

## WHY DO WE DOCUMENT?

To:

- **COMMUNICATE WITH OTHER STAFF MEMBERS TO ENHANCE RESIDENT CARE, SAFETY AND QUALITY OF LIFE**
- Provide and maintain a written record of :
  - Resident information for internal and external service providers
  - Assessments and service plan interventions
  - Positive or negative changes in residents: physical, psychological, emotional and behavioral status
  - Care/Actions/interventions taken
  - Resident response to care/actions taken
  - Interventions which work and those which do not
  - Reassessment/new or different intervention
  - Follow-up to those actions/intervention
  - Resolution of symptoms (pain, skin, behavior, etc.)
  - Resident response to medications, treatments, diets
  - Resident response to Incidents, accidents, or other adverse events
  - Resident response to therapy sessions and responses
  - Continuous reassessment as indicated

## WHAT DO WE DOCUMENT?

- Admission information
- Assessments (preadmission screens or assessments as required)
- Service/Support Plans
- Transition into and adjustment to the community or Secure Dementia unit X 3 days or more- physical, psychological, social, activity participation and dietary
- Changes in level of ADLs, skin, eating, in activities participation levels
- Changes in physical condition (shortness of breath, pain, weight loss, onset of incontinence, onset of hypotension, lethargy, skin condition, decreased ability to ambulate, etc.)
- Notification of Family, physician, dietitian, PT, OT/Speech
- Changes of or new orders and recommendations
- Results of interventions
- Behavioral problems, Triggers, Interventions, Results
- Unusual incidents or adverse reactions
- Medications and treatments ordered and given
- Physician orders
- Resident, family or Service/Support Plan meetings
- Resident/family teaching
- Family Complaints and Concerns
- Transfers to higher levels of care
- Discharge

## WHAT DON'T WE DOCUMENT?

- Normal everyday behavior
- Normal everyday participation
- Normal ambulation or mobility
- Normal continence status
- Normal eating and swallowing patterns
- Disagreements between staff members and their documentation

### **WHEN DO WE DOCUMENT?**

Documentation should take place as close to the time of the action taken, assessment completed, service plan interventions chosen, change in condition noted, adverse response, relief provided, orders initiated or changed as is possible. We need to document all of the issues noted previously as soon as we can in order to preserve the line of accurate and complete communication.

### **WHERE DO WE DOCUMENT?** (you may have different forms or locations)

- Face sheet
- Resident/Medical Record/Electronic or handwritten progress note
- Assessments internal or state required form
- Service/Support Plan
- Assignment sheet or personal care associate flow sheet
- Behavior Monitoring Tool
- Complaint/Grievance Log
- MAR/TAR
- 24 Hour Report/Communications book
- Preadmission Screens if required by State regulations

### **WHICH DOCUMENTS CAN BE LEGALLY ADDED TO OR UPDATED?** (may differ per state regulations)

- Medical Record – Licensed nursing staff , unlicensed staff if trained and permitted by facility policy, Resident Care Director, Executive Director, Dementia Program Director, Marketing/Admissions, Recreation staff, Therapy, etc.
- Interdisciplinary or progress notes can be added as:
  - Late Entry as long as that is designated by the software or in writing if hand written
  - Clarification of a previous note can be a different author than the note being clarified or amended to correct (I.E. right leg originally charted, in actuality it was the left leg)
  - After a resident is transferred to the hospital or nursing home, notes can never be removed or altered- only new notes can be written
  - After a resident is discharged – final discharge notes are mandatory in some states and can legally be added- notes can never be removed or altered- only new notes can be written
- Service Plan- ED, RCD, DPD, Trained Nursing Staff- assure RCD is aware
  - Can be added to or updated to reflect current status
- Behavior Monitoring Tool- Nursing staff, Dementia Program Director

- Can be added to or updated to reflect current status
- Complaint/Grievance Log
  - Should be added to with each new occurrence
- MAR/TAR- Licensed or Trained staff, RCD
  - Should be updated to reflect current medications and should clearly reflect all discontinued medications
  - All medications administered or held should be signed for or clearly indicated as they are given , held or changed
- 24 Hour Report- Nursing staff, ED, RCD, DPD, Marketing/Admissions
  - Should be updated and reviewed daily by each shift
- Face sheet- Per your internal policy and procedure, Nursing staff, RCD, ED, DPD, Marketing/Admissions
  - New information can be added at any time
  - New form should be reprinted to reflect changes if computerized
- Preadmission screen) – if and as required by state regulations
  - Never to be updated, only used prior to initial admission. If resident is discharged and returns or is moved to a dementia unit a new PCH screen would need to be done
  - Physician's orders- Nursing staff, RCD, ED
  - Updated with each new order change
- Medical Evaluation/History and Physical-
  - Resident Social Security Number and date of birth can be added if omitted- RCD, ED, DPD
  - Physician License number can be added if omitted- RCD, ED
  - Other Changes or corrections- MD ONLY!!! If incorrect send back to MD
    - No other changes to this form are EVER permitted
    - If additional information is missing, fax the document back to the physician and ask for corrected or omitted information.

