

The background features a teal color with concentric, hand-drawn style circles. A white heart rate line (ECG) is visible on the left and right sides, partially obscured by a central dark blue tablet. The tablet has a light blue border and three small circles at the bottom. The screen is orange and contains the following text:

Improving Nursing Documentation and Reducing Risk

Patricia A. Duclos-Miller, MSN, RN, NE-BC

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Patricia A. Duclos-Miller, MSN, RN, NE-BC, is a professor at Capital Community College in Hartford, Connecticut, in the division of nursing. She continues to advance the professional practice of nursing in her role as a professional development coordinator for Bristol Hospital in Bristol, Connecticut, where she has also served as a quality consultant.

Duclos-Miller graduated from Saint Anselm College in Manchester, New Hampshire, with a Bachelor of Science in nursing, and completed her Master of Science degree at Boston University. She is board certified by the American Nurses Credentialing Center in nursing administration.

Her professional experience includes nursing administration in quality improvement, parent-child health, home health care, and long-term care nursing, as well as practicing as a staff nurse in the specialties of medical-surgical nursing, obstetrical nursing, neonatal intensive care, and as an educator in nursing education. Her teaching experience includes former faculty positions at St. Joseph University in West Hartford, the University of Connecticut, and the University of Hartford. She is a national speaker on contemporary topics involving nurses in the new graduate transition and in the development of leadership skills, quality improvement, team building, and documentation.

She has served in key leadership positions for professional organizations, including as president and vice president of the Connecticut Nurses Association and as a member of the Connecticut League for Nursing Board of Directors. She is the author of the first and second editions of *Managing Documentation Risk: A Guide for Nurse Managers* and its accompanying handbook *Nursing Documentation: Reduce Your Risk of Liability*; *Stressed Out About Your First Year of Nursing*; and *Home Health Documentation Proven Strategies for Clinicians*. She has been a contributor to *Strategies for Nurse Managers*.

Dedication

In my 40 plus years of nursing, I have had the pleasure of working with dedicated nurses who inspire me. This book is dedicated to the nurses at Bristol Hospital who show how extraordinary they are *every day*.

It is not how much we do—it is how much love we put into the doing.

—*Mother Teresa*

Chapter 1

Contemporary Nursing Practice Includes Good Documentation

Why We Need to Think Differently About Nursing Documentation

The Institute of Medicine (IOM) recommends core competencies for all healthcare professionals, which include the ability to communicate effectively (2003). The Quality and Safety Education for Nurses (QSEN) promotes competencies that the nurse needs to practice in today's fast-paced nursing profession. The Massachusetts Nurse of the Future (NOF) Competency Committee reviewed both of these resources in addition to competencies from other states, professional practice standards, national initiatives, and the projected healthcare profiles for their state patient population. They define the NOF competencies as:

- Patient-centered care
- Professionalism
- Leadership
- Systems-based practice
- Informatics and technology
- Communication
- Teamwork and collaboration
- Safety
- Quality improvement
- Evidence-based practice (Massachusetts Department of Higher Education, 2010)

Regardless of their years of experience, today's nurses are considered competent when they demonstrate contemporary competencies. These competencies go beyond the hands-on skills and should

include QSEN and the NOF core competencies. The NOF defines communication as the ability to “interact effectively with patients, families, and colleagues, fostering mutual respect and shared decision-making, to enhance patient satisfaction and health outcomes.” The NOF competency of communication includes knowledge, attitudes/behaviors, and skills. Refer to the following table for an example of how to promote effective communication through good documentation.

Knowledge	Attitudes/behaviors	Skills
K1a Understands the principles of effective communication through various means. K1b Knows grammar, spelling, and health care terminology.	A1 Accepts responsibility for communicating effectively.	S1a Uses clear, concise, and effective written, electronic, and verbal communications. S1b Documents interventions and nursing outcomes according to professional standards and work unit policy.

NOF Nursing Core Competencies, Aug 2010

Why is nursing documentation so important even today? How is it tied to nursing practice? And how is it linked to safe patient care and quality outcomes? Documentation of patient care is a fundamental, yet critical, skill used by nurses to communicate the current health status of the patient’s individual needs and responses to care (Kelley, Brandon, & Docherty, 2011). As professional nurses, we are held responsible for ensuring safe, quality patient care. The only proof of this is through nursing documentation.

“No matter how skilled a nurse you are, poor nursing documentation will undermine your credibility if you’re ever involved in a lawsuit” (Austin, 2010).

Documenting completely and accurately is considered a professional standard of nursing practice. For every step in the nursing process, the care delivered must be evident in the medical record. We need to document the patient’s progress, condition, needs, treatment, and nursing care.

