

# Documentation Module



# “If it wasn’t documented, it wasn’t done”

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## SBAR example

### **About this Module:**

Documentation is a process of reporting and recording information used by health-care practitioners to aid in the directing of resident care based on decision making and continuity of care. Documentation is written evidence of:

- The interactions between and among health professional, clients, their families, and health care organizations.
- The administration of tests, procedures, treatments, and resident/family education.
- The result of, or resident response to diagnostic tests and interventions

Documentation is a professional responsibility of all health-care practitioners; documentation provides written evidence of the practitioner's accountability to the resident, institution, profession, and society. Additional reasons for documentation include communication, education, and research, satisfaction of legal and practice standards and reimbursement.

### **Overview:**

Documentation in the resident's medical record is a communication method that confirms the care provided to the resident and clearly outlines all important information regarding the resident. This documentation in the medical record is used to share resident information between health care professionals, to provide education to students from all types of health care professions, for research purposes, and may be used as evidence in a malpractice lawsuit.

### **Objectives:**

The objectives for this module include:

- a. Identify abbreviations on the Joint Commissions "do not use" abbreviation list
- b. Discuss the importance of nursing documentation
- c. Describe the components of proper documentation
- d. Discuss state and federal requirements concerning nursing documentation

## **Pretest:**

**Mark each statement either T (True) or F (False).**

1. The medical record is a legal document.  
 True     False
2. You can document care given by a friend if that person is trustworthy.  
 True     False
3. Documentation is a communication tool.  
 True     False
4. The two primary reasons for healthcare documentation are accountability and research.  
 True     False
5. When documenting resident care, abbreviations and symbols may not be used.  
 True     False
6. Words such as “good” or “normal” are excellent words to use when documenting a resident’s assessment findings.  
 True     False
7. White out should not be used to correct documentation errors.  
 True     False
8. Subjective data is information that the client tells you about.  
 True     False
9. To save time, it is acceptable to document administration of a medication before it has been completed.  
 True     False
10. It is important for healthcare providers to document their opinions of the care provided by other healthcare providers.

True     False

## **Answer Key**

<b>Answers:</b>			
1. T	2. F	3. T	4. F
5. F	6. T	7. T	8. T
9. F	10.F		

# Chapter 1:

## Abbreviations:

There are abbreviations that are often used when documenting the care that is provided to a resident; however, the Licensed Vocational Nurse (LVN) should ensure that he/she is only using abbreviations that are approved for use within the facility. The LVN must also understand that when abbreviations are used, there may be confusion if other staff members are not familiar with the abbreviations used.

1. Appropriate use of Abbreviations<sup>1</sup>: The use of abbreviations, symbols, or acronyms can be an efficient form of documentation if their meanings are well understood by everyone and standard abbreviations, symbols, and acronyms are used by everyone. Abbreviations and symbols that are ambiguous, obsolete, poorly defined or have multiple meanings can lead to errors which can cause harm to the residents, cause confusion, and waste time. It is important for health-care practitioners to follow the facilities approved abbreviations list and The Joint Commission’s “Do Not Use” list.
2. Approved Abbreviations: Approved abbreviations are a list of abbreviations that the medical staff has reviewed and approved for use in the facility. Most are standard abbreviations that are used in most healthcare facilities; however; the LVN should make sure to check the facility’s policy and procedures on abbreviations.
3. JCAHO (The Joint Commission) “Do Not Use List”:<sup>2</sup> Because of the increase in medication errors related to the misuse of abbreviations; the Joint Commission mandated an implementation of its “do not use” list in those facilities that seek Joint Commission Accreditation. This list prohibited the use of certain abbreviations. Listed below are some of the abbreviations on the Joint Commission’s “do not use list”

Do Not Use	Potential Problem	Use Instead
U (Unit)	Mistaken for “0” (zero), the number “4” (four), or “cc”	Write “Unit”
IU (International Unit)	Mistake for IV (intravenous) or the number 10 (ten)	Write “International Unit”
Q.D., QD, q.d., (daily) Q.O.D., QOD, q.o.d., qod,	Mistaken for each other	Write “daily” Write “every other day”

