NURSING DOCUMENTATION

OBJECTIVES
1. The learner will be able to state 2 components of documentation that meet the ‘Standard of Care’
2. The learner will be able to identify 4 characteristics of a ‘complete skin assessment’
3. The learner will be able to identify 4 characteristics of a ‘complete wound assessment’

DOCUMENTATION IS…
- Something you learn in nursing school
- Something you do everyday at work
- How you record patient vitals, diet, meds...

THE permanent record of nursing assessment and care provided…
DOCUMENTATION

➢ ‘any written or electronically generated information about a patient that describes the care or services provided to that patient’

SOME EXAMPLES...

‘Skin intact, red, and broken’

‘The skin was moist and dry’

‘Pulses are probably in both feet’
‘Examination of genitalia reveals that he is circus-sized’

‘300cc PWISOTF’
(Plus what I spilled on the floor)

‘Patient found dead: felt cold, blanket added, voiced no complaints’
‘She has no rigors or shaking chills, but her husband states she was very hot in bed last night’

‘Large brown stool ambulating in the hall’

*Documentation is the process of recording the patient assessment and the care provided*

It MUST demonstrate that the ‘Standard of Care’ has been met
STANDARD OF CARE

What is it and who decides?

Guidelines used to determine what a nurse should or should not do
Model of established practice that is commonly accepted as correct
Basis for nursing care that draws on the latest scientific data from nursing literature
Based on the premise that the registered nurse is responsible for and accountable to the individual patient for the quality of nursing care he or she receives

The nurse has a professional responsibility, and is held accountable to document patient data that accurately reflects:

- Nursing assessment
- Plan of care
- Appropriate interventions
- Evaluation of the patient’s condition
STANDARD OF CARE

Developed and implemented to define the ‘quality of care provided’

- Federal / State laws, rules and regulations
- Professional organizations establish norms for the average practitioner
- The ANA and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) have established nationally recognized ‘Standards of Care’

POLICY AND PROCEDURE

In addition-

- Nurses must understand and follow the policies and procedural guidelines of their individual facilities

LEGAL CONSIDERATIONS

The healthcare industry can be a minefield of litigation when patients

- Don’t heal as expected
- Develop unexpected complications or infections which can lead to prolonged recovery or even death

Lawsuits often involve all those who cared for the patient, including the nurse
WOUND LITIGATION ON THE RISE

- Increasing elderly population
- Regulatory climate
- Misunderstanding by families as to the cause of wounds
  - Perceived as ‘bad care’
  - Public opinion that wound cases are an ‘easy target’

LEGAL CONSIDERATION

- Nursing documentation
  - often starting point in malpractice cases
  - can either deter a plaintiff from filing a lawsuit or provide the leverage that is required to initiate one

Jurors and attorneys view what is written in the patient record as the best evidence of what really occurred

PRESSURE ULCERS

The incidence of Hospital acquired pressure ulcers (HAPUs) is considered a ‘quality indicator’ of patient care

- ‘Quality care should not result in a HAPU’
- A ‘Never Event’
- High public awareness
- Frequent involvement in litigation
- Reimbursement issues
The reality is that not all pressure ulcers are preventable. The nurse MUST be able to show that all appropriate assessments and interventions were done. …That the ‘Standard of Care’ was met.

DOCUMENTATION THAT MEETS THE STANDARD OF CARE

- Timely
- Accurate
- Comprehensive
- Complete

ASSESSMENT, ASSESSMENT, ASSESSMENT.....

✓ SKIN ASSESSMENT
✓ WOUND ASSESSMENT
✓ RISK ASSESSMENT
SKIN ASSESSMENT

1. TIMELY
   ✓ ON ADMISSION
   ✓ EVERY SHIFT OR VISIT
   ✓ FOLLOW FACILITY POLICY

   Standard of Care
   ✓ Nursing Assess
   ✓ Plan of Care
   ✓ Interventions
   ✓ Eval / Re-Eval

   Characteristics
   ✓ Timely
   ✓ Accurate
   ✓ Comprehensive
   ✓ Complete

SKIN ASSESSMENT

2. ACCURATE / COMPREHENSIVE / COMPLETE
   ✓ INTEGRITY- Alteration in Epidermis or Dermis
   ✓ COLOR- Erythema, Pallor, Cyanosis…
   ✓ TURGOR- Dehydration …
   ✓ MOISTURE STATUS-
   ✓ TEMPERATURE-
   ✓ HIGH RISK AREAS-

   Standard of Care
   ✓ Nursing Assess
   ✓ Plan of Care
   ✓ Interventions
   ✓ Eval / Re-Eval

   Characteristics
   ✓ Timely
   ✓ Accurate
   ✓ Comprehensive
   ✓ Complete

SKIN ASSESSMENT

DOCUMENT
AND REPORT ABNORMALITIES

Standard of Care
✓ Nursing Assess
✓ Plan of Care
✓ Interventions
✓ Eval / Re-Eval

Characteristics
✓ Timely
✓ Accurate
✓ Comprehensive
✓ Complete
WOUND ASSESSMENT

1. TIMELY
   ✓ ON ADMISSION
   ✓ EVERY SHIFT OR VISIT
   ✓ UPON TRANSFER / DISCHARGE
   ✓ PER FACILITY POLICY

   Characteristics
   ✓ Timely
   ✓ Accurate
   ✓ Comprehensive
   ✓ Complete

   Standard of Care
   ✓ Nursing Assess
   ✓ Plan of Care
   ✓ Interventions
   ✓ Eval / Re-Eval

WOUND ASSESSMENT

2. ACCURATE / COMPREHENSIVE / COMPLETE
   ✓ Wound Type
   ✓ Location
   ✓ Measurement
   ✓ Undermining / Tunneling
   ✓ Wound Bed Appearance
   ✓ Drainage
   ✓ Odor
   ✓ Surrounding Skin

   Characteristics
   ✓ Timely
   ✓ Accurate
   ✓ Comprehensive
   ✓ Complete

   Standard of Care
   ✓ Nursing Assess
   ✓ Plan of Care
   ✓ Interventions
   ✓ Eval / Re-Eval

WOUND DOCUMENTATION
Paints the picture & tells the story
WOUND TYPE

FOR PRESSURE ULCERS:
- If you know how to stage it - Do it!
- If you are uncertain - Describe it!

