SUBJECT: LEGAL REQUIREMENTS FOR NURSING DOCUMENTATION

1. PURPOSE:

The purpose of this policy is to present strategies to improve documentation. Specific do's and don'ts of charting are discussed. A legible, accurate medical record is a crucial health care document. It communicates important information about the individual to a variety of professionals. In the event of a lawsuit the medical record may form the basis for a plaintiff’s care or the nursing staff member’s defense.

2. POLICY:

1. Nursing services at Coalinga State Hospital shall use the Wellness and Recovery Model Support System (WaRMSS) for documenting in the individual’s medical record.

2. The WaRMSS Manual contains the minimum requirements for the documentation of client care and provides documentation formats or forms. Hospital wide documentation requirements may exceed and may take precedence over the minimum requirement of WaRMSS after approval by the Medical Records Committee.

3. Documentation by licensed nursing staff shall reflect the Nursing Process: Assessment, Outcome Identification, Planning, Implementation, and Evaluation.

4. Documentation in the medical record shall be done by licensed nursing staff, except as outlined below:

- Students may document as a part of their training when co-signed by licensed nursing staff or nursing instructor

- IPRNs, working under an intern permit employed by Coalinga State Hospital may document, but will require a co-signature by a Registered Nurse

- PLPTs may document but will require a co-signature by a licensed nursing staff.
-Non-licensed Nursing Staff employed by Coalinga State Hospital and who have completed the nurse assistant training and certification course may document on flow records. The PTA may not do total documentation, but may record observations on the IDN if they personally observed a situation.

5. Changes in an individual's physical or mental condition and abnormal lab results shall be reported immediately to a Registered Nurse who will assess and report promptly to the attending physician as appropriate. The date, time, and method of notification including whatever information was relayed to the physician or MOD, shall be entered in the IDN.

6. Errors in documentation in the clinical record shall not be obliterated by use of “white-out” or any other means.

7. All documentation in the clinical record shall be done in black or dark blue ink except as started below:

-Red ink shall be used on the Medication Administration Records to discontinue medication/treatment.

-Red ink shall be used to document “Allergies/Alerts” on the: Physician’s Order Sheet, Medication Record, Physical treatment profile, Immunization Record, Discharge Summary, Nursing Assessment, RAND and Sticker Alerts.

-Red ink shall be used to note physician’s orders and to draw the red line on the Physician’s Order sheet to note the 24-Hour Audit Check (see NPP 524 “Transcription Review of Charts & Medication Orders).

8. Felt tip pens shall not be used.

9. Do Not use ditto marks in the progress notes. (See Nursing Policy 200, for other abbreviations and symbols that are not to be used in documentation)

10. Use clear, simple, concise terms.

11. Be sure all forms are stamped with legible addressograph plate or if addressograph plate is not available, print individual’s name, birth date and CSH # on each form.

12. All entries must be signed by the person making the entry with the first name initial and full last name plus civil service classification. If signature is not legible (to others), print full name and title besides or below signature.

13. All entries must be dated and include the time the entry was written. All “Late Entries” must also include date and time written.

14. All entries must be keyed to the proper focus #

Correcting mistaken entries in documentation:

1. Draw a single diagonal line through the entry so that it is still readable. Do not obliterate the entry. Write “Error” above or beside the original words.

2. Place the date and your initials next to the words “Error”.

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N.P.P. No. 310
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>PROB NO.</th>
<th>ALL ENTRIES SHALL BE SIGNED WITH THE NAME AND TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-9-06</td>
<td>0800</td>
<td>3</td>
<td>Individual became hostile and attempted to strike out at his staff member when requested to go to dining room. Unit physician notified and individual was placed in Restraint for striking out behavior. --- Josie Smith, P.T.</td>
</tr>
<tr>
<td>4-9-06</td>
<td>0900</td>
<td>3</td>
<td>Correction for Error: Attempts to counsel were ineffective. --- Josie Smith, P.T.</td>
</tr>
</tbody>
</table>

Correcting errors of omission:

1. Late entries are those not made at the expected time of recording or observation. When making late entries:

- Insert an asterisk (*) in the margin or between the lines of the note in chronological order to correspond with the corresponding observation action or event. For example, “SEE NOTE of (current DATE and TIME).

- Asterisk (*) and enter in chronological order the current date and time. Begin the entry using the example below:

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<tr>
<td>*SEE 4-13-06</td>
<td>NOTE @ 1300</td>
<td>S&amp;R release</td>
<td>Observed in day hall responding to unseen stimuli. When asked</td>
</tr>
</tbody>
</table>
4-12-06 1300 3 What he was responding to he stated “God speaks to me by way of the TV. He is telling me to save the world.”
----------Josie Smith, PT

4-13-06 1300 3 Late Entry for 4-9-06 @ 0900 Individual appears to be less agitated and hostile. States he is no longer fearful of the food in the dining room. Removed from Restraint
----------Josie Smith, PT

Procedure for adding late entries:

1. Add the entry to the first available line.
2. Label the entry “Late Entry” to indicate it is out of sequence
3. Record the time and date of the entry
4. In the body of the entry, record the time and date it should have been made

Identify late entries correctly:

If the time of an entry does not correspond with the event being recorded, explain why. Late entries may result when:

- Important information should be added to the medical record after progress notes have been completed;

- The medical record is not available for charting at the time the nursing staff member needs it, the nursing staff forgets to write progress notes on a particular chart

- Do not ask other nursing staff members to leave some blank lines so that you can insert your progress note, it is better to add this information as a Late Entry.