<sup>1</sup> Kuhn, Ivy; Abbreviations and Acronyms in Healthcare: When shorter isn’t Sweeter: <http://www.medscape.com/viewarticle/566966-print>

<sup>2</sup> Joint Commission. (2017). Retrieved May 6, 2017, from Joint Commission: [https://www.jointcommission.org/facts\\_about\\_do\\_not\\_use\\_list/](https://www.jointcommission.org/facts_about_do_not_use_list/)

(every other day)	Period after the Q mistaken for “I” and the “O” mistaken for “I”	
Trailing zero (x.0 mg) Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MS04 and MgSo4	Can mean morphine sulfate or magnesium sulfate Confused with one another	Write “morphine sulfate” Write “magnesium sulfate”

The Institute for Safe Medication Practices has also developed an Error Prone Abbreviations, Symbols, and Dose Designations List which includes the Joint Commission’s short list.

To review the ISMP’s lists go to: [www.ismp.org/Tools/Errorproneabbreviations.pdf](http://www.ismp.org/Tools/Errorproneabbreviations.pdf)

It is important that the LVN knows and understands the different abbreviations that may result in issues to the care of the residents.

## Chapter 2:

### Components of Good Documentation:

Good documentation is a clear, concise, complete, and accurate description of the care that the LVN has given. The LVN must understand that good documentation includes observations, any actions taken by the LVN, the resident’s response, any unusual incidents, omitted treatments; safety precautions the LVN took to protect the residents, and communication with the interdisciplinary team. It tells a story that anyone reading will be able to follow.

1. Guidelines for Good Documentation<sup>3</sup>:
  - a. Report objectively, be specific and describe each complaint or situation. It is recommended to use phrases instead of complete sentences.
  - b. Write clearly and legibly, with a black ink pen only.
  - c. Start all writing with the complete date (Month, day, and year) and the time (most facilities require military time use). Finish all entries with full signature and title.
  - d. Do not use words that are open to interpretation, such as “good” or “normal” and do not leave spaces.
  - e. Chart at least every two hours in sequence and only for your actions.
  - f. Use quotation marks when documenting the resident’s statements and use only abbreviations that are accepted by the facility.

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<sup>3</sup> Hartman’s In-Service Education Sourcebook Series, The Importance of Observation and Documentation.

- g. Record all attempts to notify your supervisor or the resident’s physician and/or family. If you have to leave a message document with whom, the time and the date the message was left.
  - h. Do not erase errors. Do not use white out and cover errors. Do not obliterate error. Typically it is acceptable to correct errors in this way:
    - i. Draw a line through the wrong entry; and
    - ii. Write “Error” and initial and date the correction.
  - i. For a late entry on the medical record: the definition of a late entry should be determined by the facility’s policies.
    - i. Start the late entry with current date and time.
    - ii. Then document “late entry for\_\_\_\_\_.”
    - iii. Complete your documentation.
    - iv. Sign and date the entry.
  - j. Never chart a procedure until it has been completed. To document a procedure:
    - i. Document date and time procedure was done.
    - ii. Who completed the procedure.
    - iii. What the procedure was and any specifics required (i.e. 14 F catheter).
    - iv. How the resident tolerated the procedure.
    - v. Any follow-up care given
  - k. Make sure words are spelled correctly.
  - l. Make sure that everything that goes on with the resident is documented; good and bad.
2. Components of Good Documentation:
- a. Who
    - i. The resident is who you are documenting about. There is no need to document ‘the resident’ The whole medical record is about the resident.
  - b. What
    - i. What were the assessment findings?
    - ii. What was the resident’s complaint?
    - iii. What resident care did you provide?
  - c. When
    - i. The time when you provided care to the resident.
  - d. Where
    - i. In what place did the event happen?
    - ii. Where was the treatment given or medication administered?
  - e. How
    - i. How was the treatment completed?
    - ii. How did the resident tolerate the procedure/treatment?
  - f. Outcome
    - i. What was the outcome of the procedure/treatment?