To be recognized as professional nurses who deliver quality patient care, we must ensure documentation that is consistent, clear, and factual. In this way, the nurse validates critical thinking used for the care rendered. The American Nurses Association (ANA) introduced a tool to streamline the nursing documentation process. Principles for Documentation includes policy statements, principles, and recommendations to assist nurses with documentation. It also explains how to comply with institutional and regulatory requirements.

In addition, professional nurses must review the ANA *Code of Ethics for Nurses* and the *Scope and Standards of Practice* to ensure that they are demonstrating contemporary professional nursing care. The ANA standards identify the following characteristics for effective documentation:

- Accessible
- Accurate, relevant, consistent
- Auditable

- Clear, concise, complete
- Legible/readable (including the EMR content as it is displayed on the screen)
- Thoughtful
- Timely, contemporaneous, sequential
- Reflective of the nursing process
- Retrievable on a permanent basis in a nursing-specific manner (Taylor, Lillis, & Lynn, 2014)

The quality of the care provided to patients can only be measured by the quality of the nursing documentation. The essential components for documenting nursing care include:

- Documentation of the patient plan of care
- Evaluation of the effectiveness of the care provided
- Communication between the patient/family and other healthcare providers

Failure to completely document can have legal consequences. If nursing documentation is incomplete, contains gaps, or is not consistently completed according to the standards and the facility's policies, then it can be used to support an allegation that substandard care was provided. Incomplete documentation leaves the reader (auditor, state surveyor, juror) to conclude that the nurse did not:

- Collect sufficient data and plan safe and appropriate patient care
- Implement appropriate interventions according to professional and institutional standards
- Make sound contemporary clinical decisions
- Communicate effectively

Nurse Manager Responsibilities

As a nurse manager (also known as unit leader), regardless of clinical setting, you are responsible for assisting staff in adhering to both clinical and documentation standards. It is also your responsibility to provide continuing education, ongoing feedback, and input into policy and documentation changes. It is to your advantage to fulfill these responsibilities, because if your staff is involved in a malpractice case, then your ability to manage and meet the quality and risk management standards will be called into question. You may be asked if the staff were following the standards of care based on organizational as well as accreditation or regulatory standards.

As a member of the leadership/management team, you must demonstrate that you have a commitment to providing safe quality patient care. It is your responsibility to ensure that nursing staff comply with up-to-date standards and organizational protocols/policies. The proof for this will be in the medical record. Your role is to support an efficient and effective documentation system and create an expectation that the documentation standards will be followed.

Demonstrate support for this by:

- Developing or revising an efficient system that meets the requirements of regulatory standards
- Analyzing whether the documentation system allows for documentation of critical thinking and the nursing process
- Involving the end users in the development or analysis of the system
- Emphasizing the importance of documentation through written guidelines, policies, and performance evaluations

Nursing Process

Once a nurse has graduated from nursing school, there seems to be a myth that they never have to use the nursing process again, as it was so closely tied to nursing care plans. Unfortunately, if the nurse does not integrate the nursing process into patient care and subsequent nursing documentation, they will find themselves at risk for allegations of substandard care. The nursing process provides every nurse with an established, scientific approach to providing nursing care.

Not only does each step guide us in our approach, it also tells us how to validate what we saw, heard, felt, smelled, said, and did while providing that care. The process accounts for all significant data and actions taken by a registered nurse, the documentation of which is used for critical decision-making. Therefore, nursing documentation of patient care should follow the nursing process, as it ensures systematic care and its documentation.

Here's an example of the standard of care and use of the nursing process in the specialty field of perioperative nursing:

Perioperative nursing remarks should describe physical, psychosocial, cultural, and spiritual assessment performed before the surgical procedure, as well as specify what nursing interventions were performed and when, where, and by whom. Perioperative documentation is essential for the continuity of care and for comparing actual patient outcomes with expected ones (Tiusanen, Junttila, Leinonen, & Salanterä, 2010).

Assessment

The nursing process begins with the initial and ongoing assessment of the patient. In this step of the nursing process, the nurse is expected to use excellent critical thinking and clinical reasoning skills when gathering, analyzing, validating, and communicating data. If this—as in any other step of the nursing process—is not documented, the old adage “not documented, not done” surfaces.

Examples of assessment data include the patient's history, physical exam, laboratory data, and so on. The nurse must analyze patient data and decide which information is most useful to the care of the patient. The nurse could limit the assessment data to the admission signs and symptoms, the chief

complaint or medical diagnosis, patient presentation, or any relevant assessments made at the time. Assessment should always be evident in the medical record, as it provides a complete clinical picture of the patient as well as whether the nurse is thorough in this step of the nursing process.

Assessment data should include both subjective and objective data. When documenting this data, be aware of inappropriate documentation practices such as the “copy and paste” function in the electronic medical record, as it could become a risk management issue.

