PATIENT CARE AND DOCUMENTATION: The Balancing Act

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CE 1 CONTACT HOUR

Learning Outcome: Nurses will gain an increase in knowledge related to the ability to identify requirements of Federal, State, and Regulatory bodies for nursing documentation. Nurses will gain an increase in knowledge related to the ability to recognize that quality nursing documentation is linked to better patient outcomes.

Disclosure:

The author and planners of this CE activity have disclosed that there are no conflicts of interest related to the content of this activity. See the last page of the article to learn how to earn CE credit.

Patient Care and Documentation: The Balancing Act

"Clinical documentation is a foundation of every healthcare encounter, and through its completeness and precision, the scope of care and services provided and severity of the patient's illness can be shown" (Brazelton, Knuckles & Lyons, 2017, pg. 271).

The North Carolina Board of Nursing (NCBON) recognizes the unique "balancing act" required of nurses when providing patient care and documenting the delivery of that care in the medical record. NCBON continues to receive and investigate complaints related to poor nursing documentation. In 2019, more than 10% of the complaints received by the NCBON cited some issue related to documentation. Categories of complaints received include the following: omission of crucial patient information, inaccurate documentation, incomplete documentation, documentation that does not adequately reflect the patient's condition, lack of documentation when a provider is notified, and pre-documentation of information (North Carolina Board of Nursing [NCBON], 2020a). This article will identify the nurse's responsibilities when documenting care, discuss essential components of quality nursing documentation, and provide examples of how quality documentation of nursing care serves as an opportunity to advocate for patients.

Background

The American Nurses Association's (ANA), *Principles for Nursing Documentation: Guidance for Registered Nurses* reported that nurses often find the task of nursing documentation "burdensome" and feel it "distracts from patient care" (Matthews, et al., 2020 p. 3). Likewise, a study conducted by Pellico, et al. (2010) on the work experience of a cohort of 229 registered nurses noted participant remarks to convey feelings that documentation takes time away from patient care and causes stress related to completing nursing responsibilities within the time frame of the assigned shift. Finally, the Joint Commission's 2003 white paper, *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*, reported "increased staffing, less paperwork and fewer administrative duties" as the top areas identified by nurses as needing improvement (Joint Commission et al., 2003 p. 10).

Why Quality Nursing Documentation is Critical

During the current COVID-19 pandemic, nurses may be pulled to work on a unit they are not accustomed to with higher acuity patients. Nurses may be concerned about their own exposure to COVID-19 or about the possibility of exposing family members; and at the same time feel a responsibility to care for those who are ill with the virus. Although the demands and stress of nursing responsibilities are heightened during healthcare crises such as a global pandemic, the need for quality nursing documentation remains a crucial component of patient care. The quality of nursing documentation is a reflection of the quality of care delivered to the patient (Akhu-Zaheya, et al., 2017). Patient outcomes may be linked to the quality of nursing documentation in a patient's medical record (Collins, et al., 2013). A variety of healthcare providers across different disciplines document in a patient's medical record. The lack of important patient information may place the patient at risk. Consider the following scenario:

Patient A is a 79-year-old female who underwent a right hip replacement earlier in the day. The dayshift nurse, Cindy received the patient on the Med/Surg floor from PACU around 6:00 p.m., prior to her shift ending at 7 p.m. At 6:45 p.m., Nurse Cindy administered IV Morphine to Patient A. However, due to preparation for shift report, she failed to document the administration of the Morphine. During shift report, Nurse Cindy commented to the oncoming nurse that Patient A seemed to be resting comfortably "now".

At 7:15 p.m., Nurse Ellen (oncoming nurse), found the patient restless and moaning and believed her to be in pain. She immediately checked the patient's orders and found the patient had an order

for IV Morphine for pain. Nurse Ellen administered a dose of IV Morphine within 30 minutes, not realizing that the patient had been recently medicated. The patient subsequently became unresponsive and required the administration of Narcan and a transfer to ICU for stabilization and monitoring. Nurse Cindy's failure to document the medication administration placed her patient at risk.

In this scenario, Cindy did not set out to harm her patient. The Medical/Surgical unit was chaotic at the time and she was pulled in many directions. However, her lack of attention to detail and failure to enter pertinent information into the patient's record did cause harm to her patient.