Late entries should not be squeezed into an existing note or placed in the margins. The late entry should not be added in such a way as to appear suspicious. When writing late entries note the reason why the entry is being added to the record. Plaintiff’s attorneys scrutinize late entries. The attorney may attempts to prove that the nurse tried to alter a record to cover up an error instead of making an addition.
3. **GENERAL INFORMATION:**

Examples of inappropriate documentation:

Writing crowded around existing entries; Changes in slant, pressure, uniformity or other differences in handwriting; Erasure or obliteration; Use of different pens to write one entry; Misaligned typed notation; Impressions or lack of impressions from writing instruments on the following pages; Ink offsets or lack of impressions from writing instruments on the following pages; Additions on different dates written in the same ink, while original entries were written in different ink.

Healthcare professionals who have been named in a malpractice suit involving altered records may sue the person who falsified the records.

Types of tampering:

-DO NOT TAMPER WITH MEDICAL RECORDS!

Tampering with the record involves:

1. Adding to the existing record at a later date without indicating the addition is a late entry.
2. Placing inaccurate information into the record. The truth and nothing but the truth should go into the medical record.
3. Omitting significant facts. The omission of significant information in the medical record has serious consequences. The old adage “If you didn’t chart it, you didn’t do it” holds true.
4. Dating a record to make it appear as if it were written at an earlier time.
5. Rewriting or altering the record.
6. Destroying records.
7. Adding to someone else’s note.

Chart only care you provide or supervise:

Nursing staff should sign only those notes describing care they have given or supervised. Unlicensed staff (e.g. PTA’s) are generally not involved in writing progress notes. However, PTA’s may document the completion of tasks on flow sheets. The licensed nursing staff is expected to document the additional information such as assessments.

Avoid using the medical record to criticize other health care professionals:

Do not use the medical record as a forum to criticize other healthcare professionals. Discuss your concerns with the Unit Supervisor or designee.
Unit Supervisor or designee should be alerted to staff issues to intervene as appropriate.

Be precise in documenting the information you report to the physician:

Nursing staff are obligated to report serious symptoms to the physician. It is a legal “must” to chart every substantive conversation you have with a physician about a client, particularly any conversation in which you question a physician’s orders.

Always document on the clinical record the time of a phone call informing a physician of a change in the individual’s condition or a critical abnormal laboratory value.

Document individual/client acts:

Examples are as follows:
- An individual’s refusal or inability to provide accurate and compete information.
- Noncompliance with medical or nursing interventions such as:
  A. Staying in bed.
  B. Dietary restriction.
  C. Return appointments.
  D. Abuse or refusal of medication.

Write neatly and legibly:

One important purpose of documentation is to communicate with the health care team. Sloppy, illegible handwriting creates confusion and wastes time. More seriously, injury to the individual may result if crucial information is misunderstood or not communicated because of illegible handwriting. Simple, effective solutions to the handwriting problem include emphasizing printing instead of writing and asking the healthcare professional to scan and proofread their notes before they close the medical record.

Use proper spelling and grammar:

Progress notes that are filled with misspelled words and incorrect grammar can create negative impressions. They imply that the nursing staff member has a limited education or intellect or is careless and distracted when charting.

Spelling and grammatical errors can be prevented in a number of ways:
1. Keep a dictionary in charting areas.
2. Post a list of frequently misspelled words. Individualize the list by selecting terms and medications used frequently on the unit.
3. Write clear and concise sentences. Avoid useless and unnecessarily long words.
4. Clearly identify the subject of the sentence. Do not be afraid to include the word “I”, as in “I spoke with the individual…” It is sometimes very difficult to determine what actions were performed by nursing staff as opposed to the client, physician, or other healthcare professional.

**Document in black ink and use military time:**

The use of black or dark blue has become the trend in healthcare facilities. Red and green do not photocopy well.

To further define the exact time of day, military time or the 24-hour clock (1300 hours instead of 1:00 PM) has become the standard in healthcare facilities. This eliminates the use of AM and PM and the potential for confusion if the AM or PM is inadvertently omitted.

**Make sure that the individual’s name is on every sheet:**

Avoid the possibility of inserting the wrong pages into a different individual’s chart by stamping or labeling every side of each page with the individual’s identifying information.

**Use authorized abbreviations:**

NPPM “Approved Abbreviations and Symbols” identifies the approved abbreviations. This list should be available to all healthcare workers who document in the medical record. A major purpose of the chart is communication between healthcare workers. This cannot be accomplished when abbreviations cannot be deciphered by anyone other than the author. The Medical Records Committee reviews the list of abbreviations annually to be sure it reflects current practice. Be alert for abbreviations that could have more than one meaning e.g., CVA could mean cerebral vascular accident or costovertebral angle. When in doubt, spell it out.

**Transcribe orders carefully:**

Refer to NPPM “Transcribing of Medications Orders”.

**Chart promptly:**

Chart as close as possible to the time you make an observation or provide care. If you normally write notes while events are fresh in your mind, you won’t have to deal with even the suggestion that your recollections at the end of the shift were uncertain, confused, mistaken, or otherwise unreliable. When charting is left until the end of their shift, details that are important to note are
often forgotten. Information that is charted immediately is more likely to be accurate and complete.  
Chart after the delivery of nursing care, not before:

Avoid documenting the performance of a procedure before performing it. The information in the record may be inaccurate and will not reflect the individual’s responses to the intervention.

Charting in advance will also affect the credibility of the medical record.

Joe Silva RN, ACNS  
Nursing P&P Committee Chair

Janet Smith RN, MSN  
Nursing Administrator