- g. Follow-up
  - i. What type of follow-up was needed (e.g. retake of blood sugar level, pain re-assessment)?
- h. Accuracy
  - i. Provide accurate information when it comes to measuring. Be specific when measuring; do not use the terms “about” or “approximately.”
- i. Objective vs. subjective data<sup>4</sup>:
  - i. Objective data is what the LVN observes. It can be measured and monitored. Objective observations use the following senses: seeing, hearing, touching, and smelling.
  - ii. Subjective data is what the resident states. Usually, subjective data are symptoms. Examples of symptoms include: pain, nausea, dizziness, ringing in ears, and insomnia. Use quotation marks to document what the resident says. “I have pain in my lower left leg and I am having a hard time walking.”

## Chapter 3:

### **Basic Rules of Documentation:**

1. Rules of Documentation<sup>4</sup>:
  - a. Ensure that you have the correct resident record and that the resident’s name and identifying information is on every page of the record
  - b. Document as soon as the resident encounter is concluded to ensure accurate recall of data.
  - c. Never change another person’s entry, even if it is incorrect.
  - d. When documenting care provided to the resident, follow the **Nursing Process**.
    - i. Assessment: The LVN will be responsible for completing focused assessments on the residents for whom they provide care.
      1. Assessment is the first step of the nursing process.
      2. Involves systematic collection, verification, organization, interpretation, and documentation of data.
      3. Involves the following steps:
        - a. Data collection from a variety of resources
        - b. Data validation
        - c. Data organization
        - d. Data interpretation
        - e. Data documentation

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<sup>4</sup> White, L., Duncan, G. & Baunle, W; Foundations of Basic Nursing, 3<sup>rd</sup> Ed. 2011, Delmar Cengage Learning, Clifton Park.

4. The purpose of focused assessment is to organize a database regarding the resident's physical, psychosocial, and emotional health so that health-promoting behaviors and /or potential health problems can be identified.
- ii. Nursing Diagnosis
    1. The second step in the Nursing Process.
    2. According to NANDA-International, a nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems/life processes.
    3. A Nursing diagnosis is NOT a medical diagnosis.
    4. A Nursing diagnosis is based on the comprehensive assessment previously completed by RN.
  - iii. Planning and Outcome Identification
    1. The third step in the Nursing Process.
    2. This step includes establishing guidelines for the proposed course of the nursing action to resolve the nursing diagnosis and developing the plan of care for the resident.
    3. Outcome identification includes establishing goals and expected outcome, which provides guidelines for individualized nursing interventions and evaluation criteria to measure the effectiveness of the nursing care provided.
  - iv. Implementation
    1. The fourth step of the Nursing Process
    2. This is the performance of the nursing interventions identified during the planning phase.
    3. This step may include the delegation of some nursing interventions to qualified staff members.
  - v. Evaluation
    1. The last step in the Nursing Process
    2. This step determines whether the nursing care goals for the resident have been met.
    3. If the goal has been met, then the nurse must decide if the care changes or remains the same.
    4. If the goal has been partially met, then the nurse must decide how to modify the plan.
    5. Reason why goals are not met or partially met:
      - a. Assessment data was incomplete;
      - b. Goals and expected outcomes were unrealistic;
      - c. Time frame was not adequate; and/or
      - d. Nursing interventions were not appropriate for the resident or situation.

2. State Regulations Related to Documentation<sup>5</sup>: The LVN is responsible for knowing and understanding the regulations that oversee his/her practice. The TAC Title 22, Part 11, Chapter 217, §217.11 Standards of Nursing Practice requires all nurses, regardless of level of licensure to accurately and completely report and document:
  - a. the resident's status including signs and symptoms;
  - b. nursing care rendered;
  - c. physician, dentist, or podiatrist orders;
  - d. administration of medications and treatments;
  - e. resident's response(s); and
  - f. contacts with other health care team members concerning any significant events regarding the resident's status.