In addition to assisting with provision of safe nursing care, quality nursing documentation may provide protection for the nurse in the event his/her own nursing practice is called into question (such as a lawsuit). All nurses should consider documentation of care as an essential step in the process of patient care. Without the documentation of care, there is no evidence of that care beyond a memory, which will diminish with time. It is important to ensure that your documentation accurately reflects the quality of care provided and actions taken to safely deliver nursing services to each patient instead of merely meeting the minimum requirements.

What Defines High Quality Documentation?

ANA provides guidelines for the components of high-quality documentation, which should be "reflective of the nursing practice" (Matthews, et al., 2010, p. 12). Documentation begins at the time of arrival and continues until the patient leaves or is discharged. Further, nursing documentation should reflect only direct observations of the nurse completing the documentation (Messina, 2020).

The components of quality nursing documentation may be remembered using mnemonics, much like the *Rights of Medication Administration*. This author created the following R's of quality nursing documentation mnemonic to assist nurses when documenting entries into a medical record:

Right chart, right patient – always double check the patient name against the name in the medical record and armband for identification;

Right information in right chronological order – critically think about information while documenting to ensure what you document flows (e.g., you would not want to document administration of a medication prior to documenting the receipt of a verbal order for that medication);

Response – a patient's response to an intervention should always be noted (e.g., patient's response to pain medication);

Record of Provider contact – (e.g., attempts to reach a provider);

Response from Provider – always repeat back instructions you are given to ensure understanding and document those instructions carefully;

Rendered care – document all care rendered;

Real time – document at the time the care is completed or as close to the time of the care as possible (exceptions may include code situations and other emergencies).

There are approved standards for making changes, corrections or additions to nursing documentation that should be followed. Agency or facility policies may dictate how changes or late entries can be made in medical records. Nurses should become familiar with and follow these specific policies. The Centers for Medicare & Medicaid Services (CMS) offers guidance when making changes within the medical record in the *Medicare Program Integrity Manual*, Section 3.3.2.5 entitled, *Amendments, Corrections and Delayed Entries in Medical Documentation* (Centers for Medicare and Medicaid Services [CMS], 2016) as follows:

- Late Entry: In the event that documentation needs to be added after the original entry, it should be labeled "late entry". The information should be dated with the date the late entry is made and should state the reason the added information was not a part of the original documentation. The late entry should be signed or initialed by the individual making the entry. Many employers have specific policies/procedures for making late entries within the organization.
- Addendum – An addendum is made when new information becomes available after the original entry was made. The date the addendum is made should be recorded, the entry should be labeled "addendum," and the reason for the addendum should be noted. The addendum should be signed or initialed by the writer.
- Correction: When making a correction in a paper medical record, a single line should be drawn through the original entry, allowing the original entry to be seen and read. The individual making the correction should sign and date the correction. When documenting corrections within electronic records, follow the facility's policy regarding strike throughs or entries created in error.
- Amendment: An amendment, sometimes called a clarification note, is written to correct or clarify information documented earlier (e.g., corrections, deletions or retractions). Amendments should be clearly labeled "amendment" or "clarification" and should provide the reason an amendment is needed. The current date should be recorded and the note should be signed or initialed by the writer.
- Other tips: Documentation should be completed after care is delivered, never prior to the delivery of care. In general, nurses should document only the care they provide except in a situation such as a code or emergency where a staff member documents the entire event. Nursing documentation should be factual (what is seen, heard, palpated and the patient's care and response to care).

Check Boxes and Drop-Down Selections

The significance of merely clicking a check box or selecting a pre-populated choice from a drop-down box should not be dismissed. Although check boxes and drop-downs are time savers in lieu of narrative notes, the nurse is held to the same level of accountability and standard of accuracy as with a narrative note. Nurses should not use the pre-selected choices from a drop-down list or check box in a patient record

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without first carefully considering the selected information as doing so could result in documentation of care that was not rendered (American Health Information Management Association, 2014). It is best to be mindful and present while documenting to ensure the record reflects the patient's true care. Consider this scenario:

Nurse A was completing her documentation at the end of her shift and clicked a checkbox indicating her patient was being monitored by cardiac monitor and alarms were on and audible. However, the previous nurse (Nurse B) documented a narrative note stating the patient refused to wear a cardiac monitor. Nurse B documented notification of the provider, who verbally ordered the cardiac monitoring to be discontinued. She documented the removal of the monitor and leads.