Subjective data

This is data that can be observed but not measured. Statements made by the patient or family/significant other are examples of subjective data. Although every conversation may not be relevant to the interaction, there will be times when a patient’s words need to be recorded to establish a clear picture of how the patient perceives his or her status. There are many times that the patient may become argumentative or fail to understand the gravity of the situation, e.g., leaving against medical advice. Document what the patient said, as it may have relevance later during an episode of care. The patient’s exact words should be in the progress notes in quotation marks.

Objective data

Nurses establish patients’ clinical status based on objective data, which are observable and measurable. The physical exam of a patient includes key assessment techniques—inspection, palpation, percussion, and auscultation—which provide objective data about the patient’s health status. In other words, a nurse’s objective assessment is based on what is seen, heard, felt, and smelled. Objective data also includes lab values and test results. Always document what you assessed, including responses to interventions, such as medications or treatments. Healthcare providers find this aspect of documentation much easier to validate and include in their documentation than subjective data.

When recording objective data, there are risks that a nurse must consider. If the objective data is not reviewed in a timely manner, any reviewer of the medical record could find fault with the nurse and see it as a failure to interpret the data and address significant changes of the patient’s condition. There may also be situations in which critical objective data were present but there is not subsequent documentation of an appropriate intervention. Any of the above situations can lead to quality and risk management issues.

Unacceptable assessment documentation

When documenting subjective or objective data, be careful to do so thoroughly. Refer to Table 1.1 for examples of common mistakes entered into the medical record.

Table 1.1 Common Documentation Mistakes in the Medical Record

The entry:	The problem:	The solution:
Neuro signs WNL	Which aspects of the neurological assessment are within normal limits? Does WNL refer to cognitive, visual, musculoskeletal, cranial nerve, Coma Scale, or something else? Lack of documentation of a complete neurological assessment can lead to an accusation of failure to document assessments according to contemporary nursing standards.	Ensure that the neurological assessment section is based on current standards and divided into sections to include all of the appropriate parameters. Ensure that the staff completes the section according to policy and documentation guidelines.
Grand mal seizure	The documentation of this episode needs to have a beginning, middle and end. Start by documenting the patient's status prior to the incident, if known. Describe any report of an aura, color, posturing, or physical change during the event. Record the length of time of the event and the condition of the patient immediately following it, including both subjective (what did the patient tell you about the incident) and objective data (what were his/her vital and neurological signs) assessed by the nurse.	Here is how the nurse should have documented the event: <i>Mrs. S was ambulating to the BR with PCA. Pt. state she "felt funny". Pt. slowly lowered to floor with assistance. Pt. noted to turn pale white, facial grimace was fixed during the incident, contraction of large muscle of all extremities. Episode lasted 30-60 seconds. No observation of respiratory or cardiac distress. VSS after episode (taken w/in 1 minute), see flowsheet. Incontinent of lg. amt. of urine (500 mL). Speech slurred, disoriented and complained of tiredness for the first 30 mins. following incident. No other neuro signs affected see Neuro flowsheet. No laceration of tongue. First observed episode.</i>
Intake and output section or form is incomplete	Incomplete intake and output (I&O). It could be as simple as the hourly fluid intake or missing urinary output. Incomplete I&O data can lead to allegations of improper nursing assessment and insufficient data gathering. It could then be argued that these omissions led to a lack of critical thinking which resulted in the patient being harmed.	Ensure that all I&O sections are completed in their entirety. Complete each data entry in a timely manner. Check for accuracy in the data measured for both intake and output.

Documentation tips



- Document your assessment findings as soon as possible after you conduct the health history and physical assessment.
- If using an assessment form or computer template to answer every question, do not leave any blanks. If it does not apply to the patient, indicate that with "not applicable."
- Remember, you accept accountability for your assessment when you sign your name.
- Use direct quotes from the patient or family so that you capture the intent.
- Clarify any information that seems incomplete (Sparks, 2014).

Any gaps in your documentation with any clinical assessment tool leaves the nurse and the facility open to allegations that they failed to document assessments, and even worse, failed to address significant changes in the patient's condition. In the case of an incomplete I&O, it could be alleged that the lack of analysis of the data led to a lack of appropriate intervention, and that the inaccurate documentation was the cause of circulatory collapse, dehydration, renal failure, infection, skin breakdown, or even death.

Case Study: Patient's Fall: Court sees evidence of faulty nursing assessment

A nurse's ability to assess and provide appropriate nursing care is critical to patient outcomes. In *Nexion v. Townsend*, the court accepted the expert's opinion.

The patient was a 69-year-old woman who had been admitted to a medical facility for rehabilitation after back surgery. She was assessed as a high fall risk as well as needing two-person assistance with transfers. The patient had deep vein thromboses in her legs and was on bed rest, Coumadin™, and Lovenox®. The lab studies included INR and prothrombin time to be checked twice a week. Unfortunately, they were not done after the two initial readings. Three days prior to the patient's fall, her prothrombin time was more than twice the higher value of the normal range.

