Documentation by the Nurse

Texas Health and Human Services
Quality Monitoring Program
“If it wasn’t documented it wasn’t done”
Documentation Basics

- Documentation is factual information about the resident
- It contains information regarding:
  - The needs and conditions of the resident
  - Care provided to the resident by the care staff
- It occurs on an on-going basis
- Firsthand record of observations made by care staff
What is documentation?

- Documenting the basics includes the following:
  - Chronology: Date and Time
  - Client History
  - Interventions: Medical, Social, etc.
  - Observations: Objective and Subjective
  - Client Outcomes
  - Client and Family Response
  - Authorship: Your full Name, Credentials, and Signature
The Basics of Documentation

- Practicing the 4 C’s when documenting will ensure that you are documenting well.
  - Clear
  - Concise
  - Correct
  - Complete
The Basics of Documentation

A good test to evaluate whether your documentation is satisfactory is to ask the following question: “If another nurse had to step in and take over care for this resident, does the chart provide sufficient information for the seamless delivery of safe, competent and ethical care?”
Why document?

- Documentation is done for the following reasons:
  - To ensure that services that were paid for, for that resident, are delivered
  - Provide a picture of the resident’s condition
  - Detail how a resident is responding to treatment
  - Determine the amount of Medicare/Medicaid reimbursement a facility receives for the care of individual residents
  - It is a legal record of care that can be used in a court of law
  - Documentation influences the decisions subsequent caregivers will make regarding a client’s condition.
Purpose of documenting

- Clear, complete, and accurate health records serve many purposes for residents, families, nurses, and other health care providers.

- The data from documentation allows for:
  - Communication and Continuity of Care
  - Coordination of Services
  - Quality Improvement/Assurance and Risk Management
  - Establishes Professional Accountability
  - Legal Reasons
  - Funding and Resource Management
  - Expanding the Science of Nursing
Texas Administrative Code (TAC) Title 22, Part 11, Chapter 217, § 217.11: Standards of Nursing Practice

- (1) Standards Applicable to All Nurses. All vocational nurses, registered nurses and registered nurses with advanced practice authorization shall:
  - (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 health care team members concerning significant events regarding client's status;
TAC Title 22, Part 11, Chapter 217, §217.12: Unprofessional Conduct

The unprofessional conduct rules are intended to protect clients and the public from incompetent, unethical, or illegal conduct of licensees. The purpose of these rules is to identify unprofessional or dishonorable behaviors of a nurse which the board believes are likely to deceive, defraud, or injure clients or the public. Actual injury to a client need not be established. These behaviors include but are not limited to:

- (1) Unsafe Practice--actions or conduct including, but not limited to:
  - (C) Improper management of client records;

- (6) Misconduct--actions or conduct that include, but are not limited to:
  - (A) Falsifying reports, client documentation, agency records or other documents;
(l) Medical records.

- (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are—
  - (i) Complete;
  - (ii) Accurately documented;
  - (iii) Readily accessible; and
  - (iv) Systematically organized.

- (5) The medical record must contain—
  - (i) Sufficient information to identify the resident;
  - (ii) A record of the resident's assessments;
  - (iii) The comprehensive plan of care and services provided;
  - (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; and
  - (v) Physician’s, nurse’s, and other licensed professional’s progress notes; and
  - (vi) Laboratory; radiology and other diagnostic services reports as required under §483.50
What should be in your documentation?

- Nursing documentation should contain the following:
  - All aspects of the nursing process
  - Plan of care
  - Admission, Transfer, Transport, and Discharge Information
  - Resident Education
  - Medication Administration
  - Collaboration with other Health Care Providers
Standards for Documenting

- Since the care provided to the resident is viewed in the medical record by all of the care team to determine appropriate next steps of care, it is essential that the record be:
  - Clear
  - Accurate
  - Legible
  - Timely
  - Factual
  - Documented by the staff who performs the care
  - Organized
Rules for documenting