In this scenario, Nurse B's documentation was clear and detailed. Nurse B provided us with an excellent example of quality nursing documentation. However, Nurse A rushed through her documentation at the end of her shift without critically thinking about the information she selected to record. Thus, the information documented by Nurse A was inaccurate.

The purpose of nursing documentation is to record the nurse's findings, impressions and plans in a chronological manner. The Emergency Care Research Institute (ECRI) is a nonprofit health services research agency designated as an Evidence-based Practice Center by the U.S. Agency for Healthcare Research and Quality. A workgroup was created by ECRI in 2015 to identify risks associated with the practice of using the "copy and paste" function when documenting. As a result, a toolkit was created, *Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste* (Emergency Care Research Institute [ECRI] et al., 2016). Risks identified by the workgroup associated with copying and pasting include: less dependable documentation, documentation with unintended bias (due to less use of reasoning skills and critical thinking skills), bloated notes that do not flow well, and the overuse of copy and paste, which can result in the exclusion of current information (ECRI et al., 2016). The following scenario highlights the risks associated with the use of the copy and paste feature:

Lucy began working for a home care agency six months ago. She typically sees 5-6 patients per day. As a timesaver, Lucy came up with the idea to copy and paste a patient's prior visit notes into a current visit note with the intent of editing the note before submitting it. Lucy was called into the office as it seems that a question was raised about information contained in a visit note she submitted for Patient A related to wound care. When Patient A was contacted, he reported he no longer received wound care and had not for the past three months. Patient A's physician verified the patient was no longer receiving wound care.

Lucy realized immediately she forgot to edit the section related to wound care for this visit. However, the note contained wound measurements and documentation of a dressing change. Although Lucy tried to reassure her employer that all other information documented in the visit note for Patient A was accurate, her employer lacked confidence regarding the note accuracy and did not bill for the visit. Lucy was reminded that during her orientation she had been cautioned about copying and pasting and had signed acknowledgment of this. She was terminated for falsifying a patient record and was reported to the licensing board.

Lucy may have saved a little time by copying and pasting the old note; however, in the long run she lost credibility with her employer and she submitted documentation that was not accurate. The message is clear; do not mistake a work around for a time saver. Quality nursing documentation takes time and requires careful thought.

Federal Goals for Nursing Documentation

In 2017, the American Reinvestment & Recovery Act (ARRA) was enacted. One of the components of ARRA was the "Health Information Technology for Economic and Clinical Health (HITECH) Act". The HITECH Act proposed the meaningful use of electronic health records (Centers for Disease Control and Prevention [CDC], 2020). Meaningful use was defined as "using certified electronic health record (EHR) technology in the most meaningful way possible in an effort to improve patient care, ensuring that the certified EHR technology connects in a manner that provides for the electronic exchange of health information to improve the quality of care" (CDC, 2020, para. 2). This Act was supported by CMS and the Office of the National Coordinator for Health IT, who identified the meaningful use of the medical record as a critical national goal (CDC, 2020).

Nursing Law and Rules

The North Carolina Nursing Practice Act (1981/2019) defines nursing documentation as the "recording and reporting the results of the nursing assessment" (Definitions,

1981/2019) The North Carolina Office of Administrative Hearings (NCOAH) provides administrative rules for Occupational Licensing Boards (including the NCBON). Nursing administrative rules include guidelines related to nursing documentation (Components of Nursing Practice for the Registered Nurse, 1991/2019; Components of Nursing Practice for the Licensed Practical Nurse, 1991/2019).

