

Medical Record Documentation and Legal Aspects Appropriate to Nursing Assistants

Medical records are legal records that must be done in a very careful legal way. They must also be used in a legal way. They:

- Tell us and all the other members of the health care team about the patient, their care and treatments;
- Tell us facts about the patient or resident;
- Help people, like the doctor and the nurse, to make good decisions about the patient and their care; and
- Help us to find out how well the care that is being given is helping the person.

Documentation in these records must be:

- Complete,
- Correct,
- Done on time,
- Done in a legal way and
- Professional.

Healthcare facilities use many kinds of forms and ways to document the care that clients get. Daily care and hygiene in some places is written on a flow sheet form. In other places this care is written in a progress note. In some settings, this daily care is put into a computer. You must follow the rules set by your place of employment. Ask the nurse if you are not sure of where you should write about your client. (Burke, 2010).

Complete Documentation

Documentation must be complete. You must record everything that you do and everything that you observe. All care and all treatments must be recorded. You must also record all your observations of the patient. You must record all of the things that you see, feel, and hear, especially if they are not normal and/or not normal for the patient that you are taking care of. You have to document everything. If it is not documented, it was not done. So, if you have done it, take the time to document it. For example, if you gave your patient a complete bed bath and the patient told you that they have a headache, you must record the fact that you have given the person their bath and that they have told you that they have a headache. You should also tell the nurse about the headache as soon as possible. This observation, and all other observations that are not considered normal must be reported to the nurse right away. It should also be written in the person's medical record as soon as possible. (Burke, 2010).

Some of the care that nursing assistants and home health aides must document are:

- Baths,
- Showers,

- Oral care,
- Denture care,
- Foot care,
- Hair and nail care,
- Urinary catheter care,
- Back care,
- Turning and positioning,
- Meal intake,
- Fluid intake,
- Activities, like walking,
- Range of motion exercises if done,
- Warm soaks,
- Cold applications and
- Talks that you have had with the patient or resident and family members.

Some of the observations that nursing assistants and home health aides must document are:

- Level of consciousness,
- Orientation to time, place and person,
- Height,
- Weight,
- Urinary drainage bag output,
- Temperature,
- Pulse,
- Respiration rate,
- Blood pressure (if you can take it),
- Blood glucose readings (if you can take it),
- Color of the skin,
- Warmth and characteristics (wet, dry, etc.) of skin,
- Things that the patient or resident says,
- Things that the patient or resident communicates to you, like a frown which may mean they are angry or in pain,
- Behaviors, like anger and yelling and
- All other things that you see, hear or feel, especially if it is not normal.

Correct Documentation

All of your documentation in the client's chart must be correct. If a person's temperature was 101.4 at 2:30 pm, the reading and the time that it was taken must be written in the correct way. You should not write that it was taken at 2 pm if it was taken at 2:30 pm. And, you should not write that it was 101 degrees when it was 101.4. (Burke, 2010).

You must also write only those things that you actually do, see, hear or feel. (Burke, 2010).

For example, you should not write, “The resident is lazy today.” This may not be true. You did not see “lazy”. You thought that the person may be lazy, but you did not see or hear lazy. It may not mean that a patient is “lazy” when you see them sleep most of the day. They could be very ill. Or, it may be that they did not sleep at all the night before because the other patient in their room was noisy all night. Instead, you should write, “The patient slept from 8 am until 12 noon and was only awake when vital signs were done at 10 am.” Alternatively, if the person says they are feeling lazy, you should write and report that the patient said, “I am feeling very lazy today.” (Burke, 2010).

Timely Documentation

Documentation must also be done on time. It must be done in a timely manner. It must be done as soon as possible because documentation used to communicate about the client. It must be ready to see and ready to use for decisions. You should not wait until the end of the shift to do it. It is a very important part of care. Take the time to document and report as often as needed. (Burke, 2010).

Case Study

You are taking care of an 82-year-old resident with Alzheimer's disease. You see that this resident has suddenly become loud, angry and hostile towards other residents during breakfast in the dining room. This person has never been like this before. This is a new occurrence for this person. Let's say, you do not report or record this observation since you had planned on documenting it at the end of the shift. Then, later in the day, this resident hurts and injures a visitor with punches and slaps during an afternoon group activity.

Could this injury have been prevented?

The injury to the other person may have been prevented if the nursing assistant had reported and recorded this behavior right after it happened. The resident could have been:

- Watched more closely by the person who was running the afternoon group activity if they had known about the resident's anger and hostility that morning, or
- The person could have been given some activity in their own room, rather than being around other people that day until their problem was taken care of. (Burke, 2010).

What should the Nursing Assistant have done differently?