When the LVN fails to meet the documentation requirements, he/she could potentially be placing the resident in harm's way. For example, if a medication is not documented as having been given after it was administered, and the LVN on shift has an emergency and must leave, then there is the potential for the medication to be re-administered, leading to a possible overdose. In addition to the regulation that identifies the documentation requirements, the LVN must also be aware of the regulation that cites unprofessional conduct related to documentation. §217.12 Unprofessional Conduct<sup>6</sup> details the actions/behaviors that the LVN displays that the Board of Nursing (BON) believes are likely to deceive, defraud, or injure clients or the public. These actions/behaviors include:

- a. improper management of a resident's records; and
- b. falsifying reports, resident documentation, agency records, or other documents.

The LVN caring for the resident is ultimately responsible for any and all documentation that is done and must ensure that it is accurate.

3. Federal Regulations Related to Documentation<sup>7</sup>: In addition to the state regulations that govern the LVN's license and the practice associated with that license, there are federal regulations that dictate the specifics for documentation. The Centers for Medicare and Medicaid Services (CMS) State Operations Manual (SOM) Appendix PP details the federal requirements in §483.70 Clinical Records, F-Tag 514. This tag dictates that the nursing facility must maintain a clinical record on every resident and that the records must be complete, accurate, and easily accessible. These clinical records must contain enough information to identify the resident, a record of the most current comprehensive assessment, the plan of care based on the comprehensive assessment, the services that are being provided, the results of any preadmission screening that may have been conducted by the State, and any

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<sup>5</sup> Texas Administrative Code (TAC): Title 22, Part 11, Chapter 217, §217.11 Standards of Nursing Practice.

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=4&ti=22&pt=11&ch=217&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=22&pt=11&ch=217&rl=Y)

<sup>6</sup> TAC Title 22, Part 11, Chapter 217, §217.12 Unprofessional Conduct.

[http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=4&ti=22&pt=11&ch=217&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=22&pt=11&ch=217&rl=Y)

<sup>7</sup> CMS SOM Appendix PP: [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltc.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf).

and all progress notes. The LVN, while not directly responsible for all of this, must be sure that the section of the clinical record that he/she is responsible for contains all of the state and federally required components.

At the end of the day, the LVN must remember that when it comes to documentation of the care of a resident, if it is not documented, it was not done!

## Chapter 4:

### **Best Practices:**

It is important that the LVN understand that there are a few best practices in nursing that make the task of documentation easier and more effective. When documenting care of a resident the LVN wants to ensure that the information is provided in the best way possible to the oncoming nurse, be it another LVN or and RN. The ways in which this can be done include:

1. 24 hour communication tool:
  - a. A tool that is used to communicate resident change of condition within the past 24 hours. (i.e. falls, infections, medication changes, behavior changes, etc...).
  - b. It also includes admissions, readmissions, deaths, discharges, and room transfers.
  - c. The charge nurse at the end of each shift documents any changes in resident condition or changes on the nursing unit and reports off to the oncoming nurse.
  - d. A new 24 hour shift report is initiated on the day shift.
2. End of Shift Reports<sup>8</sup>:
  - a. Nurse shift changes require the successful transfer of information between nurses to prevent adverse events and medical errors.
  - b. Strategies to help create an effective and professional end-of shift report:
    - i. Focus on Safety, including resident's allergies, code status, mobility and level of consciousness.
    - ii. Address past medical history (if appropriate).
    - iii. Discuss physical focused assessment (abnormalities, wounds, skin assessment).
    - iv. Issues related to medication and adverse reactions.
    - v. Pain management or PRN medication issues.
    - vi. Discuss upcoming diagnostic tests.
    - vii. Discuss relevant social issues, resident behaviors.
    - viii. If appropriate discuss discharge plans.

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<sup>8</sup> Ward, J. "Making an Effective and Professional Nursing End-of-Shift Report". Nurse together.com pulled from: <http://www.nursetogether.com/making-effective-and-professional-nursing-end-shift-report> on 9/29/2015.

3. SBAR Report<sup>9</sup>:

- a. An effective and efficient way to communicate important resident information.
- b. Offers a simple way to help standardize communication.
- c. Allows parties to have a common expectations related to what is being communicated and how the communication is being structured.
  - i. **Situation:** What is going on with the resident now? Identify self, unit, resident name, room number; briefly state the problem, when it started and its severity.
  - ii. **Background:** What is going on now? Give pertinent and brief information related to the situation.
  - iii. **Assessment:** What are your focused assessment findings? Do you think the resident’s condition is deteriorating? Do you think the resident needs medication, transferring, or to be seen?
  - iv. **Recommendation:** What is your recommendation for the resident?