On the day of the fall, X-rays were done and showed no fractures. The next day, the nurses documented that there were no injuries except for purple bruising on her right buttock. Two days later, the patient was pale and her breathing was labored. She was sent to an acute care hospital but died the next day. An autopsy was performed, indicating that there had been retroperitoneal hemorrhage and multiple organ failure. The cause of death was blunt force trauma in conjunction with Coumadin therapy.

The focus of the case was on the faulty assessment and management of the patient's condition after the fall. The nurses were accused of poor assessment, as the patient had been on anticoagulant therapy, which places a patient at risk for internal retroperitoneal bleeding after blunt force trauma. The lack of appropriate and frequent vital signs as well as not recognizing signs of shock from internal bleeding was evidence of faulty assessment. The nurses did not recognize that a rapid pulse, labored breathing, mental confusion, and increased pain were signs of hemorrhagic shock (*Legal Eagle Eye Newsletter*, July 2015).

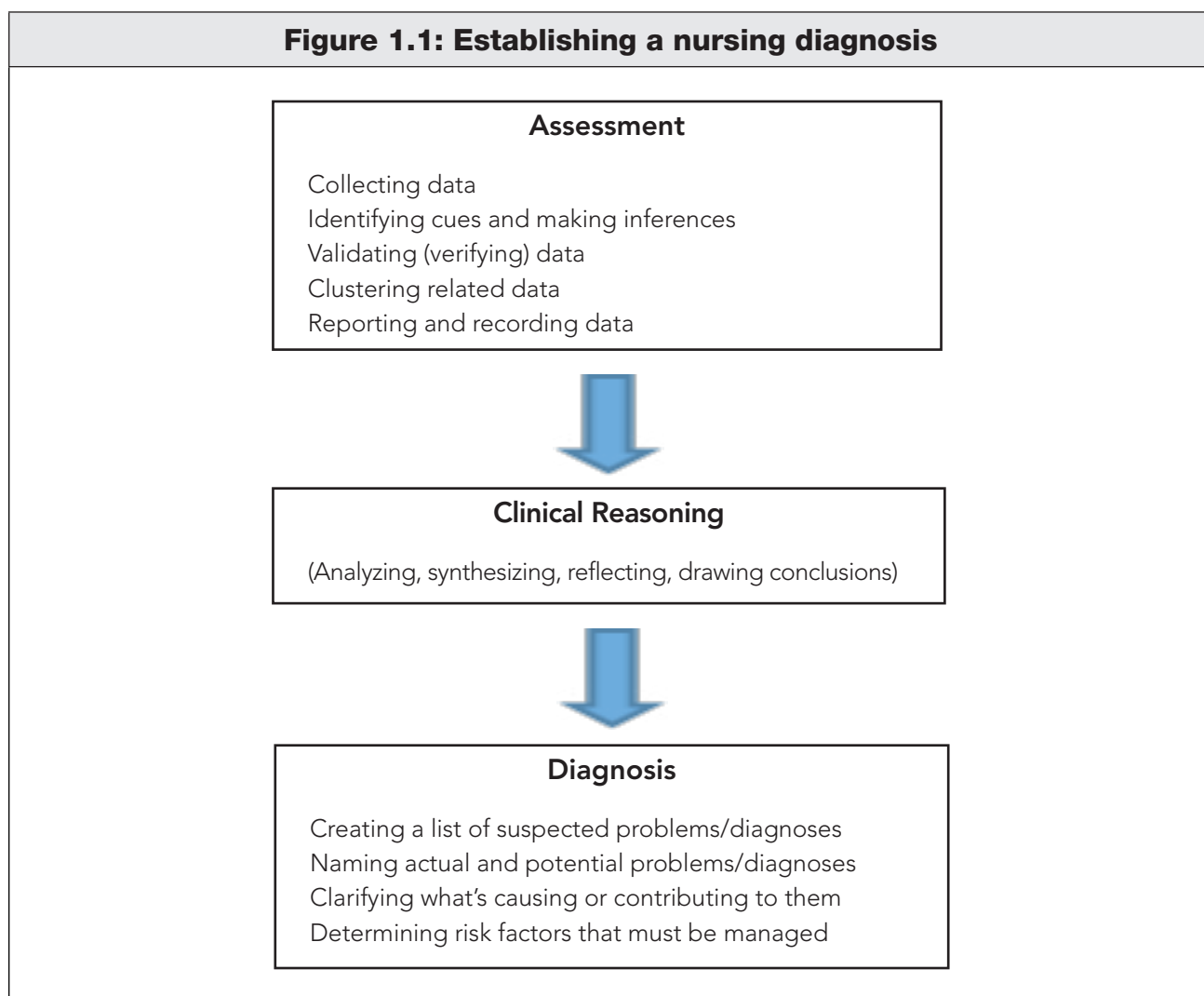
For a nurse to arrive at a nursing diagnosis and develop the most appropriate plan of care, assessment findings are crucial. Be sure that the assessment tool your staff uses demonstrates the nurse conducted a thorough, accurate nursing examination. Here are some risk management tips for documenting assessment findings:

- Describe everything exactly as found by inspection, palpation, percussion, or auscultation.
- Do not use general terms such as "normal," "abnormal," "good," or "poor".
- If you use Within Normal Limits (WNL), be sure that there is a description of what that means built within the tool. It could be a drop-down in the EMR that defines what WNL is for each body system.
- Your policy on assessment must include a minimum time frame for assessment completion and documentation. But do not box yourself in with a very tight time frame, as you will be held to whatever the policy states regardless of staff practice.

- Encourage and monitor staff compliance with documenting their assessment as soon as possible after completing it.

Nursing Diagnosis

If nurses accurately perform the assessment process, they will be able to appropriately establish nursing diagnoses (**Figure 1.1**). This step in the nursing process demonstrates that the nurse reviewed the appropriate data available at the time and made a professional determination of the clinical problem at that time. Once the nurse makes a clinical nursing diagnosis based on a thorough assessment, the rest of the process falls into place. Nursing diagnoses provide the basis for selecting the nursing interventions that will achieve the desired patient outcome.



Adapted from Taylor, et al., 2014, p. 254.

According to the NANDA International (NANDA-I) website, “A nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse has accountability” (NANDA Conference, 2013).

Simply put, the nursing diagnosis expresses the nurse’s professional judgment of the patient’s clinical status, the anticipated response to treatment, and the potential needs of the patient. It guides the nurse and subsequent providers in their understanding of the patient’s problem(s). Then the patient plan of care can be developed specifically for that patient problem. You decide where best to use nursing diagnoses. They might be used in the patient plan of care and/or on the multidisciplinary problem list in the patient’s medical record.

If your organization chooses to include the use of NANDA-I nursing diagnoses in its documentation system, you will need permission from NANDA-I. The NANDA-I diagnostic headings, along with the patient’s clinical etiology, provide a clear picture of the patient’s needs.

Outcome identification/goal and planning

The next step in the nursing process is to determine the most appropriate and realistic expected outcome for the patient. The outcome is derived from the nursing diagnosis and must be documented as a measurable, realistic, patient-focused goal. In addition, it must include a time frame as well as an objective measurable action that the patient is expected to achieve. According to Taylor (2014), the primary purpose of the outcome identification and planning step of the nursing process is to design a plan of care with and for the patient that, once implemented, results in the prevention, reduction, or resolution of patient health problems and the attainment of the patient’s health expectations, as identified in the patient outcomes. So how does this relate to documentation? This phase of the nursing process demonstrates whether the nurse has used nursing standards and evidence-based nursing interventions and has communicated the plan of care in the medical record.

Many organizations use standardized care plans that identify the nursing diagnoses, patient outcomes, and related nursing interventions that are common to their patient population or health problem. However, there is a downside to using standardized care plans. The nurse needs to ensure that the care plan is individualized to each patient, even though the plan is standard for any patient with that diagnosis. The stated patient outcome must in fact be appropriate for that patient. The copy/paste mode for this step would lead one to believe that the nurse did not truly think through the patient’s individual needs and goals. And whenever possible, the nurse needs to include that patient/family’s perspective for the goal of the treatment and time frame. The expected outcomes should reflect the continuum of care, from admission (addressing immediate and intermediate outcomes) to planning for discharge and follow-up care.

Tips for documenting patient-centered outcomes

Nurses need to first ask patients to describe two or three goals they would like to achieve. The nurse then needs to consider:

- Patient's state of health and overall prognosis
- Expected length of stay
- Patient values and cultural considerations
- Other planned therapies for the patient
- Available resources (human, material, financial)
- Current scientific evidence
- Any changes in patient status that changes your expected outcome (Taylor, et al., 2014)

Writing Patient-Centered Measurable Outcomes

When writing measurable outcomes, include a subject, which is usually the patient or a part of the patient; a verb that indicates the action the patient will complete; conditions, if applicable, that specify the circumstances by which the outcome would be completed; performance criteria, which describe the observable, measurable terms for expected patient behavior; and time frame, which specifies when the patient is expected to be able to achieve the outcome.

