding the organization's mission and vision, assisting the team to see how they fit in and making the change a collaborative effort.
- Order and organize forms: Keep them simple, user-friendly, non-repetitive and all-encompassing. Keep the number to a minimum and seek input from the team.
- Head off problems: Have the team determine the who, what, when, how, and why of documentation.
- Reassess regularly: Involve the team in the evaluation process. Stay current with performance improvement goals and reflect them in documentation. Revise, revise and revise.

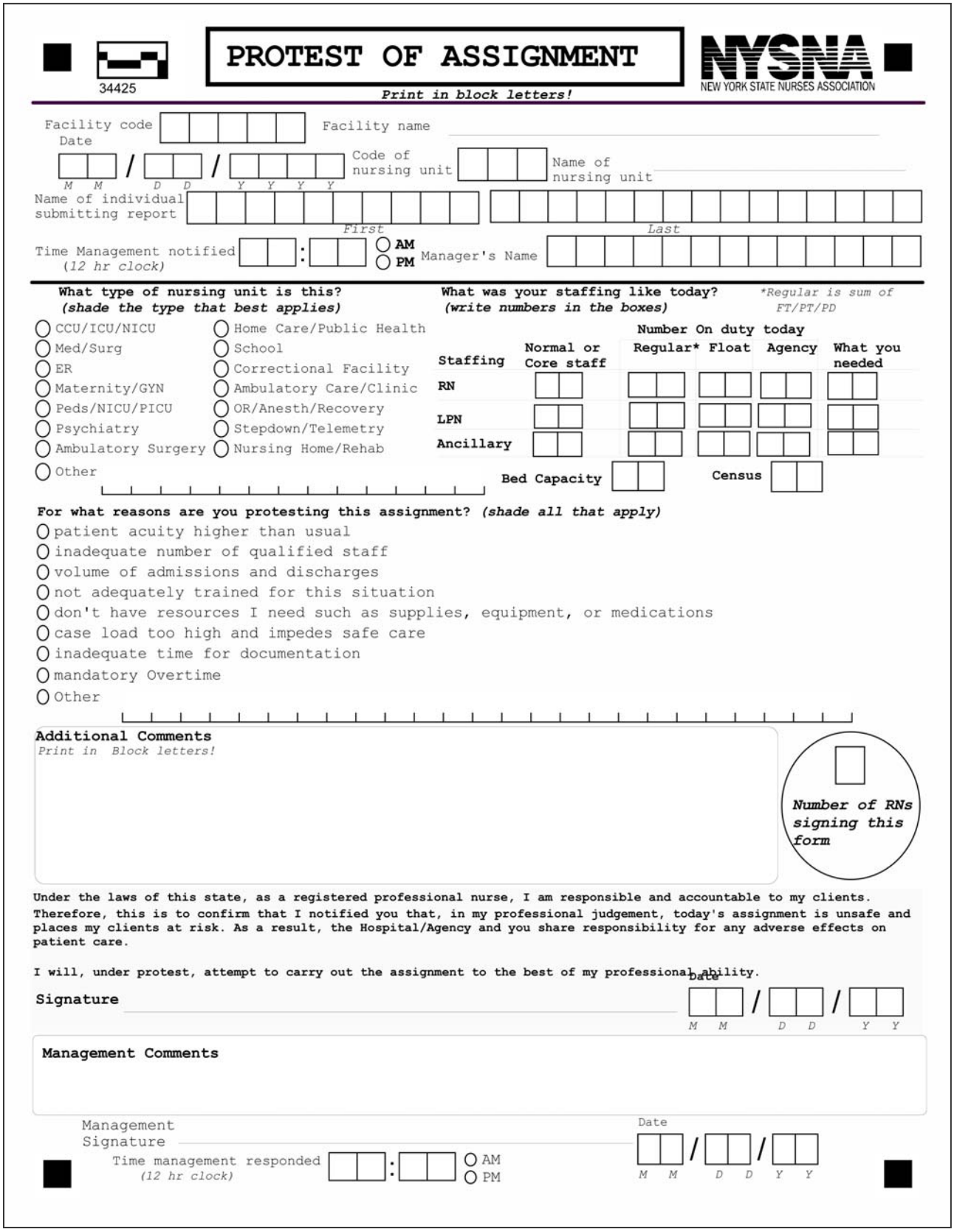
Electronic Medical Records (EMRs) according to the Institute of Medicine (IOM) will be the primary method of documentation in the future. The federal government, regulatory bodies, the media and consumers are pushing health care facilities to take a close look at the benefits of EMR. Point-of-care computer technology is one approach to address patient safety concerns. This form of technology incorporates all patient data into one place that can be accessible to caregivers at any location. This technology helps to avoid redundancy of data collection, is legible, organized complete, and accessible throughout the continuum of care, thus decreasing the chance of error (Langowski, 2005).