Example of SBAR Report:

Item	Definition	Example
Situation	One sentence description of need	Resident has become increasingly confused and combative. This is not his normal
Background	Details that give information to make an assessment. (Can be from patient’s view and from your clinical view as you inquire and research)	1. Has become increasingly confused and combative during the last 24 hours 2. Has developed incontinence of urine 3. V/S: B/P 118/74; P 102; R: 24; T:100.3
Assessment	Your position on the issue	He may have a UTI. However, he does not have a history of frequent UTIs
Recommendation	Your specific method for solving the problem	I would like to get a U/A and CS order and to increase fluid intake until results have come back

4. Why does SBAR work<sup>10</sup>?

- a. When this method is used, you and the other person are both on the same page to work on the resident issues.
- b. You are proactively giving information needed to the listener that they would need to make a decision regarding resident care.
- c. You save time by researching different options.
- d. You keep them from having to guess by giving them different options.

<sup>9</sup> Kelly, P., Nursing Leadership and Management 2<sup>nd</sup> Ed. 2008, Delmar Cengage Learning, Clifton Park

<sup>10</sup> Secret Tip on how to talk to physicians and fellow employees to really help our patients: USE SBAR; Kaiser5 Permanente, 2004 Kaiser Foundation Health Plan, Inc.

- e. Physicians already know how to use this method. They use a similar method known as SOAP when they speak to other physicians about resident care issues.

## Chapter 5

### Walking Rounds<sup>11</sup>:

Walking rounds is a reporting method used when the members of the care team walk to each resident's room and discuss care and progress with each other and with the resident (as appropriate). The LVN should become accustomed to performing walking rounds on his/her residents with the oncoming shift nurse in order to ensure that no information about any one resident is left out. If the facility does not require walking rounds as part of the end-of –the shift report, the oncoming nurse needs to make initial rounds on the residents that have had a change of condition. The goals of walking rounds are to allow the oncoming nurse to visualize the residents who have had a change of condition or status and make note of their priority and to also possibly change the plan of care for the next shift.

Walking rounds should be done with the oncoming nurse and nurse aides. This allows the nurse aides who will be on shift with the LVN to understand the same information about the residents and to know which residents they may need to observe more frequently. Walking rounds may take longer than other reporting systems; however it gives the nurses and the resident an opportunity to evaluate the effectiveness of the resident care together.

## Chapter 6

### Resources:

1. Documentation In-Service: Much of this information as well as additional information is available through a PowerPoint in-service. This in-service document will be an addition to this tool-kit module.
2. Case Studies / Examples of documentation (or a lack thereof) that lead to a bad outcome:
  - a. Brown v. DeKalb Medical Center, a case before the Georgia Court of Appeals, illustrates the need for recording all information regarding the assessment and care provided to the

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<sup>11</sup> White, L. Documentation and the Nursing Process, 1<sup>st</sup> Ed , 2003, Thompson Delmar Learning, Clifton Park

residents. In this case, the estate of a deceased patient claimed that pressure ulcers, allegedly acquired at DeKalb's skilled nursing facility, had led to a below the knee amputation of the resident's left leg. The patient had spent a month at a skilled nursing facility after having a stroke. The medical record showed that, at admission and again at discharge, the skin over her sacrum was reddened, but there was no documentation of the condition of the heels at discharge. According to a home health care nurse who examined her the day after she returned home, the patient had "blood blisters" on her heels. While a family member and the home health care nurse later disagreed about the condition of the ulcers at that time, the estate's expert nurse witness testified that in her opinion, the ulcers developed at the skilled nursing facility. Although some of them healed, new ulcers developed on the left foot and lower leg, making amputation necessary. The nurse expert testified that, although the sacral ulcer had become no worse during the patient's stay at the facility, indicating that the ulcer had been treated properly, the patient's medical record did not show that steps had been taken to prevent pressure ulcers from forming on the heels. The DeKalb nurses testified that it wasn't their practice to document normal findings; therefore, there was no documentation of a heel lesion because there had not been one while the patient was at their facility. The court rejected this rationale. The nurse's failure to document meant that DeKalb could not demonstrate that adequate care had been provided. The jury determined that the absence of documentation of a pressure ulcer was not the same as documentation of a thorough skin assessment. Therefore, they found in favor of the patient's estate and awarded damages.

