# Legal Documentation: Chart like your Livelihood Depends On It

## HOW TO PROTECT YOUR PROFESSIONAL LICENSE

as a nurse in any practice setting

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RN


# Maggie Ortiz MSN RN

## Nurse just like you!
## Different journey

ASSOCIATE DEGREE OF NURSING (ADN) 2000
ICU residency program


ADN - MSN Bridge Leadership
BACHELORS (BSN) 2016
MASTERS LEADERSHIP (MSN) 2017
Thesis: Procedural Sedation

Emergency Room (ER), Post Anesthesia Care Unit (PACU), Pre-Operative Unit (Pre-Op), Interventional Radiology (IR)/trauma call, Cardiac Cath Lab/STEMI call, Endoscopy Suite. Local agency, Travel agency, ACLS/BLS Instructor, LVN Instructor, Patient Advocate

FORMER Investigator for a Board of Nursing
Civil Expert
Administrative Expert
Nurse Consultant
Author
Speaker

# NURSE ACTIVIST

## ADVOCATE MAGGIE BORN

The Nurse’s Advocate

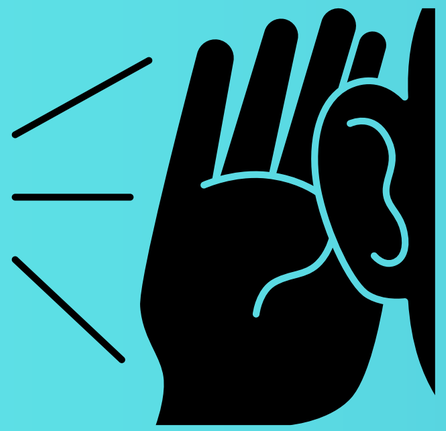




# OBJECTIVES:

This course is designed to empower you as a travel nurses to chart like seasoned professionals, thereby safeguarding your livelihood and nursing career. To empower you with practical strategies and insights into sound documentation practices, giving you confidence to chart in any practice setting.

- Understand the critical importance of documentation in safeguarding your nursing license and your livelihood.
- Learn how to navigate different policies, procedures, and electronic health record systems while maintaining diligence in charting in various setting.
- Recognize the 'what' 'how' and 'why' of nursing documentation, ensuring that no vital information is left uncharted.
- Acquire practical tips and real-life examples to enhance their documentation skills, no matter where their nursing journey takes them.



# TAKE NOTES

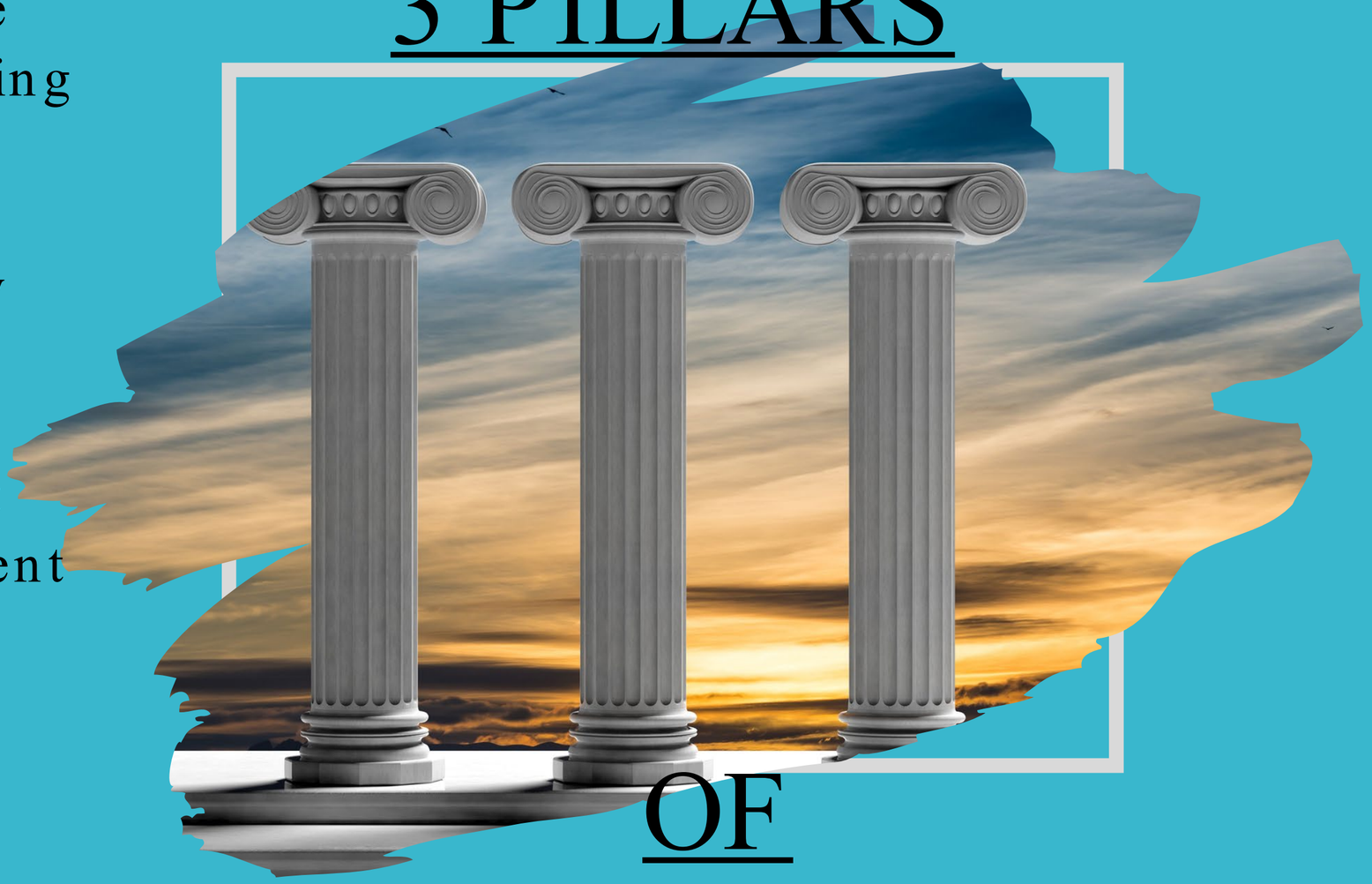
LOTS INFORMATION AND RESOURCES
NOT TO MENTION LOTS OF GOLD NUGGETS!