Conclusion

Documentation of nursing care provides multiple challenges. Although nurses are committed to providing good patient care, multiple factors impact on their ability to document well. The importance of good documentation cannot be underestimated, both in the care of the specific patient, as well as the legal protection of the healthcare provider. Documentation of nursing care provides the full picture of the planning, care and treatment that a specific patient receives in the healthcare setting.

Despite limiting factors, nurses are still ethically and legally responsible to provide documentation that is reflective of the care a patient actually receives. It must be accurate, timely and thorough. Following basic good documentation principles can help the nurse to meet these responsibilities and provide the full range of high quality patient care.

Appendix A



PROTEST OF ASSIGNMENT

34425

NYSNA
NEW YORK STATE NURSES ASSOCIATION

Print in block letters!

Facility code
Date
M M / D D / Y Y Y Y

Facility name

Code of nursing unit

Name of nursing unit

Name of individual submitting report
First Last

Time Management notified (12 hr clock)
AM PM

Manager's Name

What type of nursing unit is this?
(shade the type that best applies)

- CCU/ICU/NICU
- Med/Surg
- ER
- Maternity/GYN
- Peds/NICU/PICU
- Psychiatry
- Ambulatory Surgery
- Other
- Home Care/Public Health
- School
- Correctional Facility
- Ambulatory Care/Clinic
- OR/Anesth/Recovery
- Stepdown/Telemetry
- Nursing Home/Rehab

What was your staffing like today?
(write numbers in the boxes)

**Regular is sum of FT/PT/PD*

Staffing	Normal or Core staff	Number On duty today: Regular*	Float	Agency	What you needed
RN					
LPN					
Ancillary					

Bed Capacity

Census

For what reasons are you protesting this assignment? ***(shade all that apply)***

- patient acuity higher than usual
- inadequate number of qualified staff
- volume of admissions and discharges
- not adequately trained for this situation
- don't have resources I need such as supplies, equipment, or medications
- case load too high and impedes safe care
- inadequate time for documentation
- mandatory Overtime
- Other

Additional Comments
Print in Block letters!

Number of RNs signing this form

Under the laws of this state, as a registered professional nurse, I am responsible and accountable to my clients. Therefore, this is to confirm that I notified you that, in my professional judgement, today's assignment is unsafe and places my clients at risk. As a result, the Hospital/Agency and you share responsibility for any adverse effects on patient care.

I will, under protest, attempt to carry out the assignment to the best of my professional ability.

Signature

Date
M M / D D / Y Y

Management Comments

Management Signature

Time management responded (12 hr clock)
AM PM

Date
M M / D D / Y Y

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Charting and Documentation:
Know Your Professional Responsibility While Keeping Your Nursing License Safe

Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the course exam.

1. The purpose of documentation in the medical record include all the following EXCEPT:

   A. Provides a complete and accurate record of the planning of care and the treatment provided to a particular patient.
   B. Meets criteria for facility/agency accreditation by federal, state and private credentialing groups.
   C. Implements organizational policies.
   D. Provides information used during an investigation by the New York Sate Education Department, Office of Professional Discipline in any charge of professional misconduct.