All facts and findings that are not normal must be reported immediately and then documented in the client's medical record. It should also be reported orally to all those that care for the client.

This nursing assistant should have reported the anger to the nurse as soon as it happened. The nursing assistant should also have written this behavior in the resident's medical record. This communication is very important. Documentation and reporting should be done as soon as it happened. You should never wait until the end of the shift to write or report things that are not normal. (Burke, 2010).

Legal Documentation

Medical records are legal documents. They must be used according to the law and the policies of your place of employment. They must also be kept according to the law and the policies of your own place of employment. (Burke, 2010).

Some things that you should do in order to make sure that you treat these records as legal documents are:

- Use blue or black ink unless you are using a computer or your hospital uses a special color ink for different shifts;
- Do not use pencil or ink that can be erased;
- Write so that it can be read clearly. There should be no sloppy writing;
- Date all of your notes;
- Write the time that you write your note;
- Sign your full name and title (CNA, HHA, etc);
- Do not scribble things out if you make a mistake;
- Do not use "White Out" or any other thing that covers up writing;
- Write only facts;
- Do not chart before the fact. For example, do not check off a bath on the flow sheet until the bath is done;
- Do not use an abbreviations unless they are accepted for use by your place of employment;
- Do not allow anyone to touch or look at a medical record unless they are a healthcare provider taking care of that patient or resident;
- Keep all medical records in a safe and secure place;

- Medical records are confidential. Do not tell anyone about what is in them unless they are taking care of the person.

Professional Documentation

Documentation should also be professional. Handwriting should be neat and easy to read. Spelling should be correct. Look up the spelling of a word if you do not know how to spell it. Also, be professional and careful with what you write. These records are not the place to air your own feelings about the client and their care. For example, you should never write that “the nurse has not seen the patient all morning” or something like, “As usual, the doctor has not come to see the patient after he was called.” These statements are not at all professional. (Burke, 2010).

Some nursing assistant and home health aide notes are narrative charting. However, charting are sometimes done on flow sheets or charts where only a check mark is required to indicate the care that has been provided. A Daily Nursing Care Record is one kind of flow sheet used by nursing assistants to document their daily care. Aspects of care such as the client's daily bath, oral, denture, and hair care appear on a preprinted form. All the nursing assistant or home health aide has to do is check off the box next to the aspect of care after that care has been completed. Only rarely would the nursing assistant or home health aide have to add a word or two of detail. An example might be in the recording of a bowel movement (BM), the nursing assistant or home health aide may add whether or not the BM was small, moderate or large in amount. (Retrieved March 16, 2011 from <http://www.corexcel.com/html/body.documentation.page8.ceus.html>).

It can be a tedious and time-consuming task for the nursing assistant to make sure that each and every box is either checked off or is recorded with a zero which indicates to anyone reviewing it that the care was not done for whatever reason. For example: the client may have refused the care; therefore, it could not be done. (Retrieved March 16, 2011 from <http://www.corexcel.com/html/body.documentation.page8.ceus.html>). Nursing assistants or home health aides are required to immediately report care that was not done or was refused to the nurse. The nurse is then responsible for charting a narrative note as to why the care was not done as ordered. Although it is very time consuming for nursing assistants to check off or enter with a zero all the many boxes on the flow sheets provided for them to record care, it is important for the nurse to encourage and monitor their charting efforts. Remember, if absences appear on flow sheets, then legally care was not offered or provided. Since nursing assistants and home health aides report to nurses, it is a nurse's responsibility to periodically monitor nursing assistant or home health aide documentation for accuracy and completion. Randomly auditing nursing assistant and home health aide documentation is an effective, continuous quality monitoring endeavor that, over time, could become a rewarding nursing assistant or home health aide activity. But first, nurses need to ensure that nursing assistants and home health aides have the time available to them so that they can accomplish the level of charting that is expected of them. (Retrieved March 16, 2011 from <http://www.corexcel.com/html/body.documentation.page8.ceus.html>).

Documentation in the home health care setting or healthcare facility is very important for many reasons. The documentation about clients is kept in the organization's clinical or medical records. The clinical information or documentation about the client's progress is confidential information that provides communication to the doctor, the insurance company, cases managers, your supervisor and other team members about the client's care. For all these reasons, it is important that the care (including the aide's care) matches the care ordered. (Marrelli, 2008).

Why is Documentation so Important?

- It is the only written source for communication from you and reference for members of the health care team.
 - It supports payment for insurance coverage or denial for provided client care services.
 - It is the source for review and evaluation of the care provided.
 - It is a legal record.
 - It is important to maintaining organization certification or accreditation.
- (Marrelli, 2008).