Use a memory jog for writing outcomes. This is just one example:

- S** Specific
- M** Measurable
- A** Attainable
- R** Realistic
- T** Timeframe

Planning

The next step in the nursing process is to develop a plan of care for the patient based on the nurse's assessment and diagnosis. Documentation of this phase demonstrates that the clinical status of the patient was recognized and that the nurse then developed an appropriate plan of care. It should demonstrate that the nursing process was in place, thereby decreasing the risk of incomplete or incorrect nursing care. Every step of the nursing process needs to be evident in the medical record. This

planning step of the nursing process reveals the critical-thinking skills of the nurse. Adjustments to the plan of care reflect that the plan of care was individualized and meets the patient's needs.

Implementation

Based on the nursing plan of care and contemporary standards of care, the nurse should document the care provided for the patient. This step of the nursing process includes working collaboratively with other members of the healthcare team: the patient and the patient's family.

Examples of interventions that demonstrate this step:

- Assessing and monitoring (e.g., recording vital signs)
- Therapeutic interventions (e.g., administering medications)
- Comfort measures
- Caring behavior
- Assistance with activities of daily living (ADLs)
- Supporting respiratory functions
- Supporting elimination functions
- Providing skin care
- Managing the environment to promote a therapeutic milieu
- Providing food and fluids
- Giving emotional support
- Teaching and/or counseling
- Consultation and/or referral to other agencies or services

Other suggestions include:

- Reassessing: It can be brief or narrowly focused; reassessment confirms that the plan of care is still appropriate.
- Reviewing and modifying the care plan: The patient care plan is ever-changing based on the patient's condition. Each section of the nursing process (assessment, nursing diagnoses, implementation, evaluation) should be updated (Sparks & Taylor, 2014).

Documentation will need to include the specific nurse's intervention and the patient's response to the intervention. Risk of liability for the nurse surfaces when the actual care delivered cannot be found in the medical record. Many documentation systems capture the assessment and outcome determination but are at a loss to clearly find the nurse's plan of care and nursing actions delivered, especially when

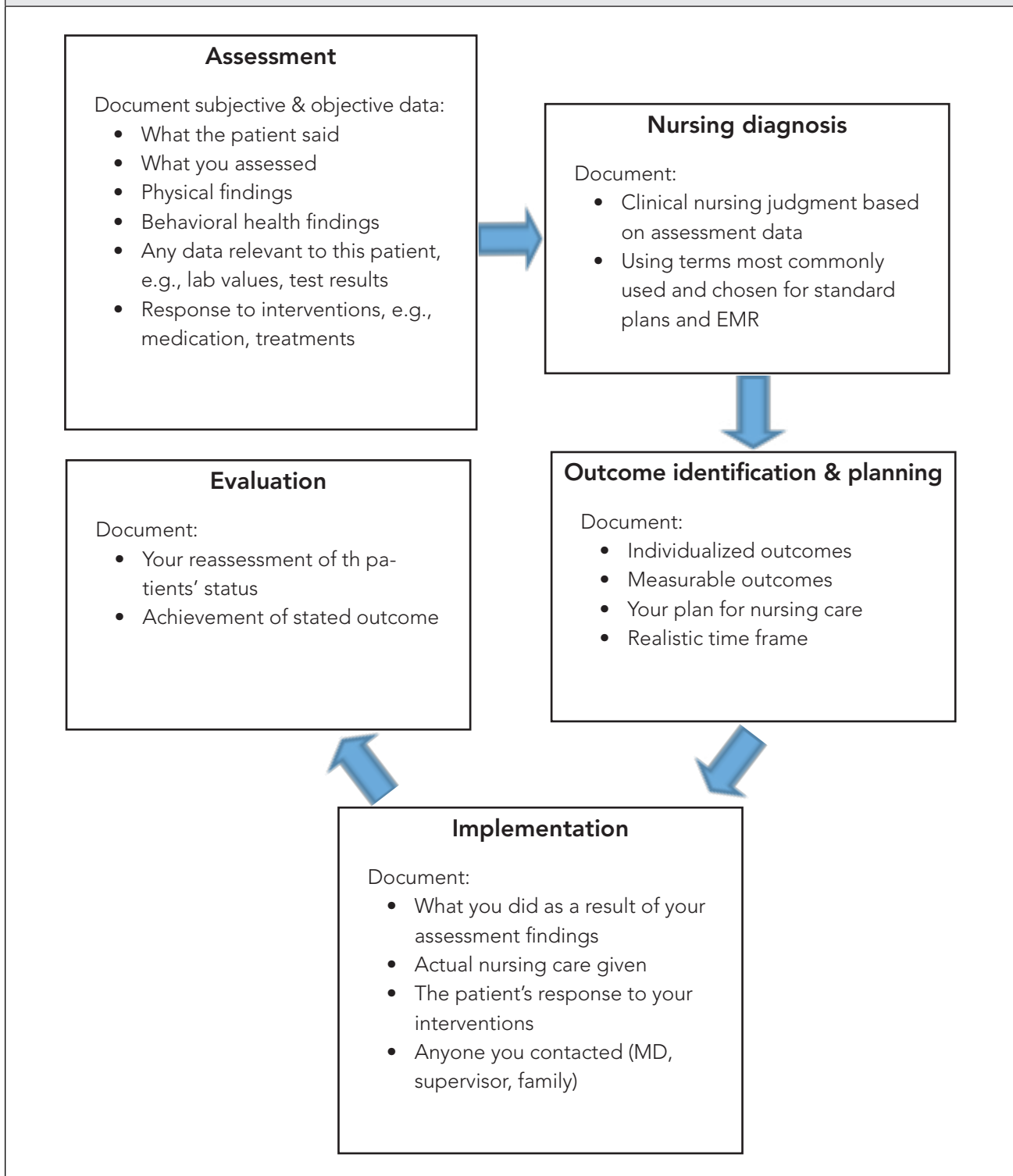
there is a variance or change in the patient's condition. Nursing documentation needs to reflect the care given, coordination of care with other team members, health teaching and promotion, and any consultation that was done on behalf of the patient.

