BCCNM LEARNING MODULE — WORKBOOK

Documentation

In Nursing Practice

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Introduction

This workbook offers activities that allow you to apply ideas presented in the module. It is organized in four sections:

Part 1 includes **workbook activities** that are related to various topic areas addressed in the learning module. As you work through the module, you will be directed to complete a specific workbook activity. Part 1 also includes pages for you to record your thoughts related to learning in this module. There are two pages: "Thoughts from Reflection Points" provides a space to jot down your thoughts related to "Reflection Points" included in the Module, while "Insights and affirmations" provides a space to note new insights related to your documentation practice. This information will be useful for you in completing your learning plan at the completion of this module.

Part 2, **"Applying My Learning"**, includes case scenarios and associated questions. Completing the questions related to the cases provides an opportunity for you to apply all of the information that has been offered in the module in the context of practice-based scenarios. When you have completed the questions, you may wish to compare your responses with those provided in the "Applying my learning:Perspectives" located in Part 4.

Part 3 This section of the workbook provides an opportunity for you to **create a plan for your professional growth**. A sample Learning Plan is provided to help you in this process.

Part 4 presents **sample responses** to Workbook Activity # 4 and to the case scenarios included in Part 2: "Applying My Learning."

PART 1

Workbook Activities

1 Workbook Activity #1

This activity provides an opportunity to explore the purposes of documentation and how effectively your current documentation practices support these.

1. First, select an example of your 'everyday' nursing documentation. There are several ways you can do this. You may wish to think back over your last day at work, recall a specific client situation and, as far as possible, recall what you documented related to that situation. Alternatively, you could imagine a 'typical' client situation in your workday and create 'typical' documentation for that situation. Or, you may wish to bring an example of your documentation from you next day at work, and use it to complete this activity. Regardless of the source, describe that documentation now in the space below.

2. Now, consider your documentation example and note down your thoughts related to the following questions:
    - How effectively did you communicate information for other health care professionals?
    - Does the information you recorded (and the way you recorded it) support the goal of provision of safe, appropriate client care by all health care professionals?
    - Does your documentation provide evidence that your practice is congruent with BCCNM Standards for Practice?
    - In the event of some legal proceeding, would your documentation provide sufficient evidence of care provided such that it is understandable several years from now?

3. What have you learned about your documentation processes in this activity? Note your thoughts here so that you can come back to them later.

2 Workbook Activity #2

This activity provides an opportunity for you to consider the interrelationships between your documentation, various directing and influencing factors and client outcomes.

1. Return to the client situation and related documentation that you recorded in Workbook Activity # 1. Using the conceptual map of documentation included in the module, explore your documentation processes and content in this situation.
    - What factors provided the most direction for your decision to document and the nature of what you documented? Was it legal considerations? Professional requirements? Personal knowledge, judgments, and ethical perspectives?
    - What did you document? Is the client's perspective or experience reflected? Did you include assessment data,as well as your actions? Did you include evaluation and client outcomes? If not, why are these not part of your documentation?
    - If the situation involved interactions with other health care professionals, is that evident in your documentation?
    - Does your documentation support you and other health care professionals in providing safe, appropriate and ethical client care?

2. Now take a few moments to reflect on this section of the module and Workbook Activity # 1 and #2. What have you learned about your documentation processes in your nursing practice? Were aspects of your documentation processes affirmed by this discussion and workbook activity? Or perhaps you have experienced some new insights regarding the extent to which your documentation fulfills the purposes of documentation in provision of safe, appropriate and ethical client care?

   Record these conclusions on the "Affirmations and Insights" page of this Workbook. At the completion of the module, you will have an opportunity to use the insights and affirmations gained in various learning activities, as part of your planning for future professional growth and development.

3 Workbook Activity #3

In this activity you will explore the direction provided within BCCNM regulatory documents for your documentation processes in nursing practice. The documents can be accessed by links in the learning module or directly from www.bccnm.ca.

1. Begin by reviewing the BCCNM Professional Standards for Registered Nurses and Nurse Practitioners. As you review the standards and associated indicators, consider how they relate to your documentation processes. In what ways do the standards and indicators provide direction for competency related to documentation in nursing practice?

When you have completed this activity, you may wish to compare your conclusions with information provided in the BCCNM Practice Support Guidelines for Documentation, p. 8 and 9.

2. Now, please review the BCCNM Practice Standard for Documentation. As you read the Practice Standard, reflecton the principles and the direction they provide for your documentation processes in your nursing practice. Does your documentation reflect these principles? Do the principles offer insights or solutions for areas of documentation that you are unsure about or find challenging? Keep in mind, you will have an opportunity to explore these principles further in the section of this module that focuses on characteristics of effective documentation.

4 Workbook Activity #4

This activity provides an opportunity for you to explore the characteristics of effective documentation by examining three short scenarios.

SCENARIO #1

Mr. Ron Brown is a 71-year-old gentleman with Type 1 diabetes admitted to hospital for treatment of an ulcer on his right heel. Diane was assigned to Mr. Brown and Diane also provided nursing care to him yesterday. Mr. Brown was alert and oriented to person, place and time. He normally had no problems with ambulation. Mr. Brown wears glasses to read and drive and he has no hearing deficits. He lives alone. Mr. Brown's discharge plan is to return to his apartment.

During her morning assessment, Diane noted at 0800 that Mr. Brown had some facial grimacing and he limped on his right foot when he walked to the bathroom. When asked, Mr. Brown tells Diane "I have pain where the ulcer is". Diane probed further to determine the characteristics of Mr. Browns' pain as constant and throbbing, and he rated it's intensity as 6 out of 10. Diane administered pain medication (Tylenol #3- 2 tablets) at 0830. Diane reassessed Mr. Brown's pain at 0945 and he rated the intensity at 1 out of 10.

