Documentation Standards

Appropriate medical documentation is essential in the home care setting. Providing detailed documentation promotes client safety and also acts as a source of communication between health care professionals. Proper documentation also proves that the nurse completed the treatments and cares.

Every day, COC nurses should reference the following documents:

1. Care Plan
2. Medication Sheet, Rationale for PRN Treatment & Medications, Controlled Substance Log
3. Flow Sheet
4. Maintenance Sheet
5. Nurse Communication Log to address non-clinical issues such as shift change, family preference, or ordering.

Charting Standards

The legal issues of documentation require that the following standards are met:

Standard	Example of Acceptable Documentation	Avoid	Detail
Vent Settings must be documented every 2 hours while in use		Documenting less than every 2 hours	Document what the client is currently doing (what is the highest pressure the client is achieving). Prescribed settings will be verified with the Plan of Care
Maintenance Activities will be documented on the date you start your shift	If you start on Saturday night, you will document all maintenance activities in the Saturday column.	Charting on wrong date. Example: if you start your shift on Saturday night, do not document on Sunday NOC.	
All documentation will be complete.	All criteria will be met as per the plan of care frequency.	Documentation that does not meet Physician orders	Failure to meet Documentation Standards will result in the individual nurse coming into the office to pick up their paycheck and fix their charting.

Standard	Example of Acceptable Documentation	Avoid	Detail
All entries must be accurate, factual, and objective.	1. *Client said, "I think I may need deep suctioning." Skin pink and warm. O2 sats 97% on RA. Mild gurgling sound with breathing. No coughing or restlessness present. Performed Simms suction with moderate amount of thick white secretions present. O2 sats 98% after suction. Gurgling resolved. Client reports, "that feels better."* *Bonnie Bell RN----------* 2. *Mr Russ states "I am going to learn insulin injection techniques by the end of the day."*	Subjective statements. **Poor Example** 1. *Client told me that she wanted suctioning. I think that she has been requesting suction too often, but did get a moderate amt of white secretions. Client felt better after suction. ---Bonnie Bell RN* 2. *Mr Russ has a good attitude.* This is subjective. How do you know he has a good attitude?	The client's health status should be described in objective terms at all times. Client statements should be written in quotations whenever possible, rather than drawing conclusions about client opinions.
	3. *IV line out that you did not witness. Found client arm board, and bed linens covered in blood. IV line and venipuncture device were untaped and hanging free.*	• Blaming client if you did not witness them pull out the line. • Documenting your opinion	Documenting your opinion will cause loss of credibility and reliability in court
Be Specific	*Client requested pain medication after complaining of lower back pain radiating to his right leg. Pain 7/10.*	• *Client appears in pain* • *Client comfortable.* How do you know client is comfortable?	• Present the facts clearly and concisely
Use permanent ink		Colors other than Blue or Black. No pencil or marker	COC requires the use of Blue or Black ink
Never provide false documentation	Documentation is done **only after** providing medications or treatments. If you document but did not provide the activities this is false documentation	• **NEVER** document before cares or treatments are provided.	• Your notes could be inaccurate • Leaves out client response to treatments.

Standard	Example of Acceptable Documentation	Avoid	Detail
Avoid Labeling & Eliminate Bias	*Found 3 cans of unopened beer in client's supply cabinet while restocking bedside supplies. Explained to client that beer is contraindicated because of his current medications. Client denies drinking any alcohol. No alcohol odor noted on client's breath. No empty cans found in the trash in client's room. Client states he understands the implications of mixing alcohol with his medications.*	• Appears spaced out, exhibiting bizarre behavior, using obscenities *Client is rude, difficult, and uncooperative.* • Language that suggests negative attitude towards client: drunk, abusive, obnoxious • Inappropriate comments or language	• Objectively describe client's behavior instead of subjectively labeling it. • Could you describe the expressions in court? • Including such remarks. can lead others in a lawsuit to believe you failed to properly care for client because of "label" • If client is difficult or uncooperative, document their behavior objectively to allow jurors to draw own conclusions.
Keep the record clean. Only include medically relevant information.	*I attempted to give the client her Depakene but she said "I've taken enough pills. Now leave me alone." Explained the importance of the medication and attempted to determine why she would not take it. Client refused to talk. Physician and COC notified of refusal.*	• General communication. Reserve for the communication log. • Do not include staffing issues or staffing disputes • Do not mention an incident report was filed. • What others say or observed unless information is serious and important • Reporting staff problems or conflict • Reporting conflict between family & client	• Staffing issues are not client care concerns. • Let COC know: call or fill out Incident report • They are not legitimate concerns about client care

