Documentation is critically important in the home care setting. Not only does it prove medical necessity but it also helps code the Outcome and Assessment Information Set (OASIS), ensures proper reimbursement, and provides legal protection. With so much at stake, it’s more important than ever to have effective documentation.

Home Health Documentation: Proven Strategies for Clinicians provides nurses and therapists with an easy-to-use reference on documentation that offers legal protection, is regulation-compliant, and helps ensure proper reimbursement. Real-life case studies illustrate examples of proper and improper documentation so you and your staff know exactly where your documentation could use improvement.

Written from a manager’s point of view, Home Health Documentation: Proven Strategies for Clinicians is easy to follow and focuses on the documentation issues that affect your home health agency the most.
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Home Health Documentation

Chapter 1

Key aspects of documentation

Learning objectives

After reading this chapter, the participant will be able to:

- Identify why documentation is important in the home health care setting
- Discuss how the nursing process is used in nursing documentation
- Describe how to use Nursing Outcomes Classification (NOC) in nursing documentation

What every nurse case manager needs to know

In home health care today, every member of the team is accountable for factual, accurate, complete and timely documentation. However, the nurse case manager is really the focus of any clinical record review. In today’s culture of quality and accountability, your role and scope of responsibilities, as demonstrated by your documentation, will bring you under scrutiny. Your documentation reveals your commitment to quality patient care. As the case manager you must recognize the importance of good clinical documentation. It is also vital that you assist everyone working on your case to practice defensive documentation and avoid the potential for legal consequences if a case is reviewed for alleged malpractice, substandard care, or fraudulent practices. According to Newfield, “Through effective communication, documentation, and post-incident procedures, proper care may be defended and unnecessary exposure avoided” (2006).

Focusing on “better rather than more” with respect to documentation is a good axiom to remember. The clinical record must be accurate and complete but does not need to be overwhelming. The information it contains is crucial for a number of people and functions. It is used to communicate patients’ progress to other clinical and nonclinical staff. It is also used by the agency’s quality and risk-management department. In all cases, the accuracy and completeness of the clinical record is essential for reimbursement from payers. If there is a question of the care that was given, it is also used by an auditor to determine substandard professional care, which may also be considered negligent. And if your agency is accredited by CHAP (Community Health Accreditation Program) or The Joint Commission, the clinical record, as well as on-site visits, is used to measure compliance with accreditation standards.
Documenting completely and accurately is considered a professional standard of nursing practice. Documentation demonstrates the quality of care given, establishes reimbursement entitlement, and substantiates the need for services (Mahler, 2001). For every step in the nursing process, the care delivered must be documented. Whether you are a clinical supervisor assisting your staff or a case manager, it is every nurse’s responsibility to fulfill the necessary requirements of good clinical care and documentation. Doing so not only validates the universally recognized professional approach to patient care, it supplies other care providers with consistent, clear communication and validates critical decision-making that is often necessary for quality patient care.

There are many research studies that have attempted to identify why nurses do not value the importance of their documentation. And in one study Moody and Snyder found an estimated 15–20% of the nursing work time is spent in documentation. Although documentation may not be valued by nurses it is still a requirement, regardless of the work setting. In today’s climate of accountability and service expectations it is more critical now than in past years. We know that documentation has changed over the last few decades in both its appearance and the advent of new technology in an attempt to facilitate data entry and access. What is still missing with these changes is the failure to demonstrate patient continuity of care and the evaluation of patient outcomes (Irving et al. 2006).

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

- Documentation of the assessment
- Documentation of the plan of care
- Coordination of services provided
- Evaluation of the effectiveness of the care provided
- Facilitation of communication with other providers
- Reimbursement for services provided

According to Marrelli, the importance of the home care clinical record relates to the fact that the clinical record is:

1. The only written source for communication among the home care team members
2. The written source that supports insurance payment
3. The written evidence of clinical decision-making
4. The legal record of client care
5. The basis for evaluation of care provided by peers; auditors; licensing, accreditation, and government surveyor review

6. The evidence that demonstrates meeting the professional standard of care (Marelli, 2001)

Failure to document completely can have legal consequences. If documentation is incomplete, contains gaps, or is not consistently completed according to the organization's policies, it can be used to support an allegation that negligent care was provided. Even worse, documentation of care or services provided when in fact they did not occur is open to “failure-of-care” accusation. These failure-of-care cases are initiated by the government when the healthcare provider submits bills for grossly substandard care that are equal to no care at all (Hess, 2005).