LOCATION, LOCATION

Correctly identify wound location

MEASUREMENT

LENGTH \( \times \) WIDTH \( \times \) DEPTH

- Longest point
- Head to toe direction
- Perpendicular to length
- Widest point
- 90 degree angle
- Deepest point

Document on Admission and per facility policy
UNDERMINING / TUNNELING

Document with measurement

APPEARANCE

Document tissue type or describe color

DRAINAGE

How much and what does it look like?
ODOR

Document presence of...

SURROUNDING SKIN

Document condition of skin surrounding wound

REALITY

Audits are enlightening…
➢ Wrong location
➢ Wrong wound type
➢ Wrong pressure ulcer stage
➢ Ever changing pressure ulcer stage…
➢ Missing assessment data
➢ Inconsistencies from shift to shift and day to day
Common Liability Issues

- Lack of documentation
- No admission assessment
- Discrepancy with prior / post facility assessment / staging
- No measurements
- Lack of interventions
  - Specialty support surface
  - Off-loading
  - Documentation of turning / repositioning

MORE Liability Issues

- Failure to identify skin breakdown
- Failure to notify doctor of changes in wound
- Failure to apply proper treatment
- Failure to obtain wound care consult

INCONSISTENCY IN DOCUMENTATION

AUDIT EXAMPLE

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<th>Date</th>
<th>Time</th>
<th>PU Stage</th>
<th>SDTI</th>
<th>Measure</th>
<th>Undermining Tuning</th>
<th>Wound color</th>
<th>Incision edges</th>
<th>Exudate</th>
<th>Exudate type</th>
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</tbody>
</table>

Good News: Wound is noted on admission:

Not so Good News:
- Inconsistent (III → SDTI → III) - actually Unstageable
- Measurement noted on day 3 / Stage III, no depth documented, ever
- Documented consistently… (in a pressure ulcer?)
- "Liquid tissue"?
- Not assessed consistently-dressing type changes shift to shift
DOCUMENTATION TIPS

Documentation should include:

- Data from Nursing Assessment
- Nursing actions / interventions taken
- Individuals notified about concerns / issues
- Evaluation of actions

Standard of Care
- Nursing Assess
- Plan of Care
- Interventions
- Eval / Re-Eval

DOCUMENTATION TIPS

- Document within timeframe outlined per facility policy
- Correctly identify LEFT and RIGHT
- Correctly identify LOCATION, especially
  - SACRAL
  - COCCYX
- Correctly stage all PRESSURE ULCERS
- Do NOT stage wounds that are NOT pressure ulcers

Characteristics
- Timely
- Accurate
- Comprehensive
- Complete

GENERAL CAUTION

Spell correctly:
- “Fecal heart tones heard”

Use appropriate words and grammar:
- “The pelvic exam was done on the floor”

Avoid inappropriate comments:
- “Patient received insufficient care today because nurse patient ratio was 1:7”
Don’t Forget
RISK ASSESSMENT

✓ Evidenced based tool: Braden / Norton
✓ Follow facility policy for frequency
✓ INTERPRET RESULTS
  ✓ Implement appropriate interventions
  ✓ Use score to adjust the plan of care

IMPROVING COMPLIANCE

➢ Staff education and support related to wound ID, pressure ulcer staging, wound assessment..

➢ Tools and visuals to assist staff in wound identification and staging

WOUND DOCUMENTATION

FORMAT SUGGESTIONS

➢ Nurse ‘friendly’
➢ Contain all components necessary for ‘complete’ documentation
  ➢ Improves probability of comprehensive doc
  ➢ Visual
# EXAMPLE

To indicate location of wound(s) on body diagram

<table>
<thead>
<tr>
<th>Wound #</th>
<th>Location</th>
<th>Wound Type / Pressure Ulcer Stage</th>
<th>Wound Measurement</th>
<th>Appearance</th>
<th>Drainage</th>
<th>Odor</th>
<th>Cleansed with Dressing Applied</th>
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<tbody>
<tr>
<td>1</td>
<td>Left Iliac</td>
<td>Pressure Ulcer Stage II</td>
<td>2 x 2 x .2 cm</td>
<td>RED</td>
<td>SCANT</td>
<td>SEROUS</td>
<td>ABSENT</td>
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</table>

# BOTTOM LINE

*Every nurse is responsible for the patient care provided and the DOCUMENTATION to support it*

# SOME OPTIONS…
NURSING TOOLS

- Nurse ‘cheat sheet’
- Pressure ulcer staging analogy
- PU staging algorithm
- Musical wound assessment

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Nursing Tools

- 'Cheat Sheet' for Nurses
- Pressure Ulcer Analogy
- Baker Pressure Ulcer Staging Tool
- Musical Wound Assessment

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Standard of Care
- Nursing Assess
- Plan of Care
- Interventions
- Eval / Re-Eval

Characteristics
- Timely
- Accurate
- Comprehensive
- Complete
Thank You