# YOU'RE A TRAVEL NURSE


# WHAT TO CHART
# HOW TO CHART
# WHY WE CHART

## TRAVEL NURSE PERSPECTIVE

# THE 3 PILLARS OF CHARTING



I. What to Chart.
- Discuss essential information that should be documented, leaving nothing to chance.

II. How to Chart.
- Discuss how to effectively chart to protect you.

III. Why we Chart.
- Discuss why we document and its critical role in patient care.

IV. Protection. BONUS

# ‘WHAT’ PILLAR

## I. What to Chart

What we do or do not chart in the medical record matters.

# THE MEDICAL RECORD

WHAT

COMMUNICATION BETWEEN PROVIDERS

IS

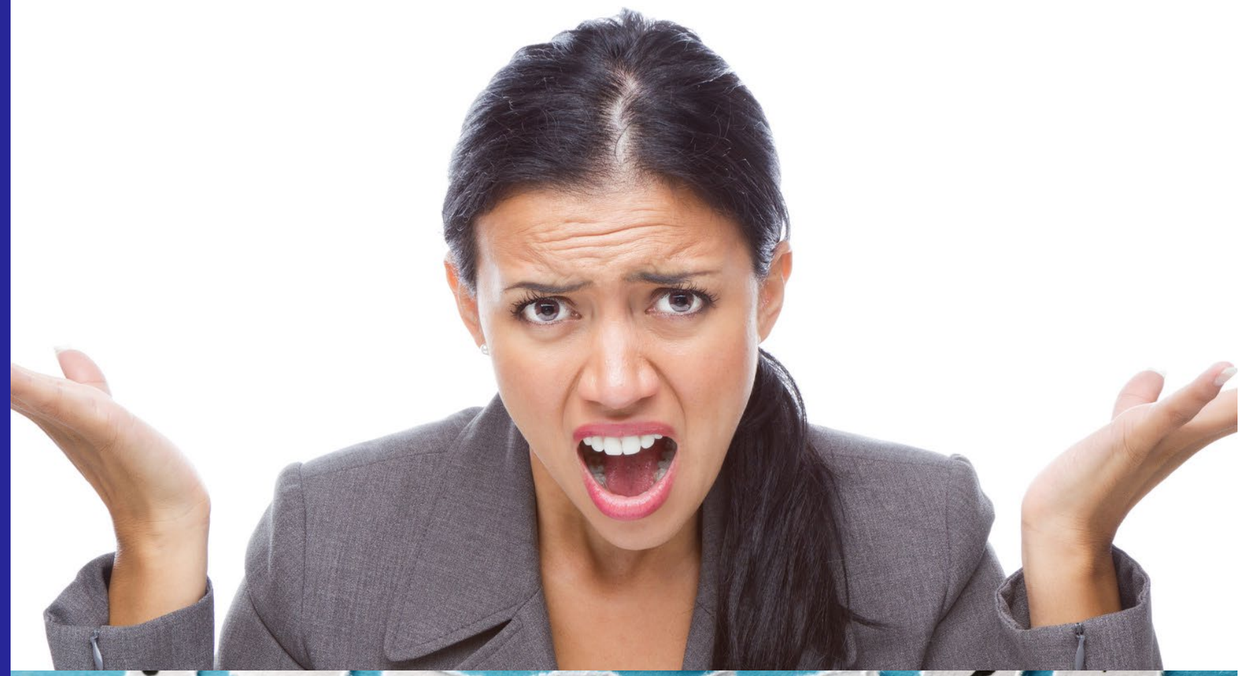
LITIGATION PROTECTION WON'T BE YOUR MEMORY


IT?

REQUIRED BY LAW

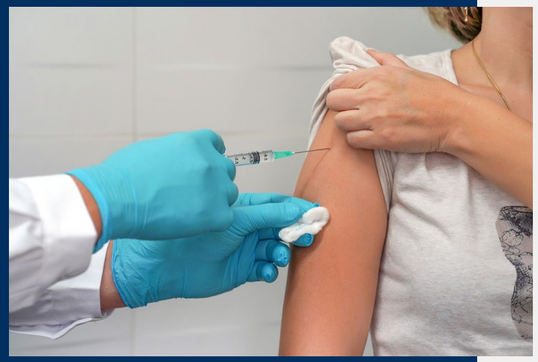
# WHAT TO CHART

The 'What' Pillar focuses on essential information that should never be left to chance. Documenting the relevant patient history, allergies, medications, and changes in the patient's condition and follow all orders, parameters and policies.



‘WHAT’

ALL YOUR CARE



PAIN

FOLLOW-UP

ANY DEVIATION FROM NORMAL LIMITS OR THE STANDARD OF CARE

HOURLY ROUNDING

# WHAT

| | | |
|---|---|---|
| FULL ADMISSION ASSESSMENT | EVENTS | COMM. ALL HEALTHCAREP ROVIDERS |
| ABNORMALS | SHIFT CHANGE | RESTRAINTS |
| PLAN OF CARE | HANDOFF | TURNING SCHEDULE |

# WHAT

WHO YOU CALLED

1 Name. Dr. Smith Cardiology.

WHY YOU CALLED

2 Patient blood pressure 90/45, HR 102 Afib scheduled to get Coreg, Imdur, Lotensin at 0900.

PLAN

3 Hold for how long. New parameter. Change vitals.

# ‘WHAT’


Code status of your patients.
nsure you know the facility policy for banding

Allergies

Nursing Diagnosis

Precautions

Monitoring i.e. CIWA, SI/HI

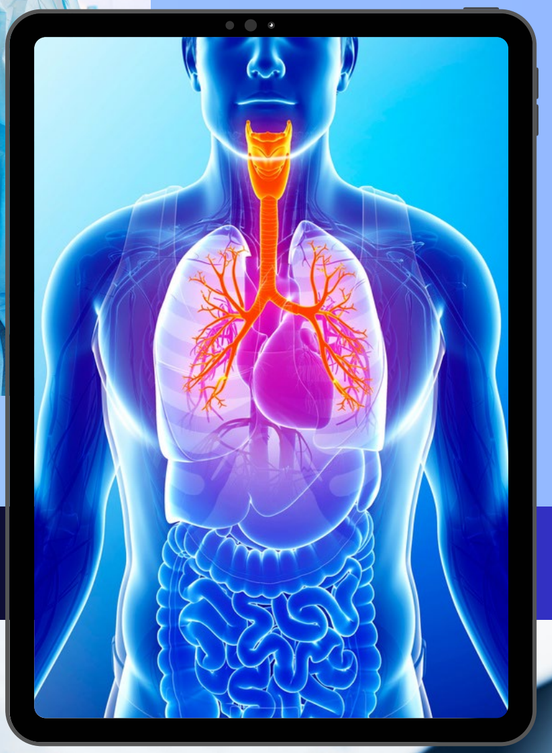
nt/Family Education. Don’t write non compliance if you haven’t educated patient