- b. A 70-year-old man suffered a stroke after undergoing coronary artery bypass grafting surgery. Subsequently, he required a permanent percutaneous endoscopic gastrostomy (PEG) tube for feedings. He was placed in a skilled nursing facility to receive rehabilitative care. The standard of care for such a patient calls for the feeding tube to be checked for residual feeding formula and flushed every four hours. Tube feeding was begun with Jevity Plus at 25 mL/hr initially and was to increase gradually if the patient was tolerating it. On three consecutive days the nurses documented that tube feeding had to be turned off for short periods because residual formula aspirated from the stomach exceeded the normal limit. After 3 days, the patient's condition improved and he was able to tolerate the Jevity at 25 mL/hr. The patient's physician wrote an order for an increase in the Jevity Plus to 65 mL/hr by PEG tube, keeping the head of the bed elevated at 30[degrees] to 45[degrees] at all times, and recording vital signs every six hours.. Nursing notes stated that at 10 PM the head of the bed was elevated to 45[degrees] and that Jevity Plus was infusing at 55 mL/hr. There was no documentation of checking for residual formula and patency of the tube, calls to the physician, or new orders for a different infusion rate, nor was there an explanation of why the infusion rate was 55 mL/hr instead of the rate ordered. The nursing staff documented that at 1 AM they heard the patient coughing. The patient was ashen and had vomit on his face; he had aspirated the Jevity Plus formula. Although he was transferred to the hospital and placed in the

ICU and intubated, the patient died later that morning as a result of aspiration pneumonia. The patient's family filed a negligence claim against the facility and members of the nursing staff. There was no documentation to show that the nursing standards of care for assessment, planning, implementation, and evaluation had been met.

- c. An elderly resident of a skilled nursing facility who suffered from Alzheimer's disease fell and was injured. The facility practiced a no restraint policy and had a sound fall prevention program in place which included hourly rounding by nursing assistants. Although the staff had followed the protocol, they had failed to document their compliance. The patient's family received an award of \$500,000.
  - d. In a 2009 case, a \$300,000 settlement was paid to the family of a deceased patient who developed Stage IV pressure ulcers during her first 2 months in a nursing home. Despite the standard of care per policy that patients were to be regularly turned and repositioned, there was NO documentation to indicate that these measures were accomplished. The medical record did however document the deteriorating condition of the patient's skin.
  - e. The Supreme Court of Mississippi affirmed a one million dollar judgment against a long term care facility related to the death of a resident who died with a 6" X 10" pressure ulcer on her coccyx. Evidence included lack of documentation of repositioning the woman and maintaining adequate nutrition.
  - f. The plaintiff's decedent, age 78, was a resident at a nursing home. She complained of dizziness and nausea in December 2004. No vital signs or blood count were taken. The next day, the decedent was found unconscious with blood on her sheets, pillow, and brief. The plaintiff claimed that the blood-soaked articles were removed and the decedent was cleaned up before her family was contacted. The decedent's daughter claimed that she was not told that her mother died of a heart attack. The chart entry on the death only noted that the decedent was found without respirations and no mention was made of her bloody condition. An autopsy found that the death was due to a gastrointestinal hemorrhage and that she had probably been bleeding internally for several days. The plaintiff claimed that several entries in the decedent's chart were false, including a notation that the decedent had received insulin injection an hour before her death, and late entries concerning bleeding which were made by nurses who were not even on duty. According to a published account, a jury returned a \$54 million verdict, which included \$4 million in compensatory damages and \$50 million in punitive damages. Eighty percent of the fault was assessed against the facility and twenty percent was assessed against two nurses.
3. Electronic Health Records (EHR) and Use of Electronic Signatures: The LVN may encounter a facility that chooses to use EHR. Not all facilities will use the same EHR software and the record may not be entirely electronic. In these cases in which facilities have created the option for an individual's record to be maintained by computer, rather than hard copy, electronic signatures are acceptable whether or not the record is entirely electronic, and when permitted to do so by the state and local law and when this is authorized by the facility's