Incomplete documentation allows for juries or surveyors to conclude that the nurse did not collect sufficient data and plan appropriate care; implement appropriate interventions, according to professional and agency standards; make good clinical decisions; and communicate effectively. A Medicare survey citation frequently results when:

- Documentation does not support that the plan of care was coordinated, or
- Services delivered are not exactly those ordered in the plan of care" (Hollers, 2004)

According to Marrelli, there are five areas that have increased in importance of clinical documentation.

<table>
<thead>
<tr>
<th>Factors contributing to importance of documentation</th>
<th>Reality check (or today's expectation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasis on value and cost</td>
<td>• Third-party payers have increased their scrutiny and control of resources</td>
</tr>
<tr>
<td></td>
<td>• Documentation must demonstrate skilled care was provided</td>
</tr>
<tr>
<td></td>
<td>• Pay for performance will be in home health care</td>
</tr>
<tr>
<td>Emphasis on quality improvement</td>
<td>• Patient outcomes are now indicators of quality care</td>
</tr>
<tr>
<td></td>
<td>• Documentation must demonstrate care and achievement of stated goals</td>
</tr>
<tr>
<td></td>
<td>• Documentation needs to demonstrate care coordination and collaboration</td>
</tr>
<tr>
<td></td>
<td>• Timely returns of the 485 and MD orders</td>
</tr>
<tr>
<td></td>
<td>• Competency assessment of the staff</td>
</tr>
<tr>
<td></td>
<td>• OASIS used for demonstrating quality care based on outcomes</td>
</tr>
</tbody>
</table>
Factors contributing to importance of documentation | Reality check (or today’s expectation)
--- | ---
Emphasis on standards of care and processes | • Defined levels of care based on evidence-based practices  
• Use of clinical practice guidelines or clinical paths  
• Government has developed clinical practice guidelines to move to a standardization in healthcare (see www.guideline.gov)  
• Patient/caregiver and payer satisfaction critical to agency’s survival
Emphasis on capturing fraud and abuse | • Clinical documentation must be F-A-C-T (factual, accurate, complete, and timely)
Emphasis on effectiveness and efficiency | • Automation to help prevent duplication of clinical and administrative information  
• Quality versus quantity in documentation  
• Effective documentation supports appropriate care

(Marrelli, 2001)

**Clinical supervisor responsibilities**

As a member of the management team, it is your responsibility to assist your staff in adhering to both clinical and documentation standards. It is also your responsibility to provide continuing education, professional feedback, and input into policy and documentation-system changes whenever possible. It is to your advantage to fulfill these responsibilities because if your staff is involved in a government audit or survey, your ability to manage and meet quality and risk-management standards will be called into question.

In home health care the clinical supervisor must not only demonstrate a commitment to providing safe and efficient patient care, but also ensure that every clinical record reflects that commitment. That is, although you must ensure that nursing staff comply with up-to-date standards, it is equally important to ensure that they document that compliance accurately and completely.

Your role is to support an efficient and effective documentation system and to create an expectation that the system be followed. It is also your responsibility to ensure competent and contemporary care is being given to the clients. The nurse case managers must have excellent assessment and documentation skills. The assessment skills are needed for reimbursement, and the documentation of that comprehensive assessment within the defined time frames determines the reimbursement (Marrelli, 2001).
Nursing management can demonstrate support for such a system by:

- Developing an efficient system that meets the requirements of regulatory standards.
- Involving the end users in the development of the system.
- Emphasizing the importance of documentation through routine audits, written guidelines, policies, job descriptions, and performance appraisals. The language should include stipulations for daily supervisory oversight, audits of the system, and feedback to the staff.

**Let the nursing process be your guide**

The nursing process, as outlined by the American Nurses Association's (ANA's) *Nursing Scope and Standards of Practice*, provides us with an established, scientific approach to providing nursing care. Not only does each step guide us in our approach, it 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, your documentation of patient care should follow the framework of the nursing process.