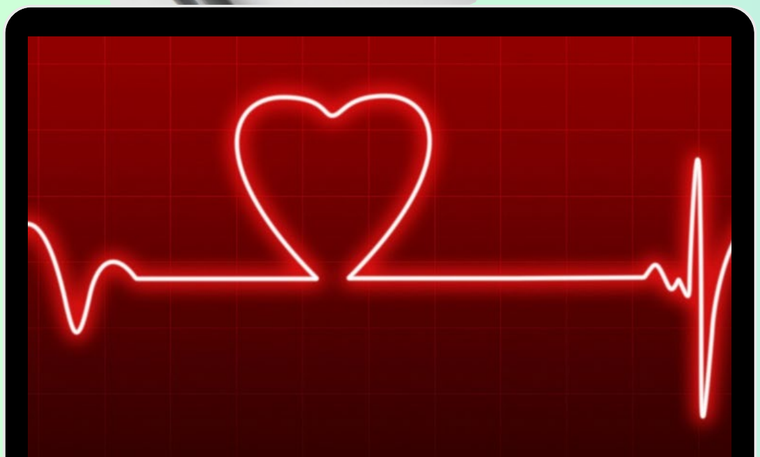

# UPDATE THE CHART!

‘WHAT’



# CORE MEASURES



‘WHAT

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# SURGICAL CARE IMPROVEMENT PROJECT (SCIP)

Prophylactic antibiotics given 1 hour or less prior to surgical incision and consistent with current clinical guidelines &d/c’ed 24 hours or less after surgery.

Cardiac surgery patients have controlled early morning glucose on post-operative days 1 and 2

Clippers (not shavers or razors) used for hair removal prior to surgery

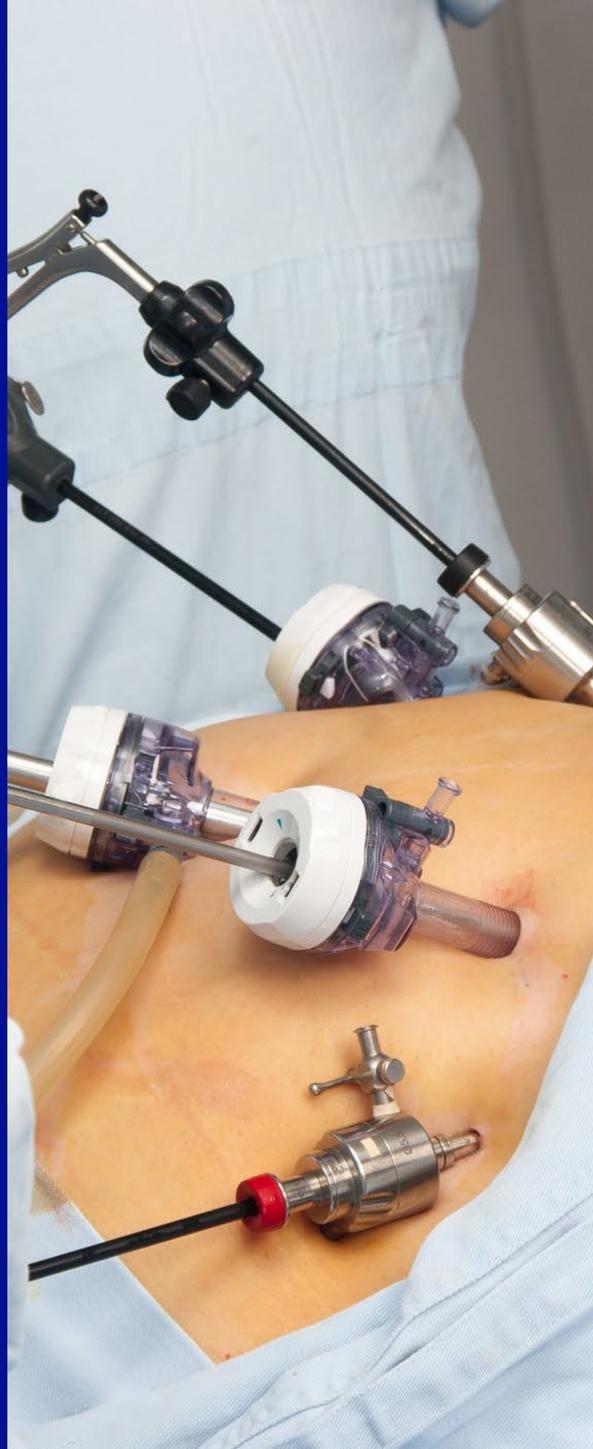
Urinary catheters removed by the first or second day post-operatively

Surgical patients who required active warming during surgery or post operatively

Beta blocker given perioperatively for patients already prescribed beta blockers prior to admission

Patients who meet recommended prophylactic venous thromboembolism (VTE) receive VTE therapy perioperatively (24 hours prior to surgery and 24 hours after surgery)

Contraindications for the prescription or use of any of the

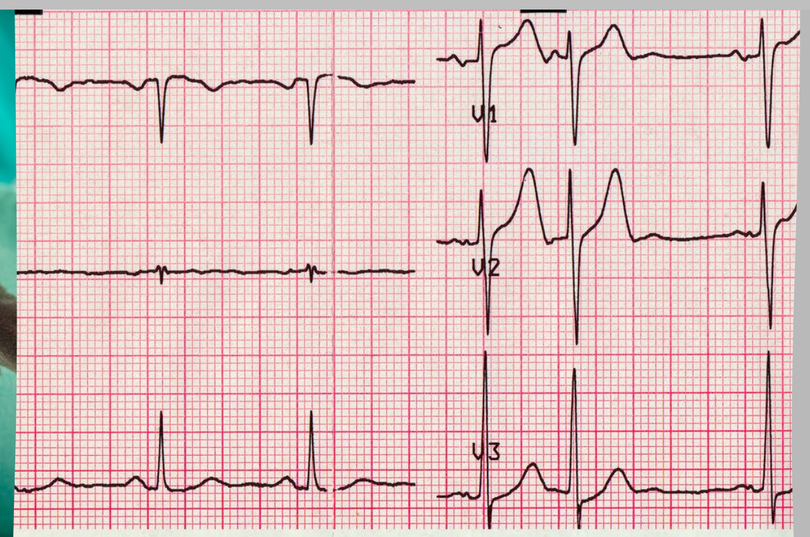


# ACUTE MYOCARDIAL INFARCTION (AMI)

Aspirin within 24 hours of arrival & d/c (MONA)
Ace ii inhibitor (ACE-inhibitor) or Angiotensin II receptor blocker (ARB) patients with Left Ventricular Systolic Dysfunction (LVSD),

Percutaneous coronary intervention (PCI) within 120 minutes of arrival for ST-elevation Myocardial Infarction (STEMI) or left bundle branch block (LBBB), if indicated by electrocardiogram (ECG)

BB, Statin, ASA, anti-platelet post stent prescribed at discharge with ALL Contraindications for the prescription or use of any of the above measures must be documented.