Diane decided to do Mr. Brown's dressing change at 0950 since Mr. Brown's pain was controlled. When Diane removed the old dressing Diane noted a moderate amount of fresh watery, bloody drainage with a small amount of green-yellow pus drainage. The ulcer area was round and the size was about 3 cm x 4 cm, the area around the ulcer was red. The ulcer borders were well defined. Most of the wound bed was granulation tissue with a smaller amount of yellow slough. Mr. Brown had decreased sensation to this area of his foot as he could not feel the coolness of the solution or feel when Diane was pressing down. An adaptive dressing, 2- 4x4 gauze and ½ abdominal pad were placed on the wound. Mr. Brown did not complain of any discomfort during the dressing change. *Diane entered the following documentation in Mr. Brown's record:*

815	Client reports pain right foot.	Diane Smith, R.N.
830	Tylenol #3 two tabs given for complaints of pain.	Diane Smith, R.N.
950	Dressing to right foot changed for moderate amount of bloody drainage with some pus. Wound looks clean and healing. Client tolerated dressing change well.	Diane Smith, R.N.

1. **Critique Diane's documentation on the care she provided to Mr. Brown. Identify what she did well, and the areas where she could improve her documentation using the characteristics of effective documentation in this section as a resource.**

4 Workbook Activity #4 con't

2. Imagine you are Diane. Document the care you provided to Mr. Brown correctly in the space below.

SCENARIO #2

Mrs. Ada Green, an 89-year-old widow, lives alone in her two story home. She is recovering from surgeryfollowing an "anterior resection" for bowel carcinoma. She was discharged with a Home Nursing Care referral for a home transition assessment and wound healing assessment because she developed a post surgical wound infection while she was in hospital. At discharge from hospital Mrs. Green was alert and determined to remain independently mobile in her own home for as long as possible. Mrs. Green has Meals on Wheels delivered twice weekly and private home support twice weekly for assistance with personal care. She is on a regular diet and is capable of managing her cardiac, pain and antibiotic medications, which her friend has labelled for her. A neighbour assists with transportation, shopping and social planning. Mrs Green has no family in town.

On the morning of October 12 at 0950, three days after being discharged from hospital, Janie, the Home Care Nurse, found Mrs Green sitting in her chair looking anxious and somewhat unkempt. She was rocking back and forth, clutching her abdomen and moaning. When asked she stated "I'm in pain" and " I can't seem to catch my breath". Her dressings were in disarray, there was a distinct fecal odour, and she was diaphoretic. She admitted that she had spent the night in her rocker, did not know the time and could not recall when she had last taken her pills or eaten. Janie took her vital signs and they were as follows: Temperature: 38 degrees Celsius, pulse 110/minute and regular, blood pressure 100/70 mmHg, respirations 28 breaths/minute and mildly laboured.

1. Imagine you are Janie. Document your assessment of Mrs. Green to this point in the space below.

4 Workbook Activity #4 con't

SCENARIO #3

Jim, a nurse in the intensive care unit of a tertiary hospital is beginning a busy day with his assigned patient. Alex, another nurse on the unit offers to help Jim out. Jim tells Alex that it would be a great help if he could give Mr. White 2 mg. of morphine IV now as Mr. White indicated that he had some pain when Jim assessed him just 10 minutes ago. Jim had not yet had time to administer analgesic to Mr. White.

Alex checks the order, asks Jim a few more questions about Mr. White, then heads off to get the morphine from the narcotic cupboard. He returns and administers the Morphine to Mr. White.

1. Suggest appropriate documentation for this scenario.

2. What other follow up care and documentation would be required in this situation?

Now take a few moments to reflect on this activity. What have you learned about your documentation processes in your nursing practice? Were aspects of your documentation processes affirmed by this workbook activity? Or did you experience some new insights regarding your documentation?

Record these conclusions on the "Affirmations and Insights" page of this Workbook. At the completion of the module, you will have an opportunity to use the insights and affirmations gained in various learning activities, as part of your planning for future professional growth and development.

5 Workbook Activity #5

This workbook activity is a self-assessment of your documentation practices. For this activity, you'll complete a self-assessment checklist based on the BCCNM Principles of Documentation, the characteristics of effective documentation and your understanding of documentation approaches. By completing this checklist, you'll be identifying your personal strengths in documentation practice and also areas where you need to further develop your documentation practice.

SELF ASSESSMENT	I WANT TO IMPROVE MY PRACTICE IN THIS AREA YES	NO	NOTES
Regardless of documentation approach, I always document all clinically significant information using the nursing process (assessment, nursing diagnosis, planning, intervention and evaluation) on the client's health record. This includes information or concerns reported to another health care provider and, when appropriate, that provider's response.			
I document the care I personally provide to the client.			
I do not document routine care that other health care providers provide a client.			
I know in which emergency situations I may document care another health care provider provides.			
My documentation is clear, concise, factual, objective. My documentation contains significant details and accurate descriptions. I avoid generalizations and I avoid vague descriptors and subjective judgments. I identify any client comments.			
I use only approved abbreviations.			
My documentation is chronological and timely.			
When I am unable to document in a timely or chronological way, I mark "late entries," recording both the date and time of the late entry and of the actual event.			

5 Workbook Activity #5 con't

Self Assessment	I want to improve my practice in this area YES	NO	Notes
I add my signature and title, or initials as appropriate, to each entry they make on the health record.			
I document legibly.			
I document comprehensively, in-depth and more frequently when clients are acutely ill, high risk or have complex health problems.			
I document care/services provided to a group and overall observations pertaining to the group on the appropriate forms. I document information about individuals in the group on their personal health records.			
I have read and understood the documentation policies of the agency and unit where I work. I document using the tools and method(s) supported by the agency and unit.			
I use documentation tools appropriately, knowing which tools becomes part of the client's health record and which do not. I ensure all necessary information about the client is documented on the client's health record.			
I maintain the confidentiality of a client's information and client record.			
I only access a client record when I have a professional need.			
For nurses who have responsibility for client records: I retain the client's record for a minimum of six years after the client is last assessed or treated. If the client is a minor, I retain the record for six years after the client reaches age 19.			