policies. If a facility implements the use of electronic signatures, they must have policies in place that identify those who are authorized to sign electronically and describe the security safeguards to prevent unauthorized use of electronic signatures. Such security safeguards (policies) include, but are not limited to, the following:

- a. built-in safeguards to minimize the possibility of fraud;
  - b. that each staff responsible for an attestation has an individual identifier;
  - c. the date and time is recorded from the computer's internal clock at the time of entry;
  - d. processes to ensure an entry is not changed after it has been recorded, and;
  - e. the computer controls what sections/areas any individual can access or enter data, based on the individual's personal identifier (and, therefore his/her level of professional qualifications).
4. Even in the case of EHR, the LVN is still held to the same state and federal standards regarding his/her documentation. Sample Nurses Notes:

a. Proper Documentation:

Example #1: 03/21/14, 0800

Mrs. GH is 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. She was reoriented to time and place. Upon assessment her skin was warm, dry, and pale but without pallor or cyanosis. Bilateral arms have purpura, but skin remains intact and without skin tears. There was no noted decubitus ulcers on her coccyx, hips, or heels. Her respirations are regular and non-labored. Lung sounds are clear except for crackles being noted in left lower lobe but improved when compared to earlier assessment done 03/20/2014. When encouraged to cough and deep breathe (CDB); crackles lessened after the CDB exercise. A pulse ox on right index finger showed saturation of 96% on 2 liters oxygen by nasal cannula. Her ears and nares were checked and are clear of irritation. Peripheral pulses are +2 at radius and +1 at dorsalis pedis pulses. Equal hand grips; her left pedal push is weaker but unchanged since admission. Per flow sheet, voided clear amber urine at 0715. She complained of abdominal pain being 7 on a pain scale of 0-10. 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

Example #2: 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

03/21/14, 0900

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

03/21/14, 1000

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

-E. Doe LVN

03/21/14, 1010

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

--E. Doe LVN

03/21/14, 1020

Ambulance arrived 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 #3: 04/18/2014, 0645

Received report from the night nurse and assumed care. Assessment completed. VSS. Resident awake, alert and oriented. Complains of pain in fractured right hip as an 8 on a scale of 0-10. Medicated with two Vicodin per MD orders. Will continue monitoring. 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 #4: 11/15/13, 0815

Focused 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, LVN

11/15/13 0820

Focused assessment findings reported to Dr. Halifax----J. Smith, LVN

11/15/13, 0825

Resident assessed by Dr. Halifax -----J. Smith, LVN

b. 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"

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”