**Assessment**

The first step of the nursing process is assessment. In this step, the nurse collects information about the patient's condition, which could include the patient's history, the physical exam, laboratory data, and so on. So as not to become overwhelmed, the nurse must decide which information is most useful to the care of the patient. For example, a nurse could limit the assessment data to the admission signs and symptoms, the chief complaint, or medical diagnosis. This first step in the nursing process—assessment—should always be evident in the medical record as it provides a complete clinical picture of the patient. In home health care the OASIS is an integral piece of an agency's clinical documentation system. The nurse must understand the importance of data collection and its long-term impact on home care. Your critical thinking skills are self-evident when you are able to combine all assessment data and the OASIS items, which then provide a complete picture of the patient and his or her care needs. According to Pentz and Wilson credibility and critical thinking are two major sources of inaccurate data collection (Yadgood et al., 2005).

An assessment should include both subjective and objective data. When documenting this data, beware of inappropriate documentation practices and focus on quality and risk management strategies.
Subjective data
In this context, subjective data are 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.

For instance, if the patient says something that can be used to demonstrate mental, behavioral, or cognitive status at the time of the assessment, documentation of the conversation can be used to measure progress or decline over the course of treatment. If patients are unable to speak or are cognitively impaired, nonverbal cues are essential in determining whether there has been any change in status.

These conversations with the patient/family will need to be captured in the clinical record in order to provide other clinicians with an accurate depiction of the patient’s current status.

Objective data
Nurses establish patients’ clinical status based on objective data, which are observable and measurable. Physical exams of patients, which include key assessment techniques such as inspection, palpation, percussion, and auscultation, provide objective data about patients’ health status. In simpler terms, nurses’ objective assessments are based on what is seen, heard, felt, and smelt. Healthcare providers find this much easier to validate and include in their documentation than subjective data. Objective data also includes the results of diagnostic tests.

When recording this data, however, there are risks your staff should consider. If the objective data is not reviewed in a timely manner, a reviewer of the clinical record may point out that you failed to interpret the data and address significant changes of condition. There also may be situations in which critical objective data were present but there was no subsequent documentation of an appropriate intervention. In addition, if the absence of critical objective data resulted in a gap in the clinical picture of the patient, it may contribute to a lack of appropriate intervention identification. All of these situations can lead to quality and risk-management issues.

Good nursing documentation should tell a story about the client and their problems. Just like when reading a book, the reader can understand the story. There is a beginning, middle, and end. The nurse must document every visit in a way that supports moving the client to the stated outcomes on the 485. Documentation also includes the client’s homebound, admission, or general assessment status as well as the skill provided at that visit. “Focus is on the patient’s problems in the documentation and why home care is involved; and, from any payer’s perspective is what they must see to authorize payment” (Marrelli, 2001).
Key aspects of documentation

Practical tips

Remember that the OASIS data elements are the basis for appropriate reimbursement and demonstrate client outcomes:

• Resolve client problems in a timely manner
• Support the client’s homebound status in functional terms
• Review your own charting and ask yourself if someone else would know “why” the client is homebound and if the care is moving the client to the stated goals

[Marrelli, 2001]

Gaps in documentation on any clinical assessment tool leave the nurse and the agency open to allegations that they failed to document assessments or failed to address significant changes of condition. For example, in the case of an incomplete assessment of I&O, it could be alleged that the lack of analysis, intervention, and accurate documentation was the cause of circulatory collapse, dehydration, renal failure, infections, skin breakdown, or even death.

For the nurse to arrive at a nursing diagnosis and the development of a nursing plan of care, the assessment findings are crucial. Be sure you are completing all assessment tools thoroughly.

Here are some risk management tips for documenting assessment findings:

• Describe everything exactly as found by inspection, palpation, percussion, or auscultation
• Do not allow the use of general terms such as “normal,” “abnormal,” “good,” or “poor”
• Be specific, and include both negative and positive aspects
• Adhere to your policies’ time frames on completion of assessments
• Document your assessment as soon as possible after completing it

Nursing diagnosis and Nursing Outcome Classification

If nurses accurately perform the assessment process, they will be able to appropriately establish nursing diagnoses. This phase of the nursing process demonstrates that the nurse reviewed the appropriate data available at the time and made a professional determination of the clinical problem(s) at that time. Once the nurse makes a clinical nursing diagnosis based on a thorough assessment, the rest of the process falls into place.

The nursing diagnosis is defined by the North American Nursing Diagnosis Association International (NANDA International) as a “clinical judgment about the individual, family, or community
responses to actual and potential health problems/life processes. Nursing diagnoses provide the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable“ (Doenges, 2006). Therefore, the nursing diagnosis expresses the nurse’s professional judgment of the patient’s clinical status, the anticipated response to treatment, and the potential nursing-care needs. It guides the nurse and subsequent providers in their understanding of the patient’s problem(s) and the plan of care developed specifically for that problem(s).