‘WHAT’

‘WHAT’

## Emergency Department (ED):

- Trauma assess: Document mechanism of injury, vital signs, and initial patient assessments.
- Procedures: procedures like sutures, splinting, or intubation.
- Pain management: Chart pain levels before and after interventions, including pain relief. What it was on dc.

Example: A patient with a traumatic brain injury requires frequent neuro checks. Document using scale per policy score changes and any interventions, increasing FIO2, mannitol.....

## Intensive Care Unit (ICU):

- Vent care: N otes on vent settings, alarms, and patient responses. VAP
- Neuro checks: Regular neuro assessments for changes in consciousness.
- Medication titration: Document titration of critical medications and patient responses .

Example: Pt arrives with a fractured arm after a fall. Document the fall details, initial vital signs, the reduction procedure, and post - procedure pain relief. Distal circulation. CARE PLAN!

## Medical -Surgical Unit:

- Post- operative care: Surgical s ite assess, drain output, & pain management.
- Diabetic care: blood sugar, insulin administration, diet.
- Wound care: Detailed wound assess, dressing changes, and patient tolerance. PT staging/expert.

Example: A post -op patient has a surgical wound. Document the wound's appearance, drainage, and any signs of infection. All patient/family education.

## Labor & Delivery:

- Fetal monitoring: Record fetal HR, contractions, & changes d uring labor.
- Labor progression: Doc cervical dilation, effacement, station.
- Pain management: Chart epidural administration, pain relief, and patient comfort.

Example: laboring mother's fetal monitor shows sudden decel heart rate. Document the event, interventions, and the baby's recovery. Escalation of care.

## Pediatrics:

- Growth & development milestones: always doc age - appropriate milestones & deviations
- Immunizations: Record vaccine administration, lot numbers, parental consent.
- Parental education: Chart topics discussed with parents, like infant care or nutrition.

Example: infant 6 - month checkup. Doc weight, length, developmental milestones, vaccines given. Parent education.

# ‘WHAT’

## Longterm Care

- ADLs
- Meds: Chart med admin, refusals, and any adverse reactions.
- Resident interactions: Record social and emotional interactions, changes in behavior, and communication with families.

Example: A resident with dementia refuses medication. Document the refusal, any attempts to administer, and communication with the family.

## Rehab

- Therapy sessions: Chart details of physical, occupational, or speech therapy sessions.
- Mobility progress: Document the patient's ability to perform exercises or movements.
- Pain assessment: Record pain levels before and after therapy sessions.

Example: A patient in rehab is working on regaining mobility after a stroke. Document their progress during therapy sessions, including any improvements or challenges.

## Assisted Living

- Wellness checks: Rec daily checks for signs of illness or changes in residents' cond.
- Med reminders: Doc assistance with medication management.
- Meals & nutrition: Chart dietary preferences, meal intake, and any dietary concerns.

Example: Client is noted to be lethargic and refusing meals. Document observations, conversations with the resident, and any notifications to the healthcare provider.

## Hospice

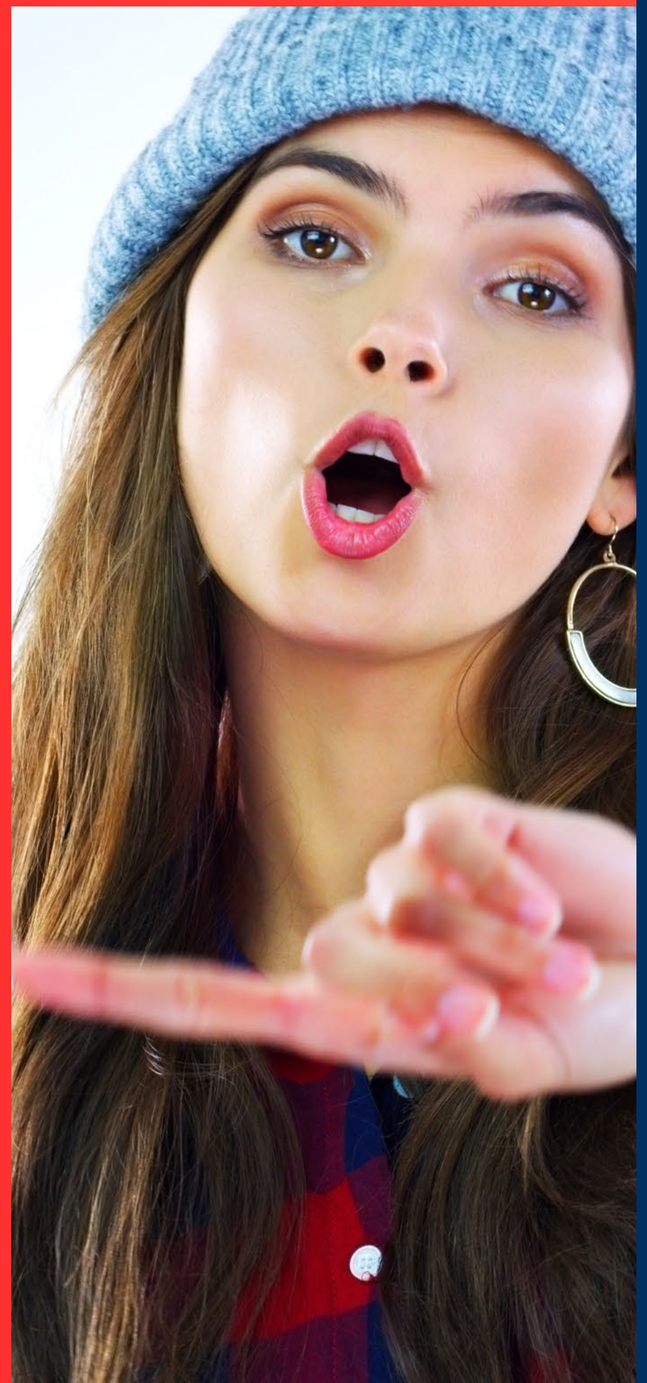
- Symptom management: Doc pain, nausea, other symptoms.
- End-of-life care: Record emotional physical support provided to patients & family.
- Med adjustments: Chart changes in medication doses or types for symptom control.