6 Workbook Activity #6

In this activity you will use the information presented in the section related to errors in nursing documentation to explore your own documentation practices, including planning strategies that will minimize future errors.

1. **Take a few moments to review your responses to the reflection points in the section you have just completed.**
   Based on your insights, select 2-3 errors that you have become aware of within your own documentation practices. Note them on the following table.

2. **For each of these errors, complete remaining columns in the table.**
   - Begin by considering why this error might be occurring. Did you not understand what was required for acceptable documentation? Or are there other factors that influence what you document?
   - Now consider what concerns you have about this error? Are there legal implications? Or is there a potential negative impact of client care?
   - Finally, what strategies could you put in place that would support you in completing effective and appropriate documentation?

An example has been provided to get you started.

Error in documentation practice	I am concerned about this error because . . .	Reasons that this error occurs in my documentation	Strategies that I can use to avoid this error in my documentation
Briefly describe error here	*What are the legal or client related implications associated with this error?*	*Note down all reasons or factors that make it challenging for you to complete accurate documentation.*	*Select strategies that will minimize or negate the reasons/ factors that are associated with this error.*
Leaving space for my initial assessment & documenting other events after that space. Returning 3 hours later to document my assessment.	This is not acceptable legal practice: it exposes me to the risk of being accused of falsifying documentation. Documenting three hours after an event increases the risk of error.	No time to document assessment when I do it: • Need to assess all 6 patients as soon as possible at the beginning of the shift. • Need to get 0800 or 2000 medications done as soon as possible. • Need to go to coffee break and/or do break relief according to unit timelines.	1. Could document that I have completed assessment when I do it, then can begin documenting other care/ events as required. Document actual assessment findings as late entry, with appropriate notation. 2. Explore with nurse manager the possibility of creating a 'checklist' assessment form that is completed separately from narrative documentation of events/ongoing care.

6 Workbook Activity #6 con't

Error in documentation practice	I am concerned about this error because . . .	Reasons that this error occurs in my documentation	Strategies that I can use to avoid this error in my documentation
Briefly describe error here	*What are the legal or client related implications associated with this error?*	*Note down all reasons or factors that make it challenging for you to complete accurate documentation.*	*Select strategies that will minimize or negate the reasons/ factors that are associated with this error.*

7 Workbook Activity #7

Documentation in Nursing Practice: Planning for Professional Growth

This final learning activity will guide you in developing a plan for future development of your documentation in your nursing practice. Please see Part 3 in the Workbook for a plan outline and an example.

1. Begin by reviewing "Affirmations and Insights" insights page in this Workbook. This page includes all the conclusions you have formed about your documentation in your nursing practice as you have worked through this module. It is, in other words, a comprehensive self-assessment of all the components that are part of, or influence, your communication. Now it's time to put that to use!

   Take some time to read through these conclusions: First, notice and acknowledge your strengths. Then pay attention to the areas that you have identified as areas for development and growth. As you read these, notice which ones seem to resonate with you or feel most important to you. Use these conclusions to determine the goals that will support ongoing growth of your documentation skills and abilities.

2. Create **three goals** that reflect your focus for development in your communication. Write these in the appropriate place in "My plan for growth in communication".

3. The next step is to **develop an action plan** that will help you meet those goals. Begin by identifying resources that you could use to assist you in meeting your goals. If you are not aware of specific resources, then begin by listing the sources you will explore in order to learn what you can do to support your growth toward your goals.

4. Once you are familiar with the learning opportunities that are available to you, create an action plan that outlines specific strategies you will use, what resources you need in order to implement these strategies (e.g. who do you need to talk to, learning materials you want to acquire, learning experiences you need to arrange etc) and, importantly, a target date for completion.

   Not sure how to do identify goals and create an action plan? The **planning for growth page** (in Part 3) has provided a brief example of this process.

5. Finally: Add your plan to your Quality Assurance file, workbook or portfolio. And remember to update it once you have completed the actions!

Notes from Reflection Points

My Documentation in Nursing Practice

Affirmations and Insights

PART 2

Applying My Learning

Applying My Learning

Case scenario one — Melanie

Melanie looked up at the clock — 11 a.m. "Wow," she thought, "It's been a busy day and I am not even halfway through yet!" After 5 years in this extended care unit, she had got used to being busy, but today seemed to be 'one of those days'. She was, as usual, the only RN on today in this 36-bed unit, along with one LPN and four registered care aides. She knew that everyone would be busy: The unit was full and the current client group required a lot of care — and that made for a heavy workload for everyone.

She paused for a moment to collect her thoughts and decide on the next thing she needed to do. While her responsibility encompassed all of the clients on the unit, there were four clients that particularly concerned her today. Two were confused and agitated and required close monitoring, another was dying and, with his family at his bedside, needed comfort care and support, and finally Mr Bell had been short of breath and coughing during the night. When Melanie had looked in on him earlier he was breathing at 24/minute, occasionally coughed up yellowish secretions and had a temperature of 37.6° C.

Her thoughts were interrupted when Jasmine, an LPN who had worked on the unit for 10 years, stopped beside her and said, "Can you come and look at Mr. Bell? He seems to be worse that he was earlier this morning. I sat him up a bit more and that helped a little, but I am quite concerned about him." Melanie nodded and they walked down the hallway to Mr. Bell's room. At first glance it was clear to Melanie that he was worse. His face was slightly diaphoretic and she could hear his coarse cough. When she asked him how he was feeling, he replied, "I feel pretty tired. This coughing is wearing me out."