#### **WHICH DOCUMENTS CAN NOT BE LEGALLY ADDED TO OR UPDATED?**

- Medical Evaluation (except as outlined above)
- Physician prescriptions or orders
- No documentation completed by another staff member can **EVER** be altered. If the note is incorrect, a new note must be written explaining the error or the original author can strike out.
- Family or resident complaints

#### **HOW DO WE EFFECTIVELY DOCUMENT?**

- Why is the note being written?
- What are you trying to say? (think it out or write it out before putting it into an electronic record)
- Use short, complete sentences
- Use punctuation between thoughts
- Keep it simple, but, be specific
  - Use newspaper-reporting format
    - **Who** was involved?
    - **What** happened?

- **When** did it happen?
- **Where** did it happen?
- **How** did it happen?
- **Who was notified (if anyone)**
- Followed by:
  - **What** did you do about it (interventions)?
  - **What** was the result of the interventions?
  - **How did the RESIDENT respond**

**CRITERIA FOR GOOD DOCUMENTATION AND RECORD KEEPING:**

- Always remember the resident's chart is a legal document
- Keep the note informative with each sentence, do not get too wordy or anecdotal
- Never assume the reader knows the resident or the situation
- Do not allow anger or attitude to be conveyed in the note
- Do not assign tasks to other personnel – (i.e. endorsed to day shift, Mary Jones will follow up with MD)
- Do not have intershift or interdepartmental discussions or disputes in the medical record
- Do not criticize another care provider or their work
- Entry should be objective and describe the issue
- Use your name or I or the PCAs name
- Do not use “this nurse, this PCA or this Program Director” as a form of identification in the note
- If the resident has said something, quote the statement EXACTLY as stated. If the statement contains offensive language, racial slurs, etc. put quotation marks around it.
- NEVER write that an incident report was completed, but, always chart the details of the incident/accident/adverse event, (Explain in detail: Vital signs, pain status, level of consciousness, range of motion, bleeding, bruising, skin tear size and location, deformity of joints or limbs, change of mental status, specific family and physician notifications, EMT notification, whether sent to E.R.. or not and if sent which one and at what time.)
- Electronic charting should follow the processes as outlined in your training.
- If charting by hand
  - Always date and time every note, the time should reflect when the note was WRITTEN.,
  - If writing a note to cover the entire shift, you may include references to specific times during the day NEVER chart 3 to 11, 7 to 3, or 11 to 7 as your times. That is BLOCK charting and is not permitted.
- Always sign the note with your normal signature – do not initial it
- Never leave spaces large enough for others to add to your note
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- Never use white out or other corrective fluids to correct errors either hand written or printed from PCC
- Never alter another staff member's notes. If a note is incorrect or clarification is needed enter a “late entry” and clarify note.
- Never alter a physician's order, fax back to M.D. and have him/her rewrite the order

- Never alter a physician's physical examination record, fax back to M.D. and have him/her rewrite the form.
- Never add instructions to medications not included in the order
- Always obtain and include the diagnosis for every medication
- Avoid the following terms:
  - **Appears to, seems to-** (the resident is or is not) state the fact, not an opinion
  - **No complaints offered-** this conveys no information and should always reflect a question asked and answered- Mrs. Jones denies pain at this time, Mrs. Jones states she has no further diarrhea.
  - **Endorsed to day shift (evening shift, etc.)** you have no right to assign tasks to other nurses or staff of which they are unaware
  - **Family notified, Physician notified-** always be specific as to with whom you spoke to, i.e. Spoke with Mrs. Jones daughter Janet, notified Dr. Rubin at 7:15 PM

A practice scenario written for a secure dementia unit follows. Please feel free to create your own to reflect issues which may NOT have been reported or handled well. I also create a "perfect note" to give to each attendee so they have an example to carry with them if they need a quick refresher. I hope you have found this information useful and an aid to your in-service education program.

## SCENARIO ONE

Mrs. Brown was admitted to the secured unit this afternoon at 1 PM, accompanied by her husband, John. She has a diagnosis of Senile Dementia of the Alzheimer's type, depression and high blood pressure. She is confused as to person and place. She scored an 18 on her Mini Mental Status Exam. She could draw the diagram, repeat no ifs ands or buts and follow the three stage command. She self-toilets and is continent of bowel and bladder, ambulates independently, feeds herself and can undress independently. Her speech is clear, but she has word finding difficulty. She hears well and uses glasses for reading only. She shies away from other residents and staff. She has been refusing her antidepressant and hypertensive medications while at home with her husband. There have been no known behavioral problems except for the medication refusal.

At 4 PM Mrs. Brown's husband, John, kissed her goodbye and left the unit.

At 5 PM, as dinner was being brought onto the unit, Mrs. Brown attempted to get past the wait staff and leave the unit. The wait staff stopped her and attempted to redirect her to the dining room, she shouted at them and struck out at them. She continued to scream "I have to get home to make John's dinner, let me go, let me go, you are keeping me a prisoner."

Exercise:

What would you do to control or correct the situation?

Have discussion

Write the note you would place in the electronic record.