Example: A hospice patient experiences increased pain. Document the pain assessment, medication adjustments, and communication with the hospice team.

## Alzheimer Memory Care Units

- Behavioral observations: Doc changes in behavior, agitation, or wandering.
- Cognitive assessments: Rec cognitive decline or improvements.
- Family interactions: Chart family visits, emotional support, and discussions about care plans.

Example: Resident with Alzheimer's becomes agitated. Doc behavior, interventions used to calm them, & family involvement in care decisions.



INCIDENT REPORTS! NEVER EVER!

Irrelevant details. Don’t clutter the medical record. Focus on what directly impacts patient care.

Care before it happened

Example: Instead of describing the patient's entire medical history, concentrate on the aspects relevant to their current condition.

Jargon or Abbreviations not approved or used in that area. Ensure your charting is understandable to other healthcare professionals.

Example: Instead of "pt c/o abd pain," write "Patient complains of abdominal pain right upper quadrant. Arms across abdomen splinting and grimacing."

Care someone else provided.

Example: It’s acceptable to say document during a code the patient is intubated and bilateral wrist restraints per the policy are applied by the House Supervisor. You can document using their name.

Cath Lab real-time documentation. There are exceptions but this is NEVER THE RULE. If you weren’t there and didn’t see it done, don’t document it!

Don’t ever leave blank spots in the chart and or between entries

# WHAT DOES YOUR PICTURE SAY?

JUST PAINT THE PICTURE OF THE CARE YOU PROVIDED.

WHEN IT'S UP ON THE BIG SCREEN WILL THE PICTURE SHOW THAT YOU WERE A 'PRUDENT NURSE?'

HELD TO: "<u>WHAT A PRUDENT NURSE WOULD OR WOULD NOT DO IN SAME OR SIMILIAR CIRCUMSTANCE.</u>"

REASONABLE MAN STANDARD.

# II. How to Chart

## ‘HOW’ PILLAR

How we chart matters and could reflect poorly on us years later via lawsuit or investigation.


# THE HOW

It's all about charting techniques that ensure clarity and precision. For instance, instead of vague descriptions, use specific and objective language in your notes. Avoid shortcuts or jargon that could lead to misinterpretation.

# HOW TO CHART

Per Requirement in Area Working

Timely, Accurate and Relevant

Organized and Concise

Legible

K.I.S.S.

# WRITE PROGRESS NOTES

- Get in the practice of writing a note in an organized fashion.
- ALWAYS FOR DEVIATION OR EVENTS!

## SOAPIE NOTES

S –SUBJECTIVE
O –OBJECTIVE
A –ASSESSMENT
P –PLAN
I –INTERVENTION
E –EVALUATION & RE EVAL

## COMMUNICATE

S – SITUATION
B – BACKGROUND
A – ASSESSMENT
R - RECOMMENDATION

# SOAP NOTE

## SUBJECTIVE

**Charting** things the patient says or information that only the patient can provide personally. This should include perceived pain, symptoms such as feelings of numbness or tingling, medical and family history, and allergies. This information is gathered through asking the patient questions and is important to record exactly as the patient reports.

## OBJECTIVE

Record what the nurse observes, hears, sees, and feels during the patient assessment. No opinion, just the facts.

## ANALYSIS

After subjective and objective assessment data is collected, the nurse should make an initial analysis of the patient's condition and identify appropriate nursing diagnoses and assign a care plan.

## PLAN

After nursing diagnosis is assigned selected then nursing care needs to be spelled out and implemented. This may include repositioning, requesting pain medication from the providers, applying oxygen per protocol, or providing emotional support. The plan should be patient-centered and based on the nursing diagnoses.

# PATIENT FALL


IN ANY SETTING

2/19/22 15:14. Pt up to BR with assist by RN &tech. Gait belt in place. Pt became unsteady and lowered to the ground. Pt noted to hit her head. Called for Emergency help. No LOC. No open wounds or abrasions noted. Pt with c/o of right hand pain, no deformity noted. Help arrived 4 person transfer back to bed. MD notified using SBAR, did inform MD pt is taking Coumadin and was noted to hit her head. Orders received. STAT CT head and x-rays ordered. Notified charge nurse. Full head to toe assessment completed as well as neuro checks see flowsheet. Order for q 15 minute Neuro checks, reported to charge nurse. Rates pain R hand 3/10. Medicated per MD order, see flowsheet. Full ROM. ICE bag applied, placed on pillow. Await results of x-ray. MPA notified by myself and provided MD with contact info to update. 911 called for immediate transfer to higher level of care.

- Use Approved Abbreviations: Familiarize yourself with appropriate abbreviations to promote accurate and efficient documentation.
- Paint a Picture of Care: Document comprehensive details, providing a vivid account of the care provided.
- To the Restraint Policy: Understand and adhere to regulations regarding physical and chemical restraints.
- To the Patient Fall Policy: Implement preventive measures to ensure patient safety and minimize fall risks.
- To the Code Status/Code Policy: Respect and adhere to patient wishes regarding resuscitation efforts, and properly communicate code status.
- To Unit-Specific Policies: Adhere to hospital protocols, including specialized procedures such as blood gas draws.
- Like you are always on camera. Uphold Ethical Standards: Always choose the right course of action and assume your actions are under scrutiny and being videoed.
- Document Defensively: Treat documentation as a crucial aspect of your practice, protecting your license and livelihood.
- Keep Your Information Updated: Ensure your documentation is timely for effective communication.

# PRESSURE ULCER

# ‘WHY’ PILLAR

## III. Why We Chart

Understand the 'why' behind our documentation efforts, recognizing its critical role in patient care.

# WHY WE CHART

Understanding the crucial role of documentation in patient care is essential. Not only does it facilitate communication among healthcare providers, but it also serves as a legal document to protect your license.