If your agency chooses to include the nursing diagnosis in its documentation system, you should promote consistency and use of correct terminology by adopting NANDA International terminology. The NANDA International diagnostic headings, coupled with the patient’s clinical etiology, provide a clear picture of the patient’s needs.

<table>
<thead>
<tr>
<th>Risk for falls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NANDA definition:</strong> Increased susceptibility to falling that may cause physical harm</td>
</tr>
<tr>
<td><strong>Examples of general risk factors</strong></td>
</tr>
<tr>
<td>History of falls; wheelchair use; 65 years of age or older; lives alone; lower limb prosthesis; use of assistive devices</td>
</tr>
<tr>
<td><strong>Physiological risk factors</strong></td>
</tr>
<tr>
<td>Presence of acute illness; visual difficulties; hearing difficulties; arthritis; orthostatic hypotension; sleeplessness; anemia; decreased lower extremity strength; postprandial blood sugar changes, etc.</td>
</tr>
<tr>
<td><strong>Medication risk factors</strong></td>
</tr>
<tr>
<td>Antihypertensive agents; ACE inhibitors; diuretics; tricyclic antidepressants; alcohol use; antianxiety agents; opiates; hypnotics or tranquilizers</td>
</tr>
<tr>
<td><strong>Environmental risk factors</strong></td>
</tr>
<tr>
<td>Weather conditions such as wet floors/ice; scatter rugs; clutter, etc.</td>
</tr>
</tbody>
</table>

*(Ladwig, 2006)*

**History of nursing outcomes**

The use of patient outcomes in documentation dates back to the mid-1960s, when for the first time nursing outcomes were used to evaluate the effectiveness of nursing care. The use of patient outcomes to evaluate healthcare dates back to Florence Nightingale, who recorded and analyzed healthcare conditions and the subsequent outcomes of those conditions during the Crimean War (Moorhead et al., 2004).
Although nurses have documented outcomes of their nursing interventions for decades, there was no common language or associated way to measure the outcomes of these interventions in the past. Today, however, a research team at the University of Iowa has given nursing a standardized terminology for nursing-specific and nursing-sensitive outcomes. This comprehensive classification of nursing outcomes is called the Nursing Outcomes Classification (NOC).

The current 2004 NOC lists 330 outcomes for use in nursing documentation. Each NOC nursing outcome has a predetermined definition, a measurement scale, and associated interventions. Each describes a possible state, behavior, or perception of the patient (this is different from nursing diagnosis, which describes a patient’s problem, either actual or potential). Once the nursing diagnosis is made, the nurse seeks to resolve it through appropriate interventions (see an example in Figure 1.1).

![Figure 1.1 Knowledge: Disease Process (1803)](image-url)

1st edition 1997; Revised 3rd edition

Or you could simply state your outcomes as:

- The patient will explain the disease state, recognize the need for medications, and understand treatments (and just add the end date of the 60-day plan)
- The patient will demonstrate how to perform health-related procedures satisfactorily by _____________ (Ladwig, 2006)

_Nursing Outcomes Classification_, 3rd edition, cited those nursing diagnoses and NOC outcomes home care nurses selected.

<table>
<thead>
<tr>
<th>NANDA diagnoses</th>
<th>Possible NOC outcomes to use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge deficit</td>
<td>Knowledge: Diet&lt;br&gt;Knowledge: Disease process&lt;br&gt;Knowledge: Energy conservation&lt;br&gt;Knowledge: Health resources&lt;br&gt;Knowledge: Infection control&lt;br&gt;Knowledge: Medication&lt;br&gt;Knowledge: Prescribed activity&lt;br&gt;Knowledge: Treatment procedures&lt;br&gt;Knowledge: Treatment regimen&lt;br&gt;Self-Care: Nonparenteral medication&lt;br&gt;Self-Care: Parenteral medication</td>
</tr>
<tr>
<td>Caregiver role strain</td>
<td>Caregiver home care readiness&lt;br&gt;Caregiver lifestyle disruption&lt;br&gt;Caregiver-patient relationship&lt;br&gt;Caregiver physical health&lt;br&gt;Caregiver performance: Direct care&lt;br&gt;Caregiver Performance: Indirect care&lt;br&gt;Caregiver well-being</td>
</tr>
</tbody>
</table>