She nodded and said, "I can see that. If it's OK with you, I would like to have a closer look at you." She counted his respiratory rate at 26/minute and then had a quick listen to his chest. She noted that he had coarse crackles in both posterior and anterior lower lung fields. His temperature was 37.7° C.

Melanie bent slightly closer to him and spoke gently. "Mr. Bell, I can see that you are not feeling well and that you are tired. Your chest sounds kind of rattly and you have a bit of a fever. I am going to call your family doctor and let him know. I'll come back as soon as I have done that and let you know what he says."

Melanie called Dr Simms and explained the situation, outlining the change in Mr. Bell's condition over the previous 24 hours. In response, Dr Simms suggested that Mr. Bell "probably has the flu that's going around" and instructed Melanie to "keep an eye on him" and to "call him back if she was concerned".

Melanie hung up the phone and pulled Mr. Bell's chart from the shelf. She made the following entry in his nursing notes:

"Client seems short of breath. Has a fever. Doctor informed."

Melanie returned to Mr Bell and, as per the unit's standing orders, gave him some Tylenol elixir "for comfort". She also made sure he was well positioned in bed and then left the room to continue with her care for

Applying My Learning

Case scenario one — Melanie *con't*

other clients. Over the next four hours, she checked in on Mr Bell several times and counted his respiratory rate, noting that it was still high. At one point she listened to his chest again, noticing that the crackles had increased. Four hours after her initial phone call, Melanie was quite concerned about Mr Bell – His respiratory rate was 30/minute, he seemed to be working harder with his breathing, his chest sounded worse, and his pulse oximeter read 92%. She knew that often when clients were sick like this, that they would be send the client to ER at the local hospital, however, Dr Simms had indicated he was happy to be called about his clients, so she decided to call him again and update him. After she had explained the situation, Dr Simms said, "I am leaving my office shortly and have to drive past the care facility on my way home, so I will drop in and have a look at Mr Bell."

Melanie reached hung up the phone, glanced at the clock and realized she has several medications that she was late dispensing. She quickly wrote a note in Mr Bell's chart, and then left the office area to attend to the medications.

Client's breathing looks worse. Doctor notified.

Dr Simms arrived 45 minutes later and assessed Mr Bell. He then wrote an order to start Mr. Bell on antibiotics and to begin supplemental oxygen via nasal prongs at 3L/minute. Melanie came into the office as he had just completed writing the orders. "Oh Hi, you're here," she said. "What do you think is happening?" she asked.

He replied, "I think he has the flu, and seems to have a bit of chest infection. I have ordered him some antibiotics and we can start some oxygen therapy and see if that makes him more comfortable. Can you check his pulse oximeter readings every two hours. If they fall below 92%, or if you think he is getting worse, please call an ambulance and send him to the ER."

As Dr Simms left, Melanie reviewed the orders he had written and faxed the prescription for antibiotics to the pharmacy. She also updated the documentation in Mr Bell's chart:

Dr in. Orders received.

1 Case Study Activity #1

CASE SCENARIO ONE — MELANIE

Please answer the following questions. When you have completed this activity, you may wish to compare your responses with those provided in the "Perspectives" section at the end of this workbook.

1. Review Melanie's documentation. In what ways does it meet criteria for effective documentation? What documentation errors are present? Where there are errors, describe how Melanie should have documented Mr. Bell's care in these situations. Provide examples of effective documentation.

2. What factors do you think influenced Melanie's ability to document appropriately in this situation? What do you think could be done that would assist Melanie to document effectively in future?

3. What are the implications of Melanie's ineffective documentation for Mr Bell's outcomes?

4. Consider the conceptual framework and directives for documentation in nursing practice. What could be the implications of Melanie's ineffective documentation for herself?

Applying My Learning

Case scenario two — Rick

Rick Ross, RN, hung up the telephone in the Emergency Department (ED) of Elsewhere General, a 30-bed rural hospital in northern British Columbia. Rick had worked at Elsewhere for three years now since graduating . . . two of those years had been on the combined medical-surgical ward, and one year as a critical care/ ED float nurse. Rick was working in the locked ED late this particular evening. The other critical care educated nurse in the hospital, Janet, had primary responsibility for two patients in the 3-bed close observation unit located between the med-surg ward and the ED.

There were no patients in the ED, but that would soon change: the paramedics were on their way with Mr. Hugo Stivic, a 58-year-old man who was experiencing chest pain. Mr. Stivic, the paramedics said, was short of breath, wearing oxygen, and had been given aspirin and three sprays of Nitrospray. Rick looked thoughtful as he picked up the phone again to call Janet. After hearing Rick's message, Janet said she would give report to the ward nurses and be down to help Rick with Mr. Sticvic's admission. Rick made one more phone call to the physician on call who, after hearing Rick's report, said she'd be to the ED within 15 minutes. She reminded Rick to institute the hospital's 'chest pain protocol'.