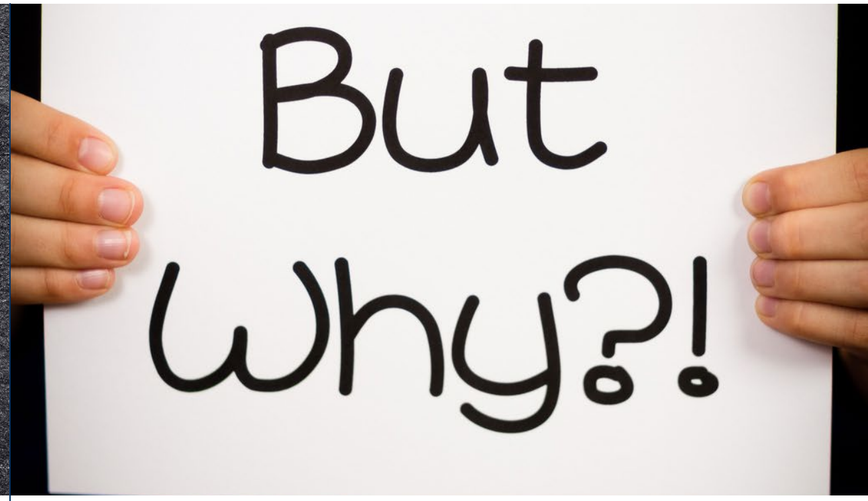
The Significance of Documentation in Patient Care


## FACILITATE COMMUNICATION

The medical record is a form of communication between all healthcare professionals. Decisions are made on what is and is not documented in the medical record.


## LEGAL DOCUMENT

Protected by federal law. It belongs to the patient and not to the healthcare provider. HIPAA and fraud can be charged with misuse.




## LICENSE PROTECTION

Charting is a pillar of professional responsibility It's not just about meeting regulations; it's about upholding the highest standards of patient care and safety because patient care and your professional reputation depend on it.

# 3rd Leading Cause of Death U.S.,.....

.....

is

US

# The IOM identifies medical errors as a leading cause of death and injury.
# 1999 Institute of Medicine (IOM)

## ..... US

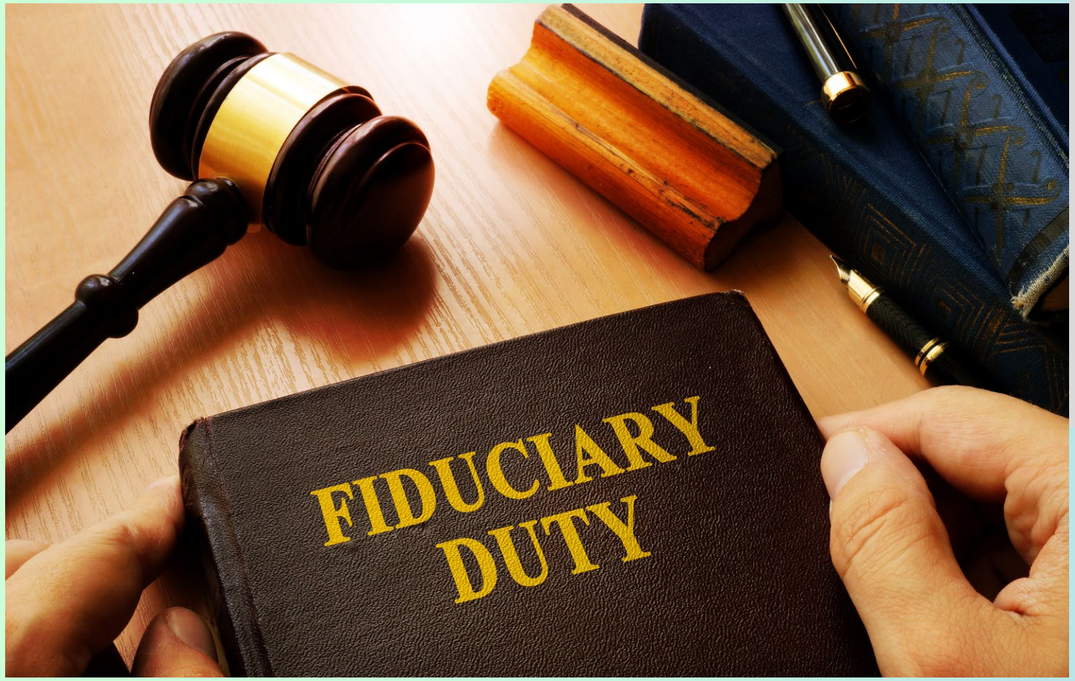
Researchers estimate that medication errors, preventable infections, venous thromboembolism, falls, and other preventable harms in hospitals take the lives of 40,000 - 98,000 or more Americans annually.

THESE NUMBERS ARE UNDER REPORTED.


# COMMON CAUSES MEDICAL MALPRACTICE

- Overworked/under-trained staff
- Inadequate/ inefficient policies and procedures
- Policies, procedures, or lack thereof can allow room for human, systematic, or mechanical medical errors
- Technical failures
- Computers, software, equipment, or medical devices aren't working properly
- Communication challenges between physician, nurse, or patient
- Patients giving incomplete or incorrect medical information to physicians, nurses receiving incorrect orders, or patients receiving improper care/prescription instructions
- Systematic communication challenges
- Medical records are not available or accessible when making healthcare decisions, test results aren't being relayed appropriately, or medical records aren't following the patient when transferred or discharged

# Why we chart





# It's our DUTY to maintain the medical record.

## WHEN DOES MY DUTY START?

01 — Duty–Nurse's responsibility to patient once relationship developed.

02 — Starts when you assume care/take report and establish a RELATIONSHIP.

03 — No relationship no duty.

# NOT CHARTED NOT DONE

EVIDENCE OF THE CARE YOU PROVIDED

Remember, in all these settings, your documentation is your lifeline. It ensures continuity of care, helps protect against legal challenges, and provides valuable insights into patient progress and needs. Cite relevant policies and procedures, use objective language, and maintain patient confidentiality. Always follow the guidelines set by the Board of Nursing and your facility.

# YOUR BEST DEFENSE IS YOUR DOCUMENTATION


DOCUMENT CARE PROVIDED.
GIVE YOURSELF CREDIT!
NOT CHARTED, NOT DONE!

REQUIRED BY BON

EX. Tx 217.11(1)(A):

(A) Know and conform to the Texas Nursing Practice Act and the board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;

(D) Accurately and completely report and document:
(i) the client's status including signs and symptoms;
(ii) nursing care rendered;
(iii) physician, dentist, or podiatrist orders;
(iv) administration of medications and treatments;
(v) client response(s); and
(vi) contacts with other healthcare team members concerning significant events regarding the client's status;

- Keep the medical record UP TO DATE!!!!! What you did and or did not document could be the difference between for example in civil court a 5-minute deposition vs. a 5-day deposition. Do you remember who you took care of 2 years ago???