(Moorhead, 2004)

Core outcomes were also selected by nursing organizations representing specialty practices such as home healthcare. According to the Home Healthcare Nurses Association the following core outcomes.
Key aspects of documentation

<table>
<thead>
<tr>
<th>Comfort level</th>
<th>Knowledge: Disease Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community risk control: Communicable disease</td>
<td>Knowledge: Illness Care</td>
</tr>
<tr>
<td>Health beliefs</td>
<td>Knowledge: Medication</td>
</tr>
<tr>
<td>Health beliefs: Perceived ability to perform</td>
<td>Knowledge: Prescribed activity</td>
</tr>
<tr>
<td>Health beliefs: Perceived control</td>
<td>Knowledge: Treatment regimen</td>
</tr>
<tr>
<td>Health beliefs: Perceived resources</td>
<td>Medication Response</td>
</tr>
<tr>
<td>Health beliefs: Perceived threat</td>
<td>Treatment behavior: Illness or injury</td>
</tr>
<tr>
<td>Health orientation</td>
<td>Self-care: Nonparenteral medication</td>
</tr>
<tr>
<td></td>
<td>Wound healing: Secondary intention</td>
</tr>
</tbody>
</table>

(Moorhead, 2004)

In using the NOC outcomes you are demonstrating evidence-based nursing practice with quantitative data to support the effects of your nursing actions and progress in the plan of care. Many of the NOC outcomes are “reliable and valid for use in documenting the effectiveness of nursing interventions” (Moorhead, 2004).

A good example of the integration and use of outcomes identification can be found in home healthcare. The Centers for Medicare & Medicaid Services (CMS) requires all Medicare-certified home health organizations to use the OASIS data set, which they have been doing since 1998. The OASIS outcomes system contains core measures that have been identified as applicable to all client groups. It also contains measures specific to client groups with a particular diagnosis or problem, the outcomes of which are measured on scales specific to them. Using the OASIS outcome system, nurses assess whether home health clients have improved, stabilized, or deteriorated (Sparks and Taylor, 2001).

Outcomes identification

If you do not elect to use the NOC outcomes then the next step in the nursing process is to determine an expected outcome, or goal, for the patient. The outcome must be derived from the nursing diagnosis and documented as a measurable, realistic, and patient-focused goal. It must include a target time or date as well as an objective measurable action that the patient is expected to achieve.

Whenever possible, include the patient/family’s perspective on the goal of treatment and the time frame. The expected outcomes also should reflect the continuum of care, from admission, addressing immediate and intermediate outcomes, for planning for discharge and follow-up care.
### Tips for documenting expected outcomes

1. Be specific
2. Be realistic
3. It must be measurable
4. Define the time frame for achieving the outcome
5. Include the patient/family’s desires and resources

*(Doenges, 2006)*

Goal setting is stated in the locator 22 on the CMS 485. Usually the goals are stated in generic terms. The best way to write goals is to think about your expectations about the outcomes and write them according to the tips above.

**EXAMPLE of GENERIC:**

“All body systems will return to WNL”

“Client will not have any urinary incontinence”

**OUTCOME BASED:**

“Client will regain independence in dressing upper body”

“Client will be able to control urinary incontinence through timed voiding” *(Hollers, 2004)*

**Planning**

The next step in the nursing process is to develop a plan of care for the patient based on the nurse’s assessment/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 shows that the nursing process was in place and thereby decreases the risk of incomplete or incorrect care. Having a written “road map” helps everyone involved provide safe and quality care.

When developing a plan of care use the following guidelines:

- Review identified nursing diagnoses and rank them in order of priority
- Use evidence-based nursing interventions or clinical guidelines/pathways
- Include nursing diagnosis, expected outcomes, nursing interventions, and evaluation of care
- The plan of care should be used as a communication tool between all home care team members and the client *(Sparks and Taylor, 2001)*
This step of the nursing process can be documented in a variety of ways. You can use a specially designed form, flow sheet, 485, daily visit notes, nursing progress notes, clinical pathway, or specific software module. But whatever format is used, remember that the patient plan of care is a permanent part of the clinical record and is used to evaluate the care that was provided. Adjustments to the plan of care should reflect a progression of care based on the client's needs.