By the time Mr. Stivic came through the doors of the ED, Janet had arrived to help Rick. Rick asked Janet if she would draw up some morphine and prepare a nitroglycerin infusion while he assessed Mr. Stivic. Rick took Mr. Stivic's vital signs, noting them on his 'cheat sheet', and asked Mr. Stivic about his pain:

- 'what would he rate his pain on a scale of 1–10 with 10 being the worst pain he had ever experienced?' . . . a 7 out of ten
- 'had his pain decreased with the nitrospray?'. . . it had gone from 10 to 7
- 'could he describe his pain?' . . . it was a crushing pain in the middle of his chest that was making it difficult to breathe • 'did his pain radiate anywhere?'...down his left arm and up into his jaw
- 'were there other symptoms?' . . . yes, he was short of breath, diaphoretic and couldn't breathe
- 'when did it start?' just after dinner time a little over an hour ago

Rick fumbled through the pile of papers that would become Mr. Stivic's chart. Finding the ED admission record, Rick documented his pain assessment like this : "*1920 hours: Patient arrived in ED experiencing severe chest pain.*"

Janet arrived back at the bedside just as Rick was obtaining blood samples from Mr. Stivic. Janet administered 2 milligrams of morphine IV to Mr. Stivic in the intravenous initiated by the paramedics, and she handed the mixed bag of nitroglycerin to Rick who proceeded to hang it and commence the infusion at 20 mcg/ min. While Rick was busy, Janet went to get the ED's 12 lead ECG machine, returned, and ran a 12 lead on Mr. Stivic. Rick reassessed Mr. Stivic's chest pain: he reported that it was now 5/10. Just then, Dr. Sinclair arrived in the ED at Mr. Stivic's bedside. She looked at Mr. Stivic's 12 lead, asked him a few more questions about the

Applying My Learning

Case scenario two — Rick *con't*

quality and timing of his chest pain, and told Rick to increase Mr. Stivic's nitroglycerin infusion to 30 mcg/min (which Rick did). She then told Rick and Mr. Stivic that she was going to arrange transfer by air ambulance to a hospital where Mr. Stivic could have a procedure called a Percuatneous Transluminal Coronary Angioplasty.

At 1940 Rick assessed Mr. Stivic's chest pain again as Jan prepared him for transfer, Rick returned to the ED record to document the care provided. Here is a copy of the pertinent portion of the ED record:

Time	Nurse's notes	Signature
1920.	Patient arrived in ED experiencing severe chest pain	RR, R.N.
1924	Bloodwork drawn	RR, R.N.
1925	Morphine 2 mg IV given for chest pain.	RR, R.N.
1926	Nitroglyceryn infusion commenced at 20 mcg/min.	RR, R.N.
1930	12 lead ECG obtained. Dr. Sinclair arrived.	RR, R.N.
1935	Nitroglyceryn infusion increased to 30 mcg/min.	RR, R.N.
1940	Patient prepared for transfer to tertiary facility	RR, R.N.

2 Case Study Activity #2

CASE SCENARIO 2 — RICK

Please answer the following questions. When you have completed this activity, you may wish to compare your responses with those provided in the "Perspectives" section at the end of this workbook.

1. Consider the characteristics of effective documentation. Identify 3 documentation errors in this scenario. How should Rick have documented Mr. Stivic's care in these situations. Provide examples.

2. What factors do you think influenced Rick's ability to document appropriately in this case? What do you think could be done to support Rick to document effectively in future.

3. What might be the implications of Rick's ineffective documentation on Mr. Stivic's outcomes?

4. Consider the conceptual framework and directives for documentation in nursing practice. What could be the implications of ineffective documentation for Rick?

PART 3

Growth Planning

My Plan for Growth in Documentation

Goals

1.

2.

3.

Action plan

People or places that I can investigate for learning strategies to help me meet my goals for growth are:

1.

2.

3.

Specific strategies that will help me in meeting my goals are:

Strategy	Resources I need to implement this	Target completion date	Other thoughts

Reminder: Add your completed action plan to your Quality Assurance Portfolio.

My Plan for Growth in Documentation

An example

GOALS

1. To become familiar with best practices related to electronic documentation.
2.
3.

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ACTION PLAN

People or places that I can investigate for learning strategies to help me meet my goals for growth are:

1. Talk to Clinical Nurse Educator and/or Nurse Leader on unit for suggestions about learning resources.
2.
3.

Specific strategies that will help me in meeting my goals are:

Strategy	Resources I need to implement this	Target completion date	Other thoughts
Example: detailed plan 1. Review resources available in my nursing unit.	1. None – just look on the shelves & on the Intranet at work!	1. During my next set of scheduled shifts	
2. Review BCCNM resources regarding electronic documentation.	2. Use work or home computer to do this. Website URLs in Learning resource section of module.	2. By end of this month	
3. Complete Literature search using CINAHL	3. Call BCCNM library for advice & assistance in doing this..	3. By end of next month	Could ask the nurse educator at work; maybe she can help me with this?

Reminder: Add your completed action plan to your Quality Assurance Portfolio.

PART 4

Workbook Activities and Case Perspectives

4 Workbook Activity #4

Scenario #1

1. **Critique Diane's documentation on the care she provided to Mr. Brown. Identify what she did well, and the areas where she could improve her documentation using the characteristics of effective documentation in this section as a resource.**

    a. Diane **did sign** each entry correctly, and she documented in a timely and chronological manner

    b. Diane **did not include objective data** about her pain assessment nor did she include all of the objective data about the condition of Mr. Brown's ulcer or his lack of sensation during the dressing change.

    c. Diane **used some vague subjective expressions:** 'clean and healing' and 'tolerated well' doesn't convey the details and accuracy of Diane's assessment and evaluation of care.

    d. Diane **did not document the effect of the analgesic** she administered to Mr. Brown.

    e. Anything else?

2. **Imagine you are Diane. Document the care you provided to Mr. Brown correctly in the space below.**

Here's an example:

Time	Nurse's notes	Signature
0800	Client limping on right foot and grimacing. When asked stated " have pain where the ulcer is". Client rated the intensity of pain as 6 out of 10.	Diane Smith, R.N.
0830	Tylenol #3 two tabs given for complaints of pain Client reassessed.	Diane Smith, R.N.
0945	Client now rates intensity of pain as 1 out of 10.	Diane Smith, R.N.
0950.	Dressing removed from right heel ulcer for moderate amount of fresh watery, bloody drainage with a small amount of green-yellow pus. Ulcer is 3 cm x 4 cm, boarders are well defined with redness noted in surrounding skin.Ulcer bed is granulation tissue with a smaller amount of yellow slough. When asked, patient stated he could not feel pressure applied to the area surrounding the ulcer and could not feel the coolness of the dressing solution. Ulcer redressed with adaptive dressing, 2 – 4x4 gauze and 1/2 abdominal pad. Client did not complain of pain during procedure..	Diane Smith, R.N.