Standard	Example of Acceptable Documentation	Avoid	Detail
Entries must be timely	Document right after or shortly after completing the task. This encourages fresh and detailed notes. If it is not documented, it is not done.	• Waiting until the end of your shift. You can forget important information. • Large time spans.	• This is a major issue in Malpractice suits. • If you wait until the end of your shift keep a list of notes that you can expand on once you can chart. • Large time spans indicate inattention to the client. Chart exact times especially when there are changes in condition or a nursing action.
Keep record intact		• Discarding original	If you spilled on the original, copy the information to a new flow sheet. Write "recorded from pg___." Keep the original attached to the new flow.
Writing must be legible to another party	Clear communication ensures client safety, provides proof that cares were completed and communicates medical information to other staff.	Sloppy handwriting	It is essential that medical information is communicated clearly in nursing documentation.
Standardized abbreviations (as recognized by COC) must be followed	Client exhibiting increased WOB.	• QD and QID as they can be misinterpreted when handwritten. • > or< • cc. Use ml instead	See the "Acceptable Medical Abbreviations" section. • Spell out Daily and Four times daily. • > or< misinterpreted for a 7 or L. Also confused with one another.
Today's date and hours worked (in Military time) must be located on the top of page 1 of your Flow Sheet	**Date:** 10/16/2013 **Day of week:** Wednesday **Time In:** 0800 **Time Out:** 2000	• Am or Pm	• Complete in the spaces provided. • Military time ensures that there is no confusion between am and pm hours

Standard	Example of Acceptable Documentation	Avoid	Detail
A full signature with professional title must follow each narrative entry	*Bonnie Bell RN*----------	Initials are not acceptable	
Adding information to another nurse's entry is not permissible.	If an error is noted, the nurse who made the entry should be notified to make a change.		Changing or modifying a client record is a Criminal offense.
Follow-up documentation is to be provided for all PRN Medications and Treatments administered	Document on the Rationale for PRN Medication and Treatment form found in the clients chart behind their MAR.	Double charting in the comments section of the flow sheet.	Double charting can lead to errors in the client records. Don't chart a symptom without charting what you did about it.
A single line will be used to indicate when an error is made. The nurse must also include their initials.	Client states he is dizzy when changing from sitting to standing *BB* ~~position.~~	• Erasing or using correction fluid is not acceptable. • Crossing out words beyond recognition • Words such as unintentional, accidental, by mistake • Words such as Large amt. imprecise • Words such as appears or apparently suggest you are unsure of your observations	• Suggest error was made or client safety jeopardized • Instead of large: dime size, pea size, etc.
Documentation should be made throughout a shift to ensure that proper details are included in charting.	• Charting should be completed at least every 2 hours. This can be on the MAR or flow sheet • Vent settings must be documented every 2 hours. • Events should be charted in the order that they occurred to avoid confusion	Charting the entire day at the end of your shift	Changes in client status are easier to spot if documentation is in chronological order. Waiting can omit valuable information from the client record.

Standard	Example of Acceptable Documentation	Avoid	Detail
Charting is to reflect all ordered treatments. Charting is proof that physician orders were completed.	If something is not charted, then legally it is assumed that it was not completed.	• Do not bring up conflicts between client or family.	• Proper documentation creates lasting impression of a job well done. • What you document tells others about the care you provide
Late Entries	Write "late entry"		• Late entries can occur if the chart was not available after providing your interventions. • Late entries can arouse suspicions and can be a significant problem in the event of a malpractice lawsuit.
Incident occurred during your shift	Fill out an incident report (IR) Instructions found on the back of the form	• Documenting IR filed with agency in your comments of the Flow sheet	Document observations/ assessments only following Incident in your comments.
Charting of legally sensitive situations	Client stated that he plans to file suit against this facility for causing his bed sores.----Dave Bevins, LPN		Document statements like this in your narrative notes and report to COC.
Never leave blank spaces on documentation	Draw a line through empty spaces until you reach your next assessment/ observation.	Skipping lines. Fill in on the first available line.	This could imply that you failed to give complete care or to assess the client completely.