- Each facility will have their own policies and procedures (PP) centered around documentation. The below are general accepted rules for documenting:
  - Document using black or blue pen (this may also be facility driven)
  - Ensure that there are no skipped lines in between sentences, as this allows for the possibility of additions to be made to the chart at a later time
  - Document only for what you have done to care for or treat the resident. You should never document a task or treatment that you did not perform or complete
  - Do not make changes to the chart unless you are correcting your own work
  - When making corrections, be sure to line through the word with one line and initial. Do not use white out or corrective tape
  - Use only facility approved abbreviations and terminology
  - Lines through any unused lines to decrease the chances of additional information being added at a later date or time.
Late entries in Documentation

- The definition of a late entry should be determined by facility policy. Documentation should occur as soon as possible after the event occurred.
- Late entries or corrections incorporating omitted information in a health record should be made, on a voluntary basis, only when a nurse can accurately recall the event or care provided.
- Late entries must be clearly identified and should be individually dated. They should reference the actual time recorded as well as the time when the care/event occurred and must be signed by the nurse involved.
- Late entries must be entered on a chart on the same shift that the care was provided and/or the event occurred, even if the information isn’t in chronological order.
Good documentation vs. Poor documentation

- Good documentation is a clear, concise, and accurate description of the care that you have given.

- Poor documentation leaves the record open to questions, with no clear direction to follow.
Common mistakes to avoid

- Failing to record resident health or drug information
- Failing to record nursing actions
- Failing to record medications have been given
- Recording on the wrong chart
- Failing to document a discontinued medication
- Failing to record drug reactions or changes in the resident’s condition
- Transcribing orders improperly or transcribing improper orders
- Writing illegible or incomplete records
Ways to improve documentation

 Whether you are a seasoned nurse or a new grad, documenting can be an issue for anyone. Here are some tips that will assist with improving the documentation:

  ➢ Be extra careful when you think you are “too busy”
  ➢ Critical values should be reported to the MD within 30 minutes of verification
  ➢ If you chart by exception, know what the defined limits are, as charting in this instance is reporting “abnormal” findings.
  ➢ Allergies should be highlighted
  ➢ Charting patterns including flow sheets will be reviewed.
  ➢ Consult the policy and procedure for accepted abbreviations
  ➢ Evaluate any new onset of pain
Sample Nurses Notes

These samples are only examples and are used for educational purposes. These samples are not to be used in actual resident charting.
Example #1: 03/21/14 0800

Mrs. GH alert, awake, and oriented to person and situation but is confused as to time and place. She is able to state her name and that she is in the nursing home but states that it is afternoon and that it is 1990. She asks you if her son got to school on time because he usually misses the bus in the morning. Was reoriented to time and place. Skin warm, dry, pale but without pallor or cyanosis. Bilateral arms have purpura but skin remains intact and without skin tears. No noted decubitus ulcers on coccyx, hips, or heels. Respirations regular and non-labored. Lung sounds clear except for crackles noted in left lower lobe but improved when compared to earlier assessment done 03/20/2014. Encouraged to cough and deep breathe (CDB); crackles lessened after CDB exercise. Pulse ox on right index finger showing saturation of 96% on 2 liters O2 by nasal cannula. Ears and nares checked and are clear of irritation. Peripheral pulses are +2 at radius and +1 at dorsalis pedis pulses. Equal hand grips; left pedal push is weaker but unchanged since admission. Per flow sheet, voided clear amber urine at 0715. C/O abdominal pain of 7 on 0-10 pain scale. Abdomen firm, distended, and tender to slight touch. Bowel sounds hyperactive in RUQ and absent in remaining quadrants. States she does not know when she last had a bowel movement. No indication of BM on flow sheet since admission. Refuses breakfast stating she is nauseous. VS 148/92, 100.6 F (oral), 114, 24. ------E. Doe, LVN
Proper Documentation

Example #1: 03/21/14 0815

Dr. J Smith notified of change of status r/t abdominal pain, absent bowel sounds. STAT Abdomen series x-rays ordered and resident placed NPO. ------E. Doe LVN

Example #1: 03/21/14 0900

Portable x-ray arrived at facility to perform STAT abdominal series -----------E. Doe LVN

Example #1: 03/21/14 1000

X-ray results called to Dr. Smith. MD orders for resident to be transferred to hospital. ----E. Doe LVN

Example #1: 03/21/14 1010

Call placed to Metro Ambulance to transport resident to North Hills Hospital ASAP. -------E. Doe LVN