4 Workbook Activity #4 con't

Scenario #2

1. **Imagine you are Janie. Document your assessment of Mrs. Green to this point in the space below.**

Here's one example:

> 0950 — found client sitting in rocking chair clutching her abdomen, rocking and moaning. A distinct fecal odour is present around client. Client states she spent the night in her rocking chair. Abdominal dressing no longer intact. Client stated: "I'm in pain" and " I can't seem to catch my breath". Client not oriented to time of day and cannot recall when she took her pills of ate last. Vital signs as follows: 38˚ Celsius, pulse 110 and regular, Blood pressure 100/70 mmhg, respirations 28 breaths per minute and client is diaphoretic and using accessory muscles to breathe.

Scenario #3

1. **Suggest appropriate documentation for this scenario.**

Jim should document his assessment. Alex should document the administration of the Morphine.

2. **What follow up care and documentation would be required?**

Jim should reassess his patient to ascertain if the analgesic was effective, then document this evaluation.

1 Applying My Learning

Perspectives

CASE STUDY SCENARIO 1: MELANIE

Review Melanie's documentation: In what ways does it meet criteria for effective documentation? What documentation errors are present? Where there are errors, describe how Melanie should have documented Mr. Bell's care in these situations. Provide examples of effective documentation.

In general, Melanie's documentation addresses the 'when' aspects of effective documentation. In spite of her busy day, Melanie documented in Mr. Bell's chart when she noted a change in his condition and/or when she interacted with the physician. In addition, she did this at the time of the event. These actions both fulfill requirements for timely documentation. The frequency of Melanie's documentation also reflects the increase in Mr Bell's acuity level. She documented three entries in the space of about 6 hours.

Now let's look more closely at what Melanie documented. Each entry is very brief. While concise documentation (how) is desirable, it is important that conciseness be balanced with providing adequate information. In fact, Melanie has omitted important information in her documentation and so the documentation is incomplete:

- In entry #1 and #2, she has not fully documented Mr Bell's condition or her actions.
- In entry #1, 2, & 3, she has not documented the content of her communication with Dr Simms, simply noting that she has called him.
- Melanie has not documented any information related to her ongoing assessment of Mr. Bell that occurred between the first and second entries.

A second concern related to Melanie's documentation is that her descriptions of Mr. Bell's condition are **not factual or objective**. (She states he "seems short of breath" and 'breathing looks worse").

Here are some suggestions about how Melanie's documentation could be improved in these situations. It is possible that your examples of more effective documentation may look somewhat different to this one. Using these examples as a guide, determine if your suggested changes have addressed the issues we have identified.

Entry # 1:

Client's face is pale and slightly diaphoretic. Respiratory rate is 26/min, with use of accessory muscles noted (shoulders). On anterior and posterior auscultation, breath sounds are clear in upper lung fields, with coarse crackles in lower lung fields bilaterally. Client states he 'feels pretty tired'. Coughing occasionally, productive for small amounts of yellow tinged sputum. Temp: 37.7° C orally. Pulse rate 85/min. Blood pressure: 125/68. Dr Simms notified of client's current condition and changes over night.
Dr advised ongoing observation. Tylenol elixir 650mg given as per unit protocol.

Perspectives

CASE STUDY SCENARIO 1: MELANIE

Missing entries — documented at time of care

Ongoing assessment should provide updates on previously noted concerns, and add any new information. For example: Client's respiratory rate remains at 28/min; work of breathing unchanged. Continues to expectorate small amounts of sputum.

Entry # 2: (at hour 4)

Client's face diaphoretic; Respiratory rate 30/min. Use of accessory muscles (shoulders) noted. On auscultation: coarse crackles audible in right lower and mid lung field, as well as left lower lung field. Client states "he is really tired." Coughing more frequently for small amounts of yellowish sputum. Temp 37.2° C, pulse 92/minute. Blood pressure: 145/75. SpO2 92%. Dr Simms notified re changes in condition since ____ (time of first phone call). Dr states he will come in to assess client.

Entry # 3

Dr Simms assessed client and orders received. Antibiotics pending from pharmacy. Client commenced on oxygen via nasal prongs @ 3L/minute. SpO2 96% on oxygen. Pulse 85/min; Blood pressure 135/65. Respiratory rate 24/min. Respirations less labored, with minimal accessory muscle use noted since oxygen therapy commenced. Client states he feels 'more comfortable' but 'still a bit short of breath'.

What factors do you think influenced Melanie's ability to document appropriately in this situation?

What do you think could be done that would assist Melanie to document effectively in future?

Factors that may have influenced Melanie's ability to document appropriately include the following:

- Perhaps this is Melanie's usual pattern of documentation? It would be helpful to know if the lack of detail in her documentation is typical of her documentation or if it is just occurring today — and is influenced by her workload.
- Her workload: she has several clients she is 'concerned about' and it is evident she is experiencing a 'busier than average' day.
- The overall acuity of current clients in the extended care unit is 'higher than normal'. This has increased workload for all staff, and means there is less opportunity for her to get assistance with her client care.
- Melanie appears to be recording all information in the nurses notes – suggesting that the unit documentation 'standard' appears to narrative –style documentation. While this has advantages of having all information in one area and also allows for descriptive detail, this type of documentation takes time. This may be why Melanie's documented entries were brief.