Approved Flow Sheet Abbreviations

Using standardized abbreviations and guidelines for entries is essential for ensuring that legal standards are met and that standards of care are followed.

Vital Signs- Frequency as per plan of care.				
Body Temp A-Axillary Te-Temporal Ty-Tympanic O-Oral R-Rectal	**Resp. Effort** ND – No Distress L-Labored Fl – Flaring MR – Mild Retracting SR – Severe Retracting A B-Abdominal Breathing	**BP** L-Lying Si-Sitting St-Standing E-Elevated in bed	**Pain Rate** 0 (None)-10 (Agonizing) D-Declined to Rate Pain **FLACC Score** 0- 10: Please refer to FLACC Scale to score	**Breath Sounds** C L– Clear CR – crackles D – Diminished S-Stridor IW – Insp. Wheezing EW – Exp. Wheezing CS-Coarse Fn-Fine EA-Equal Aeration

Ventilator Settings	**O2 LPM or Room Air (RA)**	**Systems Checks**
Record every 2 Hours ◦ Initial you verified prescribed settings as per Plan of Care ◦ All other areas, document what client is currently achieving not what the prescribed setting is	Document if client is on RA-Room Air O2- Record LPM	N- Within normal limits for your client S- Significant Findings. Follow up with an explanation in your comments as to why it is significant and what you did as a result of your assessment/ observations.

Secretions				
Skin Color P-Pink PA – Pale D – Dusky Cy-Cyanotic Ja-Jaundice	**Secretion Color** C L– Clear Cldy– Cloudy Cm – Creamy Y – Yellow G r– Green R – Red Pi-Pink	**Secretion Amount** S – Small M – Medium L – Large	**Consistency** Thick (Tk) Thin (Th) Copious(C) **Number of Passes** Record number of times catheter inserted	**Suction Location** Nasal (N) Simms (S) Oral (O) Deep (D)

Intake / Output				
Bladder or Bowel Amt. S-Small M-Medium L-Large	**Cathing Location** U-Urethral M-Mitrofanoff	**Liquid Intake** PO-Oral GT-G-tube GJ-J-tube	**Bowel Consistency** F- Formed/Normal L-Loose H-Hard/lumpy G-Grainy S-Soft	**Bowel Color** Br-Brown Bl-Black Gr-Green R-Red Y- Yellow

Client positioning / Repositioning			
I-Independent B-Back R-Right side	L-Left side T-Tummy LE-Legs Elevated SW-Swing	Ch-Chair/couch WC-Wheelchair St-Stander F-Floor	E-Elevated in bed RB-Recline in Bed P-Pillow under Shoulder
Activity Level			
A-Awake	S-Sleep	R-Restless	

Acceptable Medical Abbreviations

General Terminology

ā	Before	OU	Both Eyes
A&O	Alert and Oriented	p̄	After
ABD	Abdomen	p.c.	After Eating
a.c.	Before Eating	P&PD	Percussion & Postural Drainage
BD	Bronchial Drainage	PO	By Mouth
BID	Twice a day	PR	By Rectum
BP	Blood Pressure	PRN	As Needed
BPM	Beats per Minute	Pt	Patient
CA	Cough Assist	Q	Every
c̄	With	Qh	Every Hour
dc	Discontinue	Q4h	Every Four Hours
Dx	Diagnosis	QOD	Every Other Day
F/U	Follow up	R	Right
G/J	Gastrojejunal Tube	Ref	Refused
GT	Gastrostomy Tube	ROM	Range of Motion
gtt	Drops	Rx	Prescription
HA	Headache	s̄	Without
HO	History of	SOB	Shortness of Breath
HR	Heart Rate	STAT	Immediately
HS	At Bedtime	Sx	Symptoms
Hx	History	TID	Three Times per Day
L	Left	TO	Telephone Order
mg	Milligram	Trach	Tracheotomy
mL	Milliliter	Tx	Treatment
NKA	No Known Allergies	UD	As Directed
NKDA	No Known Drug Allergies	URI	Upper Respiratory Infection
NPO	Nothing by Mouth	UTI	Urinary Tract Infection
NS	Normal Saline	VT	Vest Therapy
OD	Right Eye	WOP	Without Pain
OS	Left Eye		

References

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