Evaluation

In this step of the nursing process, the nurse reviews the patient's progress toward meeting the established outcomes. The documentation needed in this step includes the nurse's comments on whether the assessment, diagnosis, achievement of outcomes, plan of care, and nursing interventions were successful. Nurses need to understand that evaluation of their care must be clearly documented. They need to ask themselves:

- Has the patient's condition improved, deteriorated, or remained the same?
- Were my nursing diagnoses accurate?
- Have the patient's needs been met?
- Did the patient meet the outcome documented in the plan of care?
- Do I revise or discontinue the nursing interventions?
- Why did the patient fail to meet the goal? (Sparks, 2014)

If the nurse uses the evaluation step correctly, the documentation will reflect safe, quality nursing care. Refer to **Figure 1.2** for an overview of documenting the nursing process.

Figure 1.2: Documenting the nursing process

Case study

Scenario: A patient complains of chest pain. The nurse takes the patient seriously, as the subjective complaint may indicate a myocardial infarction. He or she acts quickly, performing a focused assessment and documenting the essential information. Here are the critical elements of good documentation of a patient with chest pain.

Documentation of subjective and objective data

2/15/16 16:00

Patient stated, "Nurse, I am having chest pain." See Pain Flow sheet for description, location, intensity noted. Patient in bed, increasingly anxious; used calm, reassuring behavior with patient. Redirected her to focus on remaining calm for interventions to work. Patient responded, and pulse and respirations decreased. See VS sheet.

The patient's exact description of the symptom was noted; the nurse used quotation marks around the patient's words, rather than recording his or her interpretation of them.

On the pain flow sheet, the nurse indicates *pain was located in the substernal region, radiating to the left shoulder, described as crushing. Pain level 10 out of 10.* The nurse appropriately uses the pain scale to measure the level of intensity, as well as pain location and characteristic.

The nurse also notes on the pain flow sheet: *No preceding activity or past history of this type of pain. Steady pain: 2–3 minutes. No SOB.* This indicates the frequency and any precipitating factors.

Patient care flow sheet indicated that the initial pulse and respirations at the time of the nurse's initial assessment of pain were:

2/15/16 16:00 P: 120 R: 40 BP: 146/90

2/15/16 16:04 P: 96 R: 28 BP: 124/85

In the cardiopulmonary section of the patient care flow sheet, the nurse writes:

SR (sinus rhythm), monitor fluctuated from S-tach to SR. No JVD. O2 sats on RA: 92%

O2 sats on 4 L via cannula: 98%

The nurse documents the vital signs, noting sinus tachycardia, an increased respiratory rate, and above-baseline blood pressure for this patient. In addition, the nurse records auscultation of heart sounds (e.g., regular/irregular heart rate, murmur, gallops, rubs).

Case study (cont.)

The nurse assesses lung sounds, the respiratory rate and pattern, and measures abnormal O₂ saturation via pulse oximetry. The patient's actions are already noted as increasing anxiety. There is no clutching of the chest by the patient. Skin assessment is also conducted and documented.

In the cognitive section of the patient care flow sheet, the notations indicated: No changes in mental status, no decreased level of consciousness, disorientation, or confusion.

In the narrative notes, the nurse notes: Skin cool, clammy, no peripheral edema, ashen in color. No cyanosis noted.

Documentation of what was done: Intervention

The nurse continues to document interventions and the patient's response to the nursing interventions.

Frequent monitoring:

- The VSs were noted every few minutes until the chest pain subsided. The nurse continues hourly VSs, pain assessments, and signs and symptoms of the patient.
- All treatment activities are documented, including cardiac enzymes, ABGs and EKG, SL NTG, morphine sulfate, etc.
- Fluid intake and output: Recorded every four hours.