Rules about Documentation: The Basics

Certain rules need to be followed when completing documentation for the clinical record. Documentation reports what was done and occurred during your shift. Effective documentation practice includes the following:

List the patient's name and your credential, according to your organization's protocol.

Report on each assigned task or duty (as noted on aide assignment form) for each shift or visit.

Complete patient note for every shift or visit.

Finish the documentation as soon as the work is completed, e.g., as soon as the work is completed, write it on the visit/shift record prior to leaving.

Record any client refusal to have a task performed along with the reason if given on the visit note and make sure to notify your supervisor.

Speak with the supervisor, if in doubt about any documentation issues.

Your client may be asked to sign or initial the visit documentation or other agency form (in the case of a home health visit).
(Marrelli, 2008).

Documentation Tips

Print neatly or write legibly

Use black or blue ink, not pencil (your organization may specify a preferred color of ink).

In the case of a home health visit, for every note, identify the patient's name, the time arrival, and departure and date.

Sign each note and include your title after your name, e.g., CNA, HHA.

Be factual, accurate, and specific.

Chart only the care you provided.

Avoid relying on memory.

Do not make assumptions, draw conclusions, or assign blame.

Ask your supervisor for any documentation policies and procedures at your organization.

Correct mistakes as per organization policy.

Notes should show that the nursing assistant or home health aide follows the assignment (Marrelli, 2008).

Ask your supervisor if you don't know how to document something. (Marrelli, 2008).

The Supervisor's Review of your Documentation

Client notes may be reviewed by the supervisor. Narrative and checklist notes show the actual care provide patients. This review is a common part of an important process called "quality improvement" (QI) or performance improvement (PI). These are ongoing processes that continually strive to improve care and organizational operations. It may include supervisory visits of care at the health care facility or in the home, documentation reviews, patient satisfaction surveys, and physician comments. (Marrelli, 2008).

About Documentation, Accreditation, and Quality

You may be caring for a patient when a surveyor or site visitor comes with the nurse to meet with your client. These visitors can be from accreditation organizations, such as the Joint Commission on Accreditation Healthcare Organizations (JCAHO). Accreditation organizations define national standards for care and organizational quality improvement initiatives. The accreditations surveyors visit to validate that specific standards are met by accredited organizations. Surveyors or site visitors could be from the state or federal agencies, or from your own organization's QI team. Accreditation requires QI or PI and site visits. It is one of the ways of assessing the quality of care patients receive from an organization. The home health aide documentation assists in demonstrating the provision of safe and effective personal care to patients. This is an important part of any

accreditation or regulatory review of the organization's operations related to patient care. (Marrelli, 2008).

What to Document: Supporting Professionalism

It is important that your documentation match the information on your assignment sheet or care plan and instructions by the nurse. To any record reviewer, the documentation should paint a clear picture of the patient's condition and the needs that require your special care. The information should be factual and objective because the clinical documentation is the paper trail of care provided and the patient's response to that care. Again, in your documentation, it is important not to be judgmental about your patient's lifestyle choices or cultural background. For example: "I kept telling Mrs. Smith not to smoke and now she's coming out of the hospital again with pneumonia." A better documentation would be "Mrs. Smith reports that she just came home from the hospital with pneumonia. Aide called office at 2:00 p.m. and informed the supervisor that when she arrived, the patient was smoking in the home without supervision. (Marrelli, 2008).

Your organization may have examples of documentation for you to review to improve your documentation. Your organization may also have examples of effective notes or correctly completed checklists. (Marrelli, 2008).

Documentation Examples

Here are some examples of documentation. Notice the difference between the first two and last two notes. The first two notes provide specific information related to the client's mobility and medication compliance. Note that when a change in the client's skin was observed, it was reported to the nurse right away with the time and the nurse to whom the problem was reported. The second two notes demonstrate inappropriate documentation. Health care workers should not express an opinion on a paper that is part of the patient's clinical record. The nursing assistant or home health aide should not administer medications (ear drops) and always should follow the organization's policy regarding medications. (Marrelli, 2008).

Two Examples of Writing Right

7/15 8:30 AM: Morning care performed. Ambulate in corridor with walker. BM today. Took meds in morning slot. Red area on coccyx reported to nurse Sarah Smith. **Sally Murphy, HHA**

7/15 11:00 AM Morning care done including shampoo. ROM exercises done. Absorbent underpad changed 2x. Drank coffee and juice with help. No BM today. **Martin Jones, HHA**

Two Examples of What Not To Write

7/15 9:00 AM: Assisted with shower. Nurse should have ordered shower chair as client

was very shaky. This lady should be in a nursing home.. *Cindy Smith, HHA*

7/15: Assisted with shave, foot soak. C/O earache + put drops in ears. *Dana Byer, HHA*

Conclusion

It is important to remember that documentation is the paper trail of the care provided and the patient response to that care. These records must be complete, accurate, timely, legal and professional. Well done medical records help the members of the healthcare team to communicate and coordinate care. (Burke, 2010). Effective clinical documentation paints a picture of the patient and the care provided. When writing clinical documentation keep in mind that effective documentation addresses two important standards: It demonstrates the care that was provided to the patient; and it is required by Medicare, accreditation, and other regulatory bodies. (Marrelli, 2008).