### Medicare care planning

<table>
<thead>
<tr>
<th>Qualifying service</th>
<th>Key components of documentation</th>
</tr>
</thead>
</table>
| Skilled observation and assessment                      | Findings and judgments  
Contacts with physician when indicated  
In-depth assessment of issues or body systems relevant to patient's medical instability |
| Client education                                        | Comprehension level  
Subject matter taught  
Response to the teaching  
Knowledge and skills acquired |
| Therapy services                                        | Performance of treatments based on MD orders  
Response to treatment  
Any efforts to locate caregivers who can learn to safely and appropriately perform treatments  
Communication with MD of any evidence of ineffective treatment |
| Management and evaluation of a complex plan of care      | Interventions and evaluations showing management of the plan  
Successes and failures  
Modifications made  
Patient/caregiver satisfaction and condition  
Capability and endurance of the caregivers  
Contribution of other professionals |

(Hollers, 2004)

What to write in a home healthcare patient’s plan of care can be a difficult task for the case manager. We are bound by the Medicare CoPs and must follow their directives. According to the Medicare CoPs, “the POC must contain all pertinent diagnoses, including:

- The patient’s mental status;
- The types of services, supplies, and equipment required;
- The frequency of the visits to be made;
- Prognosis;
- Rehabilitation potential;
- Functional limitations;
• Activities permitted;
• Nutritional requirements;
• All medications and treatments;
• Safety measures to protect against injury;
• Instructions for timely discharge or referral; and
• Any additional items the HHA or physician choose to include.”
   (CMS Publication 100-2, Chapter 7, Section 30.2.1)

Unfortunately, one of the most commonly cited deficiencies in home healthcare is the failure to follow the plan of care. Be sure that you have a thorough assessment to begin the process. Then decide the critical nursing interventions and measurable outcomes. Some agencies have software to help the case managers. The OASIS data is integrated into the plan of care (485). However, it still requires the case manager to analyze the assessment data and determine the pertinent diagnoses and the development of a realistic plan of care.

Out of the top 10 state deficiencies cited for home health agencies in Arizona for fiscal year 2006–2007, three related to the adherence to the plan of care:

• Home health services shall be provided by the home health agency in accordance with a written plan of care established and authorized by a physician
• The plan of care shall be based on the patient’s diagnoses and the assessment of the patient’s immediate and long-term needs
• The plan of care shall include the following: Treatments, medications, and any drug allergies; and type and frequency of services to be provided (Arizona Dept. of Health Services, 2007)

Stoker reported the top 10 deficiencies cited for home health agencies nationwide in 2004, including plan of care and examples of the need for good nursing documentation:

1. Plan of care was not established or reviewed
2. Plan of care did not cover patient diagnoses, services, or visits
3. The clinical record was incomplete as it failed to include findings
4. Assessments did not include medication review
5. The clinicians did not notify the MD to significant changes in the patient’s condition
6. Drugs and prescriptions were not given as ordered
7. The HHAide supervisory visits were not conducted as needed
8. There was no evidence of coordination of services
9. The clinical record did not identify coordination of services
10. The case manager (RN) did not routinely reevaluate the patient care needs.
   (Stoker, 2005)

**Implementation**
Based on the nursing plan of care and contemporary standards of nursing care, the nurse then documents the care provided for the patient. This phase of the nursing process includes working collaboratively with other members of the healthcare team, the patient, and the patient’s family. Implementation may include some of the following interventions:

- Assessing and monitoring
- Therapeutic interventions
- Comfort measures
- Assistance with activities of daily living
- 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
- Referral to other agencies or services (Sparks and Taylor, 2001)

Documentation will need to include the specific nurse’s intervention and the patient’s response to the intervention. It should reflect the coordination of care, health teaching and promotion, and any consultation that was done on behalf of the patient. Like the documentation of planning, the documentation of care provided can be assigned to a specific form or location in the clinical record.

**Evaluation**
In this step of the nursing process, the nurse reviews the progress made in achieving established outcomes. The documentation needed to validate this step includes the nurse’s comments on whether his or her assessment, diagnosis, achievement of outcomes, plan of care, and nursing
interventions were successful. In addition, when developing a documentation system or a continuing education program for nurses, ensure that each nurse assesses the effectiveness of the nursing process.

In determining whether the patient received high-quality care the nurse must document the patient's response to care, the patient's compliance with prescribed medications and therapies, the progress being made toward the stated goal, and the caregiver's ability to learn and resume all or part of the treatment plan (Hollers, 2004).

If the nurse uses the evaluation phase properly, the documentation will reflect high-quality nursing care.