Example #1: 03/21/14 1020

Ambulance arrives to transport resident to hospital. Copies of all records provided to transport team. VS taken prior to release from facility: 144/94, 124, 24, 101.4F -------E. Doe LVN
Example #2 04/18/2014

0645: Received report from the night nurse and assumed care. Assessment completed. VSS. Resident awake, alert and oriented. Complains of pain as an 8 on a scale of 0-10 in fractured right hip. Medicated with two Vicodin per MD orders. Will continue to monitor. Discussed plan of care with resident. Goals are to have pain level at or below 5 for the duration of the day and for resident to walk around nurse’s station at least once by the end of the shift. Resident verbalized understanding. Call light within reach. ------A. Dunn, LVN
Example #3: 11/15/13  0815
Assessment performed, resident with C/O SOB, states “I just can’t seem to catch my breath and I am coughing up green phlegm”. On auscultation, breath sounds decreased in bases bilaterally, coarse rhonchi bilaterally in upper lobes, accessory muscle use noted bilaterally, breathing is shallow and lips are cyanotic. Vital signs assessed; temp: 100.5, BP: 110/76, HR: 108, RR: 32, SpO2: 95% on room air. -----J. Smith, RN

Example #3: 0820
Assessment findings reported to Dr. Halifax----J. Smith, RN

Example #3: 0825
Resident assessed by Dr. Halifax -----J. Smith, RN
Poor Documentation

Example #1
6th Oct 09: Dave appears upset this morning and was reluctant to have his dressing changed. Dave complaining of a temperature and advised to take 2 acetaminophen (500mgs) every 4 hours. Wound swab taken. Next visit for 7th October 2009 at 10.00

Example #2
“unresponsive and in no distress”

Example #3
“The need to maintain dialogue with the family regarding the appropriateness of limiting futile care to the resident is noted”
Poor Documentation

Example #4

“She diuresed pretty well. I gave her 40 of Lasix and she put out 2000 liters

Example #5

“Pleasant man lying comfortably in bed. Appears to be somewhat uncomfortable”

Example #6

“The resident is difficult historian. The question is as to what is going on with the patient”
Samples of Nursing flow sheets

The flow sheets shown below are just examples of some of the different types of flow sheets on the market. These examples should not be used for the purposes of charting on your residents. These are only examples.
Nursing Assessment Flow Sheet
### Daily Nursing Note Flow Sheet

#### VITAL SIGNS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Temp</td>
<td>Temp</td>
</tr>
<tr>
<td>Pulse Rate</td>
<td>Pulse</td>
</tr>
<tr>
<td>Respiration Rate</td>
<td>Resp</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>B/P</td>
</tr>
</tbody>
</table>

#### SKIN

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin WNL</td>
<td>Skin WNL</td>
</tr>
<tr>
<td>Rash</td>
<td>Rash</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>Pressure Ulcer</td>
</tr>
<tr>
<td>Skin Tear/Cut</td>
<td>Skin Tear/Cut</td>
</tr>
<tr>
<td>Stress</td>
<td>Stress</td>
</tr>
<tr>
<td>Venous or arterial ulcer</td>
<td>Venous or arterial ulcer</td>
</tr>
<tr>
<td>Other open lesion</td>
<td>Other open lesion</td>
</tr>
<tr>
<td>Wound</td>
<td>Wound</td>
</tr>
</tbody>
</table>

#### DIGESTIVE SYSTEM

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI WNL</td>
<td>GI WNL</td>
</tr>
<tr>
<td>GI Concerns</td>
<td>GI Concerns</td>
</tr>
<tr>
<td>Metabolic</td>
<td>Metabolic</td>
</tr>
<tr>
<td>Constipation</td>
<td>Constipation</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Vomitus</td>
<td>Vomitus</td>
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</table>

#### CARDIOVASCULAR

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tachycardia</td>
<td>Tachycardia</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>Bradycardia</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Hypotension</td>
<td>Hypotension</td>
</tr>
<tr>
<td>Cardiovascular Distress</td>
<td>Cardiovascular Distress</td>
</tr>
</tbody>
</table>

#### NEURO/MUSCULAR

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
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</thead>
<tbody>
<tr>
<td>Weakness</td>
<td>Weakness</td>
</tr>
<tr>
<td>Paralysis</td>
<td>Paralysis</td>
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</table>