Perspectives

CASE STUDY SCENARIO 1: MELANIE

Strategies and actions that would assist Melanie to document effectively in the future include:

- Focusing her documentation on relevant information will assist her in finding the balance between concise documentation and including sufficient detail in her documentation. For example:
  - » Considering all phases of a client situation in documenting
  - » Considering if what she documents includes enough detail so that someone who had not been present could still fully understand the situation.
- Focusing her documentation on factual and objective information: this will assist her in providing clear, unambiguous, and complete information about client situations.
- Melanie did a reasonable job of documenting in a timely manner for three of the events with Mr. Bell. Building from that partially established pattern will assist her in timely documentation of all of her actions, all client data and conversations with other health care professionals.
- Workload management. This is a challenge for most nurses today. While there is no simple answer to finding time in a busy day for documentation, it is helpful to view documentation as one final step in any aspect of provision of care for a client — and to not consider the care completed until documentation is done. Considering the type of documentation that supports nurses to complete timely and appropriate documentation may be helpful. Would Melanie find it easier to be 'up-to-date' with her documentation if there was a standardized documentation tool she could use?

What are the implications of Melanie's ineffective documentation for Mr. Bell's outcomes?

Earlier we noted that the brief documentation entries that Melanie made were incomplete. They lacked full information about Mr. Bell's condition, did not provide details of her actions and did not include the nature of the phone conversations she had had with Dr Simms. In addition, the information she did provide related to Mr. Bell's condition did not provide a clear, factual 'picture' of his status at those times. From this, it is clear that this documentation would not allow other nurses or other health care professionals to:

- understand what Mr. Bell had experienced during that time period
- use this information in their own planning related to Mr. Bell's care

In other words, Melanie's inadequate documentation both makes it challenging for other health care professionals to provide optimal care for Mr. Bell (because they are not fully informed) and, potentially, also places Mr. Bell at risk for inappropriate care. Melanie's inadequate documentation can have adverse effects on Mr. Bell's outcomes.

Perspectives

CASE STUDY SCENARIO 1: MELANIE

Consider the conceptual framework and directives for documentation in nursing practice. What are the possible the implications of Melanie's ineffective documentation for herself?

Like all Registered Nurses, Melanie is required to meet legal, professional and agency directives for documentation. Given that nurses' documentation is a legal evidence of care provided and client's responses to that care, 'what' Melanie documented is a concern. The information missing from her documentation may be interpreted as evidence that she had not provided safe, appropriate and ethical care for Mr. Bell in this situation. In addition, the vague nature of her statements related to Mr. Bell's condition, could be construed to mean that she was not capable of appropriate assessment. In short, Melanie's documentation places her at risk of being accused of not providing adequate care for Mr. Bell if, for some reason, his situation became the focus of legal proceedings.

According the BCCNM Practice Standard for Documentation, nurses' documentation is a record of professional practice and care provided for a client and, as such, provides evidence of whether or not a nurse has applied the nursing knowledge, skills and judgment according to their BCCNM Professional Standards of Practice. The Practice Standard further states that nurses should document "timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes" (BCCNM, 2008, p.1). When we consider Melanie's documentation in light of these directives, it is evident that her documentation does not align with these requirements. However, when we read the story of Melanie and Mr. Bell, we can see that she was conscientious and committed in the care she provided for him — she assessed him frequently, recognized the significance of his change in condition, and communicated with his physician regularly to ensure he received appropriate care. And yet, because of the brevity of her documentation, the vague client descriptions and missing information, her documentation does not provide evidence of her providing care according to the Professional Standards of Practice. As we noted above, Melanie's documentation does not provide evidence of her having provided adequate care; it also places her at risk of a professional practice inquiry.

Finally, Melanie is required to follow the Extended Care Unit's documentation policy and the agency's directives in her documentation. We do not have information related to these policies in this case, but can assume that the policies will reflect legal and professional requirements for nurses' documentation. From this standpoint, it seems possible or even likely, that Melanie's documentation does not meet unit or agency requirements in this situation.

2 Applying My Learning

Perspectives

CASE STUDY SCENARIO 2: RICK

Consider the characteristics of effective documentation. Identify three documentation errors in this scenario. How should Rick have documented Mr. Stivic's care in these situations. Provide examples.

Incomplete documentation (what):
As in scenario #1, concise documentation is desirable, but Rick has omitted important information in his documentation. Rick does not chart the chest pain assessment he performed as clear concise statements that describe his assessment, rather he simply charts "patient experiencing chest pain". Nurses' charting often lacks detail that describes accurately the care that was provided. Nurses also often miss documenting the client's assessment, but document the interventions that were performed (for example, Rick documented "Morphine 2 mg IV administered").

It's also a common error in documentation to miss documenting the evaluation of interventions. This is also an error in Rick's documentation. Although Mr. Stivic's chest pain has decreased considerably with intervention, it would be impossible to know this from reading Rick's documentation.

A good test to evaluate whether your charting is satisfactory is to answer the following Question. If another RN had to take over this patient's assignment, do the nurses' notes provide enough information for that nurse to maintain consistency of safe, competent and ethical care? Would that RN

know that Mr. Stivic was short of breath and diaphoretic and whether Mr. Stivic's chest pain had been relieved, and what intervention worked for him?

Rick did perform a full pain assessment. I'd suggest he chart it like this:

Time	Nurse's notes	Signature
1920	Patient arrived in ED wearing oxygen 40% by face mask. Patient is having difficulty speaking and states he is short of breath. Patient's skin is clammy. Patient states he is currently experiencing chest pain 7/10. Patient states the pain started after dinner and is 'a bit better' since the paramedics gave him nitrospray. He states it was 10/10 before the paramedics arrived. Patient describes the pain as 'crushing' in the 'middle of his chest' that radiates down his left arm and into his jaw.	RR, R.N.