Oxygen therapy:

- The nurse documents the patient's initial pulse oximetry reading, respiratory assessment findings, and ABG results, when they were notified.
- The pulse oximetry assessments are documented every hour until within normal range, and every four hours thereafter. Based on ABG results, O₂ could be decreased.
- O₂ decreased to 2L.

Continuous cardiac monitoring:

2/15/16 16:03 Patient placed on cardiac monitor. Patient informed as to the reason for continuous monitoring. Patient verbalized understanding.

The nurse notes the time the patient was first placed on the cardiac monitor and the nurse teaching about the reason for the monitor. The nurse also records which lead is being displayed on the strip and the flow sheet. The patient's rhythm strip is labeled with the patient's name and strip intervals. Subsequent rhythm strips are obtained according to MI protocol (such as change in condition, ectopic beats noted, or arrhythmia). Each strip has a notation as to the heart rate and rhythm, PR-interval, and QRS-complex duration. The patient does have an ST-segment elevation, which is noted on the strip.

Case study (cont.)

2/15/16 17:02 Dr. Smith notified of 2mm ST elevation. New orders received and transcribed. O2 increased to 4 L, 12 lead EKG done. Stat SL NTG, Chest pain unrelieved by NTG. Morphine 2 mg. IV PRN given.

The nurse documents notification of the physician for a significant change from the initial strip. It is very important that the nurse records the physician's response to the patient's condition.

Drug and IV therapy:

The Medication Administration Record (MAR) notes the names, dosages, times, and routes of the medications the nurse gives. The nurse also documents the patient's vital signs after each dose of nitroglycerin and morphine. The pain flow sheet indicates the patient's response to the NTG and morphine.

On the IV section of the patient care flow sheet, the nurse documents his or her assessment of the IV site—the date and time the IV line is inserted, catheter gauge, and person who does the insertion. The nurse also notes the catheter size, dressing type, and condition. During the remainder of the shift, the nurse documents his or her assessments of the IV site and line patency.

Activity:

2/15/16 17:30 Patient informed of activity limitations due to change in her cardiac status. Patient stated, "Don't worry, I'll call you before I do anything." The nurse notes the patient is on bed rest and his or her instructions regarding patient activity limitations.

Communication:

This nurse demonstrates good documentation of his or her communication with other healthcare team members. It is found in the narrative notes, the names of those notified, time of notification, etc.

Emotional support:

2/15/16 20:10 Patient increasing in anxiety, attempted to get the patient to talk about her feelings and the source of the anxiety. Offered medication to assist in decreasing her anxiety. Patient agreed to medication.

The nurse offers and documents emotional support to help the patient cope with the physical and psychological impact of her condition.

Case study (cont.)

Transfer to ICU:

This patient does not need to be transferred, but if she had, the nurse would have given a verbal handoff report and documented the aspects of the patient's condition that warranted the transfer. The report to the ICU nurse would have been documented. The nurse would also have recorded the name of the person who accompanied the patient and which monitoring devices were in place during the transport. The nurse or another healthcare provider would have to document how well she tolerated the transfer.

Documentation of what was taught

The patient's teaching plan needs to be tailored to the patient's condition and treatment. Documentation of patient/family teaching needs to include what was taught, the method of teaching, the materials used for teaching, how well the patient/family understood the teaching, etc. The "teach back" method would also be documented. In this case, nurses should discuss the following with this patient:

- Disease process
- Diagnostic tests and the reason for them
- Treatment options such as angioplasty, stents, or thrombolytics
- Signs and symptoms of an MI
- Signs and symptoms to report
- Actions to take when chest pain returns
- Medication management (i.e., prescribed drugs and their names, dosages, times to take them, route, any potential side effects, and how to store the medications)
- Smoking cessation advice
- Diet management
- Activity and rest patterns
- Community support groups, cardiac rehab centers (Sparks, 2014)

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Improving Nursing Documentation and Reducing Risk

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In the age of electronic health records and value-based purchasing, accurate and complete nursing documentation is crucial. Proper documentation affects not only quality of care, but also facilities' costs and revenues.

Redundant documentation wastes time and money, while inadequate documentation negatively affects Joint Commission core measures and can result in license suspensions or legal action against a healthcare facility—an expensive and often damaging outcome.

Nurse managers, especially new nurse managers, do not clearly understand their legal accountability for poor or inadequate documentation created by nursing staff who report to them. While each state's nurse practice act (NPA) differs, every NPA addresses nursing liability for documentation; however, many nurse managers remain unaware of these and other regulations that hold them accountable for the documentation crafted by their nurses.

This book helps nurse managers create policies, processes, and ongoing auditing practices to ensure that complete and accurate documentation is implemented by their staff, without creating additional time burdens.

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