MEDICAL RECORD DOES NOT BELONG TO YOU!

# WHY NOT.....

- You didn't do that care
- It's not your login
- Contradicts other charting
- You are being asked to delete and re-document. NO! Change time etc.


# ‘PROTECT PILLAR

IV. PROTECT YOUR LIVLIHOOD

# HOW TO PROTECT YOURSELF AS A NURSE



## SELF CARE

Start with the basics
SLEEP AND FOOD!

Exercise

Journal

HAVE FUN!

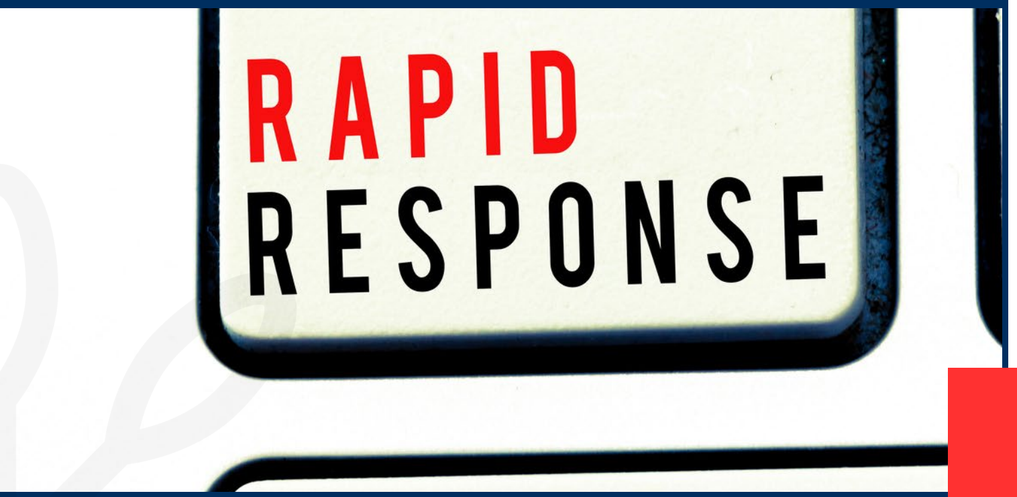
KNOW RULES AND REGS. USE THEM!

## GET INSURANCE

Start with your own insurance company

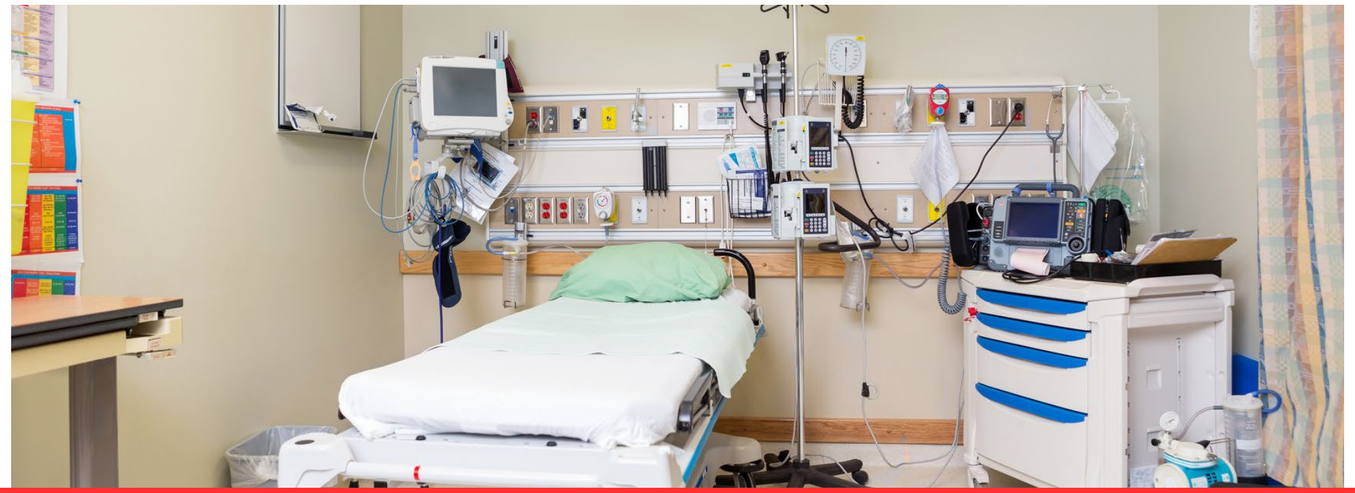
GEIO
MERCER
NSO

Not knowing,
Doesn't mean your not accountable!