2. Common documentation problems include:

   A. Facility policies not being followed.
   B. Actual practice is not documented completely.
   C. Illegible handwriting.
   D. All of the above.

3. In 2004 the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) developed a list of common abbreviations that are considered "dangerous," that is, they lead to frequent errors, interfering with patient safety. Among them are all the following EXCEPT:

   A. "ml" for milliliters; it can be mistaken for micrograms.
   B. "U" for units; it can be mistaken for "cc" when written hurriedly.
   C. "Q.D", which can be mistaken for "Q.O.D" or "Q.I.D." if written hurriedly.
   D. "D/C", which may be interpreted as discontinue or discharge.

4. The American Hospital Association's (2001) survey found that for every hour of patient care, nurses spend on average:

   A. Approximately 2 hours in mandatory documentation.
   B. Between 20 and 30 minutes in mandatory documentation.
   C. Between 30 and 60 minutes in mandatory documentation.
   D. Over 1 hour in mandatory documentation.

5. Multiple regulatory agencies impact on documentation requirements for nurses in New York State. Among them are:

   A. The Joint Commission on Accreditation of Healthcare Organizations.
   B. The Department of Health and Human Services, Center for Medicare and Medicaid.
   C. The New York State Department of Health.
   D. All of the above.

6. Multiple factors impact on nurses' ability to document. All the following are true EXCEPT:

    A. The sometimes excessive and duplicative documentation requirements of regulating and accrediting agencies.
    B. The shortage of nurses at the bedside making for larger patient loads, resulting in hurried care, and in order to comply with increased documentation due to increased patient loads, hurried documentation.
    C. Fatigue on the part of the nurse due to higher case loads, mandatory overtime and documentation requirements.
    D. Use of Standards of Patient Care which provide guidelines for documentation.

7. Although standards for documentation are not universal, those standards set forth by the American Nurses Association (2002) provide basic principles that can be applied to most any healthcare setting.

    A. True.
    B. False.

This scenario applies to questions 8 and 9:

Ms. QRS is a 72 year old patient on a medical unit. Yesterday during routine patient care, the certified nursing assistant (CNA) reported to the registered nurse that the patient had a reddened area on her left buttocks approximately the size of a quarter; the skin was intact. The nurse has worked with this CNA for many years and trusts her judgment. The aide reports that she turned the patient, so that she is not lying on the left buttocks and applied lotion. The registered nurse documents the following:

"Reddened area on left buttocks; lotion applied; patient turned onto right buttocks. N. Nurse, RN"

8. What about this note puts the nurse most at risk?

    A. Nothing; this is an example of good documentation.
    B. The nurse documented the data reported by the CNA as if she herself observed and cared for the patient.
    C. The nurse neglected to address the patient's emotional and cognitive state.
    D. The CNA did not chart the information about the patient's condition and her interventions.

9. Later that day, Ms. QRS puts on her call bell to summon the nurse because of her low back pain. The nurse walks to Ms. QRS's room to find her turned on her left buttocks, rather than on the right side, as the CNA had reported to the nurse. The nurse repositions Ms QRS and assesses the reddened area, which now has a small decubitus ulcer rather than a reddened area. The nurse provides decubitus care. The best example of the documentation that follows would be:

    A. Patient found lying on left buttocks rather than on right buttocks as reported by CNA; approximately 2 cm decubitus ulcer noted; decubitus ulcer protocol followed. Incident report completed.
    B. 2 cm decubitus ulcer noted on left buttocks; protocol followed; patient repositioned to avoid left buttocks.
    C. Patient complained of low back pain; 2 cm decubitus ulcer noted on left buttocks. Decubitus ulcer protocol followed; patient repositioned to right buttocks; afterwards, patient reported only mild soreness; pain at 1 on 0-10 scale.
    D. Patient now has decubitus ulcer of approx 2 cm on left buttocks; CNA received written warning about not following decubitus ulcer protocol.

