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Documentation and Legal Aspects
for Certified Nursing Assistants

Developed by

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In-service Self-Study Packet & Test

Meets the Documentation and Legal Aspects **1.0 In-service Hour** *required by the Florida Department of Health/Board of Nursing for Certified Nursing Assistants*

Baptist Health

Documentation and Legal Aspects Self-Study

OBJECTIVES:

At the end of this class you will be able to:

1. Describe the purpose of documentation.
2. Document in a complete, correct, timely, legal and professional manner.
3. List some of the aspects of care that must be documented.

Medical Record Documentation

Medical records are *legal records* that must be maintained in a very careful and legal manner. 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, his/her 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 his/her 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.

Hospitals and nursing homes use many kinds of forms and ways to document the care that patients 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 still other hospitals and nursing homes, this daily care is put into a computer. Many hospitals and nursing homes are now using a computer. They do not use any paper forms any more.

You must follow the rules that are in place at your own hospital or nursing home. Ask the nurse if you are not sure of where you should write about your patient or resident.

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.

If you give your patient a complete bed bath and the patient complains of a headache, you must record the fact that you have given the person the bath and that he/she is complaining of a headache. You should also tell the nurse about the head pain 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.

Some of the care that nursing assistants 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 involved you the nursing assistant, the patient or resident and/or family members.

Some of the observations that nursing assistants 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 anger or pain,
- Behaviors, like anger and yelling and
- All other things that you see, hear or feel, especially if it is not normal for the patient you are caring for

CORRECT DOCUMENTATION

All of your documentation in the patient or resident 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.

You must also write only those things that you actually do, see, hear or feel. 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 him/her sleep most of the day. The patient could be sleepy because of the illness. Or, it may be that s/he did not sleep at all the night before because the other patient in the room was noisy all night.

Instead, you should write, "The patient slept from 8 am until 12 noon and only woke up when vital signs were done at 10 am"; or, if the person says s/he is feeling lazy, you should write and report that the patient said, "I am feeling very lazy today".

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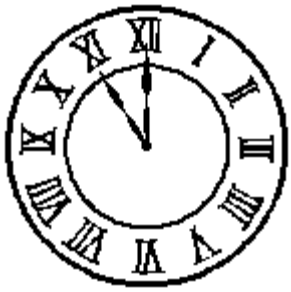
TIMELY DOCUMENTATION



Documentation must also be done on time. It must be done as soon as possible because documentation is used to communicate about the patient or resident. 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.

For instance, you are taking care of an 82-year old patient who has a history of Alzheimer's disease. One morning, he suddenly shows signs of anger and becomes very hostile to anyone who enters his room. You know that this is different behavior for him but you do not document it right away because you are very busy. Later on that day, this patient becomes more violent and throws his lunch tray at the nurse, causing an injury.

Could this injury have been prevented?

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

- Watched more closely for worsening behavior if the nurse had known about the patient's anger and hostility that morning, or

- the doctor could have been notified about the sudden change in behavior and maybe he would have prescribed a medicine or ordered a test to make sure it was not something else going on with the patient

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 patient's medical record. It should also be reported orally to all those that care for the patient.

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 person's medical record. This communication is very important. Documentation and reporting should be done as soon as it happens. You should never wait until the end of the shift to write or report things that are not normal.

LEGAL DOCUMENTATION

Medical records are legal documents. They must be used according to the law and the policies of your own hospital or nursing home. They must also be stored according to the law and the policies of your own hospital or nursing home.

Some things that are 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, PCA, 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 hospital or nursing home;
- 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 <u>not</u> the place to air your own feelings about the patient and their care. For example, you should <u>never write</u> 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.

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SUMMARY

Medical records, whether or not they are on the computer or on paper, hold very important information about the patient including the patient's health history and current condition. This information is private and confidential and should not be shared with anyone who is not taking care of the patient. These records must be complete, accurate, timely, legal and professional. A thorough medical record helps the members of the healthcare team to communicate better and to coordinate care more easily.

References

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Pulliam, Jo Lynn. (1998). The Nursing Assistant: Acute, Subacute and Long-Term Care. New Jersey: Brady, Prentice Hall.