Figure 1.2 shows the flow of the process and identifies the tools associated with each phase.
Key aspects of documentation

Assessment
Definition: Subjective and objective data from patient’s health history, physical examination, medical record, diagnostic test results

Tools:
- Physical-assessment form
- Nursing admission assessment
- OASIS
- Diagnostic test results forms
- Computer software module

Nursing Diagnosis
Definition: Clinical nursing judgment based on the assessment data

Tools:
- Plan of care (485)
- Patient-care guidelines
- Clinical pathways
- Medication reconciliation record
- Progress notes
- Problem list
- Computer software module

Outcome Identification
Definition: Specific measurable outcome

Tools:
- Nursing Outcome Classification (NOC)
- Plan of care
- Clinical pathway
- Computer software module
- Federally mandated documentation systems

Planning
Definition: Establish care priorities, set measurable goals/outcomes with target dates, describe interventions

Tools:
- Plan of care (485)
- Patient care guidelines
- Clinical pathway
- Discharge plan/summary
- Computer software module

Implementation
Definition: Actual nursing interventions delivered

Tools:
- Skilled visit flow sheets
- Progress notes
- Computer software module

Evaluation
Definition: Reassess data, nursing diagnoses, and interventions for achievement of stated outcome

Tools:
- Skilled visit flow sheets
- Clinical pathway
- Computer software module

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**Figure 1.2** Nursing process flow chart

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Home Health Documentation 17
Organizational policies, protocols, and practices

When nurse experts are asked to review a medical record in preparation for a legal case, they rely heavily on the clinical record to determine the following:

- Did the healthcare provider meet the policies and protocols of the organization at the time of the care?
- More importantly, did the healthcare provider meet the standards of nursing practice at the time of the care?

It is therefore the responsibility of the nursing management team and the nursing staff to follow the established policies of the organization and that this compliance is demonstrated in the documentation system for that organization.

Organizational policies, protocols, and practices will always be called into review when there is an allegation of substandard patient care. Nursing practice will be held to national and local professional nursing standards, which are available through the ANA and through specialty nursing associations. If you derive your policies and procedures from these, your organization will be better able to justify that the care that was delivered met established professional standards.

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.”
Case study

Good documentation reflects the nursing process

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 what the patient said: Subjective data

7/15/07 1600
Patient stated, “Nurse, I am having chest pain.” See pain flow sheet for description, location, intensity noted. Patient in chair, 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 section of flow sheet.

The patient’s exact description of the symptom was noted, and the nurse used quotations 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. Pain level 10 out of 10. The nurse appropriately uses the pain scale to measure the level of intensity.

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.

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

7/15/07 1600 P: 120 R: 40 BP: 146/90
7/15/07 1604 P: 96 R: 28 BP: 124/85

Documentation of what was assessed: Objective data

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

AR. Irregular regular rhythm. No JVD. O2 sats on RA: 92%.
Color ashen, skin cool and clammy.

The nurse documents the vital signs, noting 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.)

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

In the cognitive section of the patient care flow sheet, the notations indicated:
Chapter 1

Case study

Good documentation reflects the nursing process (cont.)

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 his or her interventions and the patient’s responses.

Frequent monitoring: The VSs were noted every few minutes until the chest pain subsided. 911 was called. All treatment activities are documented, including medications administered, such as aspirin and/or nitroglycerin.

Oxygen therapy: The nurse documents the patient’s initial pulse-oximetry reading, respiratory-assessment findings.

The pulse-oximetry assessments are documented until within normal range or transferred to emergency personnel.

Cardiac monitoring: 7/15/07 1615
Patient placed on cardiac monitor by EMS. Patient informed as to the reason for continuous monitoring.

The nurse does document notification of the physician of the patient’s change of condition and transfer to the hospital. He or she records the physician’s response and his or her actions.

Communication: The nurse is good at documenting his or her communication with other healthcare team members. It is found in his or her narrative notes, names, time of notification, etc.

Emotional support: 7/15/07 16200 Patient increasing in anxiety; reassurance given and questions answered.

Transfer to hospital: This patient needed to be transferred, and the nurse documented the aspects of the patient’s condition that warranted the transfer. The report to the physician was documented. The nurse also would have recorded the name of the person who accompanied the patient and which monitoring devices were in place during the transport.

Documentation of what was taught

The 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.
Key aspects of documentation

Resources


References


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