5. Documentation Activity:

- a. Resident Information: Mrs. Anne Dixon is an 87 year old resident. Dr. MacLeod is her primary physician. Matthew Dixon is her son and is named as her agent on her advance directives. She has a diagnosis of hypertension, osteoporosis, osteoarthritis, dementia, and Type II diabetes. Her functional abilities include: ambulation with the assistance of a walker, requires some assistance with activities of daily living (ADLs), bathing, grooming, and toileting.
- b. What happened: The direct care staff were alerted by hearing a loud crash and yelling in the resident’s room. The roommate Emily Miles witnessed Mrs. Dixon fall. At 1300 Anne is found lying on her right side on the floor at the bedside in front of the night table. She denies any loss of consciousness, but is not sure if she bumped her head. She has a 2 cm abrasion on the right side of her forehead that is oozing blood. She is moving all her limbs and complains of pain at 6/10 for a “sore right shoulder”. A large amount of bruising is noted to the right shoulder. Vital signs are BP: 130/86; T: 98.2; P: 94; R: 22; O2 sat: 95% on room air. Anne also tells the staff that she was trying to get the magazine from her night table so she could get up and read in her easy chair. When she got up, she became dizzy and fell. She is awake and aware of her surroundings after the fall. Her speech is clear and coherent and hand grips are strong bilaterally. The physician was notified of the adverse event at 1315. The physician orders neuro-vital signs for 3 hours, every 15 minutes, 2 tablets of extra strength Tylenol 500mg/tablet for pain every 6 hours as needed, and an x-ray of the right shoulder. Anne is assisted back to bed with the assistance of a second direct care staff. The laceration on her forehead received first aid treatment from the nurse. The family was notified of the adverse event. Anne was instructed to ask for help when she gets up to read or to use the bathroom. She was asked to call the nurse if she is in pain. The client was left in bed in a safe position.
- c. Your assignment: Document the client’s fall and interventions that were done. Be sure to follow proper documentation requirements.
- d. **Answer Key:** What the student should have documented:
  - i. 10/06/2015.....1400.....A loud crash and yelling heard in the resident’s room. The roommate witnessed the event. Resident found lying on right side on the floor at the bedside in front of the night table at 1300. Resident denies loss of consciousness or bumping her head. A 2 cm abrasion oozing bright red blood is noted on the right side of the forehead. Moving all limbs, but complains of a “sore

right shoulder”. Circular bruising of 10cm noted to the right shoulder. Pain in right shoulder is 6/10 as per the numeric pain scale. Vital signs: BP: 130/86; T: 98.2; P: 94; R:22; O2 sat: 95% on room air. Pupils are equal and reactive to light. Resident states that she was trying to “get the magazine from her night table so she could get up and read in her easy chair”. When she got up, she became dizzy and fell. Awake and aware of her surroundings when asked. Speech is clear and coherent and bilateral hand grips are strong. Dr. MacLeod notified of injuries and fall at 1315. New orders received. Physician requests a call at 2000 for updated report on client’s condition. Resident assisted back to bed with a second direct care staff. 3 cm laceration on forehead cleansed with normal saline and 2x2 dressing applied. Ice pack placed to right shoulder. Son Matthew Dixon was notified and will come this evening to visit. Resident instructed to ask for help when getting out of bed. Resident verbalized understanding. Resting in bed – magazines and call light within easy reach and bed in lowest position. Refuses side rails. Resident also instructed to call if pain increases. Falls precautions protocol implemented. Will continue to monitor and assess as needed.....J. Jingle, LVN

- e. Some additional thoughts to discuss with students:
  - i. The documentation could have stated that “oriented to time, person, and place when asked”, instead of stating “awake and aware of surroundings”. Or it could state the responses to the questions that were asked to assess orientation.
  - ii. There could be an expansion on the witnessing roommate’s comments if there were any, without identifying her.
  - iii. It is not advisable to document the physician orders in the progress notes, but it is appropriate to state if “new orders” or “no new orders”. Remember to state the exact words of the physician when the incident was reported, or if the incident was reported to a supervisor.
  - iv. Remember that safety measures and instructions or teaching should be documented, as well as the results of the discussions that were had with the resident.
  - v. The student should be sure that they have adequately documented on the emotional status and pain of the resident.
  - vi. Have the student ensure that their documentation is clear and that the story is easily identifiable.
  - vii. Finally, the student should ensure that their documentation meets both legal and professional standards.

6. SBAR:

SBAR is a technique designed to communicate critical information succinctly and briefly.



- S** **ituation**  
*What's going on with the patient right now?*  
*(Identify yourself, identify the patient, state the problem concisely.)*
- B** **ackground**  
*What's the background on this patient? How did we get to this point?* (Review the chart. Anticipate questions. State the relevant medical issues.)
- A** **ssessment**  
*What do I think the issue is? Why am I concerned?*  
*(Provide your observations and evaluations of the patient's current state.)*
- R** **ecommendation**  
*What should we do to respond to the situation?*  
*(Suggest what should be done to meet the patient's immediate needs.)*
- R** **esponse**  
*Collaboration resulting in a plan of action. (Listen for/seek feedback to ensure responder understands the issue.)*