#### RESPIRATORY SYSTEM

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
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</thead>
<tbody>
<tr>
<td>Shortness of breath</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Dyspnea</td>
<td>Dyspnea</td>
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</table>

#### BEHAVIORAL

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>Dementia</td>
</tr>
<tr>
<td>Gait disturbance</td>
<td>Gait disturbance</td>
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</tbody>
</table>

#### URINARY SYSTEM

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine Perm</td>
<td>Urine Perm</td>
</tr>
<tr>
<td>Urinary Incontinence</td>
<td>Urinary Incontinence</td>
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</table>

#### PHYSICAL FUNCTIONALITY

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bladder Control</td>
<td>Bladder Control</td>
</tr>
<tr>
<td>Bowel Control</td>
<td>Bowel Control</td>
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</tbody>
</table>

#### MEDICATIONS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipyretics</td>
<td>Antipyretics</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Antihistamines</td>
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</tbody>
</table>

#### OTHER CONCERNS

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Fever</td>
</tr>
<tr>
<td>Headache</td>
<td>Headache</td>
</tr>
<tr>
<td>Pain</td>
<td>Pain</td>
</tr>
</tbody>
</table>

#### ASSESSOR'S SIGNATURE/DATE

<table>
<thead>
<tr>
<th>Signature/Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor's Signature</td>
<td>Assessor's Signature</td>
</tr>
<tr>
<td>Date of Assessment</td>
<td>Date of Assessment</td>
</tr>
</tbody>
</table>

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**Notes:**
- Document specifics regarding Other Concerns and changes in condition on opposite side of page.
- Format for recording data: Yes/No, With/Without, Improves/Decreases, Upstream/Downstream, Marking level of consciousness.
# Nursing Skin Assessment Flow Sheet

## Weekly Skin Integrity Review

**Skin Condition:**
- Skin Intact
- Dry
- Bruises
- Rash
- Redness
- Skin Tears
- Blisters
- Other.

If Open Area: □ New □ Old

**Signature/Title:**  
**Date:**

---

**Skin Condition:**
- Skin Intact
- Dry
- Bruises
- Rash
- Redness
- Skin Tears
- Blisters
- Other.

If Open Area: □ New □ Old

**Signature/Title:**  
**Date:**

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**Skin Condition:**
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- Blisters
- Other.

If Open Area: □ New □ Old

**Signature/Title:**  
**Date:**

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- Other.

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**Date:**

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**Skin Condition:**
- Skin Intact
- Dry
- Bruises
- Rash
- Redness
- Skin Tears
- Blisters
- Other.

If Open Area: □ New □ Old

**Signature/Title:**  
**Date:**

---
## Vital Signs Flow Sheet

### Resident Profile
- Admission Date:
- Height on Admission:
- Weight on Admission:
- Usual Weight:
- Adjusted IBW:
- Reason for Adjustment:
- Baseline Blood Pressure:
- Baseline Pulse:

### Temperature Location
- O - Oral
- R - Rectal
- A - Axillary

### Pulse Location
- R - Radial
- A - Apical

### Suggested Parameters for Evaluating Significant Unplanned/Undesired Weight Loss
- Interval:
- Significant Loss:
- Deviation:

### Vital Signs and Weight Record

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Blood Pressure</th>
<th>Temperature</th>
<th>Pulse</th>
<th>Respiration</th>
<th>Weight</th>
<th>Diet</th>
<th>Date Modified/Initials</th>
<th>Nurse's Signature</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Wound Assessment Flow Sheet
Neurological Assessment
Flow Sheet

**Glasgow Coma Scale**

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
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<tbody>
<tr>
<td></td>
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</table>

**Initials**

<table>
<thead>
<tr>
<th>S</th>
<th>O</th>
<th>M</th>
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</table>

**GCS Total**

<table>
<thead>
<tr>
<th>Motor</th>
<th>Sensory</th>
<th>Verbal</th>
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<tbody>
<tr>
<td></td>
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</table>

**Movements**

<table>
<thead>
<tr>
<th>Right Arm</th>
<th>Right Leg</th>
<th>Left Arm</th>
<th>Left Leg</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**Blood Pressure**

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Pulsus</th>
<th>Intake</th>
<th>Output</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Physician**

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Initials</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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References


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