Perspectives

CASE STUDY SCENARIO 2: RICK

Further, Rick should have documented the effect, or lack of effect, of both the morphine and nitroglycerin on Mr. Stivic's chest pain at initiation and with the increase in dose.

Not identifying a 'Late Entry' (how):

Rick didn't complete his documentation until all nursing actions were carried out, approximately 15 minutes after he began to provide care for Mr. Stivic. When it is not possible to document at the time of providing care a 'late entry' is required. The length of time between care and documentation that is considered 'late' should be defined by agency policy.

Rick should have clearly identified his documentation as 'late entries' indicating the time the care was provided and the time of documentation.

Inappropriate documentation of assisted care (who):

Generally RNs should document the care that they personally and directly provide. Documenting for others who are providing direct care may lead to inaccurate documentation and this could affect the continuity and quality of client care. In situations when two nurses or a nurse and another health care provider provide care or services together (witnessed care), the RN who is assigned to the client should document the actions and the client's responses, noting that another RN or care provider assisted.

Rick documents Janet's care (administration of Morphine and obtaining the 12 lead) but does not identify Janet as the care provider. This could lead to the erroneous assumption that Rick was not assisted and actually performed this care.

What factors do you think influenced Rick's ability to document appropriately in this case? What do you think could be done to support Rick to document effectively in future.

Influencing factors:

The urgency and acuity of the patient's status

Mr. Stivic came into the ED experiencing chest pain, and was potentially experiencing a myocardial infarction. His situation demanded urgent care and interventions had to be carried out quickly to prevent and further damage to his heart muscle. This context of urgency likely influenced Rick's ability to document.

The staffing ratio on the unit

Rick did have Janet's help when Mr. Stivic was admitted and this was a positive influencing factor on his documentation. It does seem, however, that a bit more assistance may have given Rick the time to document more completely and in a timelier manner.

Perspectives

CASE STUDY SCENARIO 2: RICK

Rick's knowledge of documentation

Is this Ricks typical pattern of documentation? It would be helpful to know if the lack of detail in his documentation a pattern in his documentation.

The agency policies on documentation It's hard to know in this brief case what 'style' of documentation Elsewhere General has adopted. Certainly many ED records are streamlined and contain checklists for more standard assessment criteria while still meeting the requirements for effective documentation. It appears, however, that Rick's documentation is in a more narrative format. In essence, the style of documentation used at Elsewhere General may influence Rick's ability to document effectively.

Supporting Rick's documentation:

Clear agency forms /policies

Elsewhere General may consider reviewing it's documentation policies and practices and adopting or creating clear ED records based on directives that support effective documentation.

Documentation 'refreshers'

It's quite possible that Rick is not fully aware of his legal and professional responsibilities surrounding documentation. Rick could work with his educator to develop a plan to improve his documentation, than access resources to help him review and/or learn more about effective documentation.

ED staffing

This is a challenge for most health care agencies today. While there is no simple answer it's likely that more staff in urgent and emergent situation would permit documentation to occur alongside safe, appropriate and ethical care.

What might be the implications of Rick's ineffective documentation on Mr. Stivic's outcomes?

A major problem was that Rick's documentation was incomplete. It lacked full information about Mr Stivic's chest pain and did not provide details of the evaluation of nursing interventions to relieve his pain.

Rick's documentation did not provide a clear, factual 'picture' of his status or whether it changed with intervention. From this, it is clear that this documentation would not allow other nurses or other health care professionals to:

- understand what Mr Stivic had really experienced during that time period
- use this information in their own planning related to Mr. Stivic's care.

Simply, Rick's incomplete documentation makes it both challenging for other health care professionals to provide care for Mr Stivic (because they are not fully informed) and, potentially, also places Mr Stivic at risk for inappropriate care.

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CASE STUDY SCENARIO 2: RICK

Rick's documentation did not appropriately describe Mr. Stivic's care in terms of who assisted Rick nor did it document accurately the timing of Rick and Janet's care. These errors would not likely affect Mr. Stivic's outcome in this particular case however if Rick repeated these errors in other situations, this lack of factual documentation may cause challenges for other health care providers trying to maintain consistency of care in Rick's absence.

Consider the conceptual framework and directives for documentation in nursing practice. What could be the implications of ineffective documentation for Rick?

Legal and professional requirements:

Like all Registered Nurses, Rick is required to meet legal, professional and agency directives for documentation. Given that nurses' documentation is legal evidence of care provided and client's responses to that care, 'what' Rick documented is a concern. The information missing from his pain assessment documentation may be interpreted as evidence that he had not provided safe, appropriate and ethical care for Mr Stivic. Further, the vague nature of his statements could be interpreted to mean that he lacked knowledge of appropriate pain assessment or that he did not know to evaluate the effect of the interventions he provided. In short, Rick's documentation places him at risk of being accused of not providing adequate care for Mr Stivic if this situation became the focus of legal proceedings.

According the BCCNM Practice Standard for Documentation, nurses' documentation is a record of professional practice and care provided for a client and, as such, provides evidence of whether or not a nurse has applied the nursing knowledge, skills and judgment according to their BCCNM Professional Standards of Practice. The Practice Standard further states that nurses should document "timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes" (BCCNM, 2008, p. 1). When we consider Rick's documentation in light of these directives, it is evident that his documentation does not align with these requirements. His documentation is brief, provides only a vague description of pain assessment and is missing evaluation of interventions. Rick's documentation does not provide evidence of providing care according to the Professional Standards of Practice. This places him at risk of a professional practice inquiry.

Agency's directives:

Finally, Rick is required to follow the Emergency Department 's documentation policy and the agency's directives in his documentation. We do not have information related to these policies in this case, but can assume that the policies will reflect legal and professional requirements for nurses' documentation. From this standpoint, it seems possible or even likely, that Rick's documentation does not meet unit or agency requirements in this situation.