10. Multiple formats exist for documentation in the medical record. Despite the various formats, they should all do the following:

    A. Establish and utilize common terminology and abbreviations across all forms;
    B. Not duplicate information from form to form and be consistent, without contradiction.
    C. Promote current, timely charting.
    D. All of the above.

11. There are multiple documentation formats; the one the nurse uses is based on:

    A. The specific preference of the nurse.
    B. The policies of the facility in which the nurse is employed.
    C. HIPAA requirements.
    D. The only JCAHO approved format.

12. Eggland's (1993) three critical documentation points include all the following EXCEPT:

    A. Be accurate.
    B. Be inclusive.
    C. Be concise.
    D. Be complete.

13. In order for the healthcare record to reflect the totality of nursing care, a basic rule of thumb is to make sure that each note addresses: Who, What, Where, When, Why and How.

    A. True.
    B. False

14. When should the nurse document the care that is provided to a patient?

    A. At the end of each shift.
    B. As soon as is reasonably possible after the care has been provided or the event has occurred.
    C. Prior to providing additional care to a patient.
    D. As long as the documentation is complete prior to discharge, the nurse can be flexible regarding the time of documentation.

15. When a nurse needs to correct erroneous information in the patient's medical record, the correct procedure is:

    A. It is never permissible to correct any information in a patient's medical record.
    B. The nurse should make every effort to completely cross-out the entry or preferably, use a product like "White-out." This is permissible as long as the nurse provides the date and time of the correction, as well as her/his signature..
    C. A single line is drawn through the erroneous information and the rationale for the correction is provided (for example, wrong patient chart); the correction is dated and signed by the nurse.
    D. A single line is drawn through the erroneous information without providing any corrective information. That should be provided in the margin of the document.

16. In the event that the nurse omits information in a patient record, to avoid the appearance of tampering with the legal document, the nurse should request that the next shift save space for her or him, and complete the charting at the first available opportunity.

    A. True.
    B. False.

17. Although the Healthcare Insurance Portability and Accountability Act (HIPAA) provides federal law regarding privacy, there may be times when breaching this privacy is medically necessary. An example of such an exception is:

    A. When documenting in a patient's record, it is permissible to refer to another patient, by the second patient's full name, if there was a disagreement between the two patients that impacts the first patient.
    B. When a patient has complaints about care received and threatens litigation, the nurse has an obligation to document, in the medical record, the specific complaints of the patient, as well as her side of the story.
    C. When the patient is a danger to him or herself or to someone else, such as in the case of child abuse.
    D. When the patient denies permission to have family members informed about medical treatment.

18. The following appeared in Mr. XYZ's chart: "Patient upset during diabetic teaching; refuses to inject insulin 2 IU; wants to sign out AMA." What is problematic about this note?

    A. It lacks objective information about what the nurse means by "upset".
    B. It neglects to include what care the nurse provided, or what interventions she took in response to how the patient felt and what he wanted to do.
    C. The abbreviation "IU" should be spelled out to read "international units".
    D. All of the above.

19. The nurse has just found Ms. ABC crying in her room after ending a phone call. The nurse came into Ms. ABC's room to change a dressing. Prior to beginning the procedure, the nurse brings up the issue of Ms. ABC's tearfulness. The nurse listens actively, validates the patient's feelings and provides information which helps the patient to problem solve, all while changing the dressing. Afterwards, the nurse documents the following: "Dressing changed; small amount serosanguinous drainage noted, no redness or swelling, wound healing well." What is problematic about this note?

    A. This note is accurate and reflects the care provided.
    B. The note is not complete; it is missing the emotional care provided by the nurse which is more reflective of the total care provided.
    C. The note does not address the patient's temperature.
    D. None of the above.

20. A nurse is being investigated by the New York State Education Department, Office of Professional Discipline after a charge of professional misconduct. During this procedure, the nurse's documentation, related to the specific incident likely would be investigated.

    A. True.
    B. False.