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Quiz

1. Documentation in the medical records must be:
 - a. Complete,
 - b. Correct,
 - c. Done on time,
 - d. All of the above

2. Some of the care that nursing assistants and home health aides must document are:
 - a. Baths, Showers, Oral care, Denture care, Foot care, Hair and nail care,
 - b. Urinary catheter care, Back care, Turning and positioning, Meal intake,
 - c. Fluid intake, Activities, like walking, Range of motion exercises if done,
 - d. Warm soaks, Cold applications
 - e. All of the above

3. Some of the observations that nursing assistants and home health aides must document are:
 - a. Level of consciousness, Orientation to time, place and person, Height, Weight,
 - b. Urinary drainage bag output, Temperature, Pulse, Respiration rate, Blood pressure,
 - c. Blood glucose readings, Color of the skin, Warmth and characteristics of skin,
 - d. Things that the patient or resident says, Things that the patient or resident communicates
 - e. Behaviors, like anger and yelling
 - f. All of the above

4. Observations that nursing assistants and home health aides must document are, all things that you see, hear or feel, especially if it is not normal.
 - a. True
 - b. False

5. Some things that you should do in order to make sure that you treat these records as legal documents are:
 - a. Use blue or black ink unless you are using a computer or your hospital uses a special color ink for different shifts;
 - b. Write so that it can be read clearly. There should be no sloppy writing;
 - c. Date all of your notes;
 - d. Write the time that you write your note;
 - e. Sign your full name and title (CNA, HHA, etc);
 - f. Write only facts;
 - g. Keep all medical records in a safe and secure place;
 - h. Medical records are confidential. Do not tell anyone about what is in them unless they are taking care of the person.
 - i. All of the above

6. Some things that you should NOT do in order to make sure that you treat these records as legal documents are:
 - a. Use pencil or ink that can be erased;
 - b. Scribble things out if you make a mistake;
 - c. Use “White Out” or any other thing that covers up writing;
 - d. Chart before the fact. For example, do not check off a bath on the flow sheet until the bath is done;
 - e. Use an abbreviations unless they are accepted for use by your place of employment;
 - f. Allow anyone to touch or look at a medical record unless they are a healthcare provider taking care of that patient or resident;
 - g. All of the above

7. One Example of Writing Right is:

- a. 7/15 8:30 AM: Morning care performed. Ambulate in corridor with walker. BM today. Took meds in morning slot. Red area on coccyx reported to nurse Sarah Smith. **Sally Murphy, HHA**
- b. 7/15: Assisted with shave, foot soak. C/O earache + put drops in ears. **Dana Byer, HHA**
- c. Neither A or B
- d. A or B

8. An Example of What Not To Write is:

- a. 7/15 9:00 AM: Assisted with shower. Nurse should have ordered shower chair as client was very shaky. This lady should be in a nursing home.. **Cindy Smith, HHA**
- b. 7/15 11:00 AM Morning care done including shampoo. ROM exercises done. Absorbent underpaid changed 2x. Drank coffee and juice with help. No BM today. **Martin Jones, HHA**
- c. A and B
- d. A or B

9. Reasons why the clinical record is important are:

- a. It is the only written source for communication from you and reference for members of the health care team.
- b. It supports payment for insurance coverage or denial for provided client care services.
- c. It is the source for review and evaluation of the care provided.
- d. It is a legal record.
- e. It is important to maintaining organization certification or accreditation.
- f. All of the above

10. Some basic rules about documentation are:

- a. Complete patient note for every shift or visit.
- b. Finish the documentation as soon as the work is completed, e.g., as soon as the work is completed, write it on the visit/shift record prior to leaving.
- c. Record any client refusal to have a task performed along with the reason if given on the visit note and make sure to notify your supervisor.
- d. All of the above

11. Some documentation tips are:

- a. Sign each note and include your title after your name, e.g., CNA, HHA.
- b. Be factual, accurate, and specific.
- c. Chart only the care you provided.
- d. All of the above

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Blank Answer Sheet

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.

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Answers to Quiz

1. D
2. E
3. F
4. A
5. D
6. D
7. A
8. A
9. F
10. D
11. D