# KNOW POLICIES

Nursing Code
Incident Report
Rapid Response Note
Transfer



Your license could depend on it…

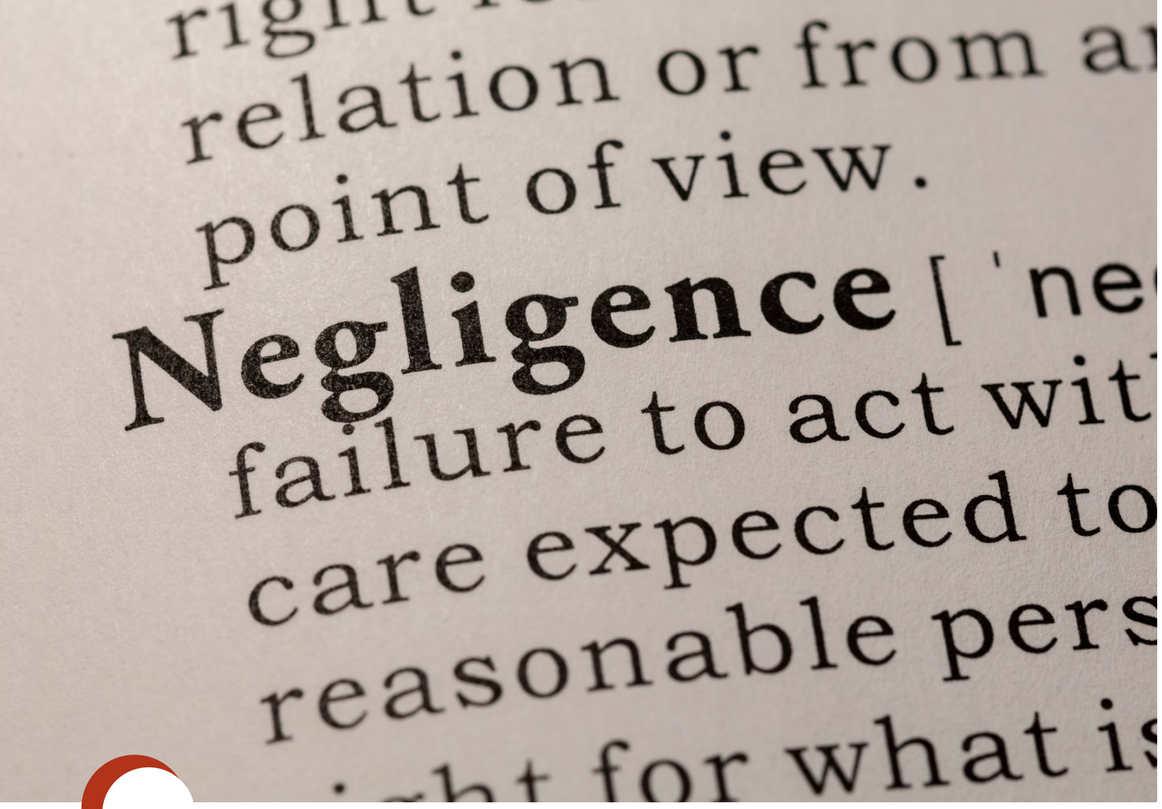
KNOWLEDGE IS POWER

- ASAP –provide care 1st. Real-time best practice. OBJECTIVE – JUST THE FACTS! Use quotation marks.
- All care provided. Use templates appropriately. Create them. Use tools available time efficiency. Care not provided & why.
- All communication with any team members about patients. COMMUNICATION HUGE!
- All abnormals and follow-up. Use tools like critical lab templates.

# NURSING TIPS/ TRICKS DOCUMENTATION

- RIGHT CHART
- CHART REAL TIME & LEGIBLY (PAPER)
- DOCUMENTATION ALL EVENTS: MISSED TX, REFUSE MEDS, FALL
- DATE, TIME, SIGN ALL ENTRIES
- ADD ENTRIES LATER AFTER AN EVENT. NOT DOCUMENTING LE OR ADDEDUM. FOLLOW FACILITY POLICY.
- USE ONLY APPROVED ABBREVIATIONS.
- KNOW, FOLLOW & USE POLICY! THEY WILL USE IT AGAINST YOU, USE IT AGAINST THEM!
- DO NOT DEVIATE FROM POLICY. IF, IF GET DETAILED ORDER.

## TEST FOR SUCCESS




# "REASONABLE MAN STANDARD"

What a NURSE IN THE ICU, ER, PACU would or would not do in the same and or similar circumstances.

## NEGLIGNCE CHARGE IS NO JOKE

Evidence-Based Practices (EBP)
Peer-reviewed articles
Policies & procedures guidelines
Nationally recognized SOC


ALL TO DEMONSTRATE NURSING NEGLIGENCE

# 3 CRITERIA FOR NEGLIGENCE


1. Breach of duty

   Was there a relationship

2. Duty owed

   In the relationship was there an obligation owed?

3. Injury/Harm

   Cause injury or harm?

Will you remember charting 2 years from now on Patient X?

<u>WHY</u> we chart care! How will you prove you didn't violate the criteria for negligence?

NOT CHARTED, NOT DONE!

# THE INTERSECTION OF YOUR LICENSE AND THE LAW.....


## ADMINISTRATIVE LAW = BOARDS OF NURSING

- YOUR LICENSE FALLS UNDER ADMINISTRATIVE LAW
- APPLY & ACCEPT THE LICENSE PLEDGE TO MAINTAIN NURSING STANDARDS
- USUALLY GOVERNED BON CAN FALL UNDER ATTORNEY GENERAL OR HEALTH AND HUMAN SERVICES

## RULES AND REGS

- FOUNDATION OF NURSING PRACTICE
- STATE NPA DICTATES YOUR LICENSE TO PRACTICE
- KNOW ALL LAWS & ETHICAL RULES OF PRACTICE

## PUNISHMENT

- CAN SANCTION, SUSPEND, REMEDIATE, PROBATION, REVOKE. EACH STATE HAS A DISCIPLINARY PROCESS –
- INTRODUCE YOURSELF TO YOURS
- NCBSN –UNDER INVESTIGATION - REVIEW

# COMMON FAILURES

- Failing to properly monitor a patient and missing a change in their vital sign
- Failing to respond to a patient in a timely manner.
- Failing to call MD to report an acute change in a patient
- Failing to update a patient's chart with any changes in his or her progress.
- Using incorrect abbreviations on a patient's chart causes a team member to misinterpret the care provided causing injury.
- Failing to feed a patient, turn, and or bathe
- Failing to record a patient's condition in their chart accurately.
- Failing to ensure that all medical equipment is working properly prior to use on a patient.
- Failing to call a rapid response in a patient who had a change in status as evidenced by an Increase in heart rate and change in rhythm and not following the RRT policy
- Consenting a patient
- Failure to advocate for the patient
- Failure to have the education, training, and knowledge to care for a patient


- Get Malpractice Liability Insurance: Protect yourself and your career from unforeseen legal risks.
- Stick to Your Expertise: Don't float to unfamiliar units lacking proper education, training, and knowledge.
- Know Your Nurse Practice Act: Familiarize yourself with the regulations governing your nursing practice.
- Stay in Your Lane: Practice within your scope and rely on evidence -based science within your specialty.
- Embrace Continuous Learning: Identify your weaknesses, educate yourself, and stay updated on advancements.
- Follow -up on Delegated Tasks: Ensure tasks are completed, promoting safe and efficient patient care.
- Obtain and Follow Orders: Adhere to prescribed orders to maintain patient safety and well -being.
- Remember the Five Rights: Administer medications safely by verifying the right patient, drug, dose, route, and time.
- Foster Respectful Relationships: Be kind, professional, and respectful to all, including patients, staff, and physicians.
- Simplify Documentation: Write clear, concise, and easily understandable notes at an eighth -grade reading level.

10 TIPS

# Continuing Education

Continuing education is vital for nurses to stay updated with the latest techniques, technologies, and practices. Utilize online resources, attend workshops, and seek mentorship to enhance your knowledge and skills

# KNOWLEDGE IS POWER

STANDARDS OF NURSING PRACTICE
UNPROFESSIONAL CONDUCT
GROUNDS FOR DISCIPLINE



# I CHALLENGE YOU!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# ADVOCATE MAGGIE MSN RN