The Components of Nursing Practice for the Registered Nurse (RN) (1991/2019) identifies the necessary elements of RN nursing documentation noted as being pertinent to the client's health. Elements include information that is accurate and descriptive, completed in a timely manner, containing information related to communication with others, and the verification of administration and waste of controlled substances (Components of Nursing Practice for the Registered Nurse, 1991/2019). The Components of Nursing Practice for the Licensed Practical Nurse (LPN) (1991/2019) identifies the necessary elements of LPN nursing documentation noted as being pertinent to the client's health. Elements include information that notes client response to care, information that is accurate and descriptive, completed in a timely manner, containing information related to communication with others and verification of the administration and waste of controlled substances (Components of Nursing Practice for the Licensed Practical Nurse, 1991/2019). For additional information, read the details of these administrative rules via the links provided below.

- Components of Nursing Practice for the Registered Nurse: http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0224.pdf
- Components of Nursing Practice for the Licensed Practical Nurse: http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20

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licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0225.pdf

Specific acts or behaviors that may result in investigation and possible discipline of the RN/LPN license are identified in the North Carolina Administrative Code (Investigations: Disciplinary Hearings, 1991/2019). Acts relevant to nursing documentation include: failure to make client information available to another health care professional, failing to maintain an accurate record of all pertinent health care information as defined in the Components of Nursing Practice for the Registered Nurse (1991/2019) and the Components of Nursing Practice for the Licensed Practical Nurse (1991/2019), and falsifying a client's record or the controlled substance records (Investigations; Disciplinary Hearings, 1991/2019).

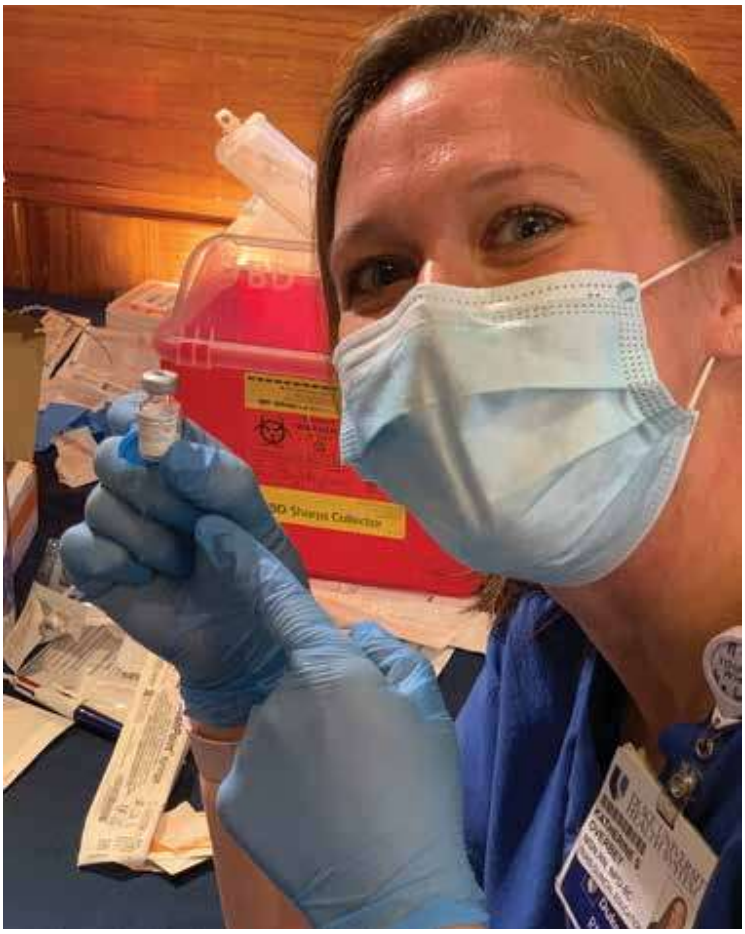
Additional Guidance Documents from the North Carolina Board of Nursing

The NCBON created position statements to provide direction to nurses in applying nursing law and rules to their nursing practice. Although a position statement is not nursing law, it does provide clarity when attempting to interpret law and rules. Position statements (NCBON, 2020b) are located on the NCBON website at https://www.ncbon.com/practice-position-statements-decisions-trees

STOP NOW AND REVIEW THE FOLLOWING POSITION STATEMENTS:

- History and Physical Examination Position Statement for RN Practice https://www.ncbon.com/vdownloads/position-statements-decision-trees/history-and-physical.pdf
- RN Scope of Practice – Clarification Position Statement for RN Practice https://www.ncbon.com/vdownloads/position-statements-decision-trees/rn-position-statement.pdf
- LPN Scope of Practice – Clarification Position Statement for LPN Practice https://www.ncbon.com/vdownloads/position-statements-decision-trees/lpn-position-statement.pdf
- Physician Orders Communication and Implementation https://www.ncbon.com/vdownloads/position-statements-decision-trees/physician-orders.pdf
- Standing Orders Position Statement for RN and LPN Practice https://www.ncbon.com/vdownloads/position-statements-decision-trees/standing-orders.pdf

The Position Statement entitled, *History and Physical Examination Position Statement for RN Practice*, provides guidance for the RN related to the documentation of a history and physical exam (NCBON, 2018a). The *RN Scope of Practice – Clarification Position Statement* defines the recording of information by the RN as, "Those communications required in relation to all aspects of nursing care" and contrasts reporting and recording (NCBON, 2017b). The *LPN Scope of Practice Clarification Position Statement* is relevant to nursing documentation as it defines and clarifies the LPN's documentation responsibilities and components of documentation required (NCBON, 2017a). The *Physician Orders Communication and Implementation Position Statement* applies to the practice of the RN and the LPN when accepting verbal orders from providers. It was created to identify the types of providers from which a nurse may accept a verbal order and guides the nurse in ensuring documentation of the verbal order is complete and accurate (NCBON, 2018b). Finally, the *Standing Orders Position Statement for RN and LPN Practice* identifies the components of documentation needed when implementing a Standing Order (NCBON, 2018c).



Duty to Provide Quality Nursing Documentation

Quality nursing documentation is essential to research. During a pandemic, information may be gleaned from the medical record that can be used to support the many ways nurses contribute to improving patient outcomes (individual and population health) and the effectiveness of treatment. Nursing documentation helps to establish patterns of illnesses and responses. This information may guide future

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Read the article and online reference documents (if applicable).

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care and be used for evidence-based practice guidelines for treatment (Sensmeier et al., 2019).

Quality nursing documentation is also a professional duty. A risk specialist for the Nurses Services Organization (one of the largest providers of malpractice insurance for nurses), noted that "documentation is a core nursing competency and is one of the nurse's primary professional responsibilities" (Reiner, 2020, p. 1). When viewed as a primary nursing responsibility, quality documentation becomes equal in importance to the actual delivery of care and an ethical responsibility owed by nurses to their patients and to other medical professionals.

A Change in Perspective

In order to move beyond viewing nursing documentation as simply a chore to complete before the end of shift, it may be helpful to think of documentation as an opportunity to showcase hard work and demonstrate the excellent level of patient care delivered. When viewed in this manner, quality nursing documentation becomes a way to grow professionally and a step in the direction of ensuring patients are afforded the best possible outcomes.

Conclusion

Nursing documentation is a basic requirement at the federal, state and regulatory levels. However, quality nursing documentation requires taking nursing documentation to the next level. Consider the self-satisfaction of a job well done, the possibility of improving patient outcomes, the contribution to "meaningful use" of the electronic patient record for other healthcare providers, and the peace of mind quality documentation will provide in the event your practice is questioned. If you have questions or need further clarification regarding nursing documentation or any practice matter, reach out by phone to one of the NCBON Practice Consultants (NCBON main number: 919-782-3211).

Readers are encouraged to review the following documents:

- American Nurses Association (2010) Principles of Nursing Documentation https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf#:~:text=ANA%E2%80%99s%20Principles%20for%20Nursing%20Documentationidentifies%20six%20essential%20principles,Suite%20400%20Silver%20Spring%2C%20MD%2020910-3492%201-800-274-4ANA.%20www.Nursingworld.org (Information included in ANA's publication includes recommendations for documentation and identifies uses of nursing documentation within the healthcare team).
- The ECRI (2016) Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste https://www.ecri.org/Resources/HIT/CP_Toolkit/Toolkit_CopyPaste_final.pdf

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Matthews, J., Bruflat, C., & members of ANA Principles for Nursing Documentation Work Group. (2010). ANA's principles for nursing documentation guidance for registered nurses. https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf

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