

**How to Receive Your CE Credits**

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**Purpose**

The purpose of this course is to discuss Medical Record Documentation and the essential element, standards, guidelines of medical record documentation. This course will give examples of the guidelines on documentation, and maintaining confidentiality.

**Objectives**

1. Discuss the purpose of Documentation.
2. Describe how to document in a complete, correct, timely, legal and professional manner.
3. List the aspects of care that must be documented.
4. Understand how to document in accordance to the medical record guidelines.
5. Understand the importance of maintaining confidentiality.

**Purpose of Documentation**

There are standards in health care that exist and are essential. Some of the most important elements that surround these standard of care is keeping a medical record of the treatments, procedures, and care provided to patients. Keeping these records requires legal



documentation. In the legal system, documentation is regarded as an essential element (Gutheil, 2004). Extending the risk management dimension, failure to document relevant data is itself considered a significant breach of and deviation from the standard of care (Gutheil, 1997). The patient's record provides an enduring version of the care as it evolves over time and a reference work of value in emergent, and non-emergent care, research, quality assurance, patient outcomes, and effective delivery of patient care.

Regardless of how effective care delivery has been, good care is often judged on the provision of documentation and record keeping that is timely, clear, and complete (Peate, 2009). The rule of documentation is that if it is not documented in the patient medical records, the care was not done. The patients' medical records are legal records that must be done in a very careful legal way. Furthermore documentation of care is the primary source of reference and communication that tells the entire health care team members:

1. About the patient
2. Patient care and treatments
3. Aids in good decision making for the patient positive outcomes
4. Determines the effectiveness on treatments
5. Tell the health care team about patient facts

The Data Protection Act 1998 provides a definition of a healthcare record as: a health record for the purposes of the Act is one which relates to the physical or mental health of an individual which has been made by or on behalf of a health professional in connection

with the care of that individual. It is prudent to document, and follow the medical record guidelines on documentation.

### Medical Record Guidelines

Documenting in the Medical Record Guidelines	
Activity	Rationale
Write legibly always using black indelible ink. DO not use Blue ink or a pencil	Writing legibly can prevent miscommunication, and medical errors. Ink must be used because pencil can be erased permitting the record to be altered. Indelible ink will not smudge or become difficult to read. Black ink reproduces more effectively when duplicating records to share only with the health care team.
Whenever something is documented by “you” always sign the entry made, list your job title, and date and time your entries using a 24 hour clock.	A signature indicates that you have made the entry and should further clarification be required then you can be consulted. Using your title can also make it easier to locate the exact person if further clarification is needed. Dating and timing your entries allows a bystander to note when actions occurred and when observations were made.
Only record what you have observed, <b>never make entries for another person based on “here say.”</b>	Only you can vouch for what you have observed.
Care interventions should only be described and documented after they have been provided. You should not falsify your records.	Documenting care prior to delivery is incorrect and could be seen as fraudulent. <b>Refer to the violations of the Nurse Practice Act Standards on falsifying records.</b>
Recording should be done in a timely manner.	If you wait until the end of the shift you may have forgotten important information that needs to be recorded
If errors are made and you need to amend or alter your records then you must not erase, use correction fluid or score through an entry. A single line through the error, signed or initialed next to it if needed.	Erasing or using correction fluid or scoring through an entry can indicate you are trying to hide or cover up an entry, a single line allows the original entry to be audited.

When using electronic charting record documentation never share your password or give your smart card to anyone. Always log off when your documentation is completed or after making an entry.	If you share your password or fail to log off after an entry has been made others can access the record and alter this, the record will then appear as if you have made the. entry
Source: Adapted from: Dimond, 2005; Carter, 2007; Ellis and Bentz, 2007; Nursing and Midwifery Council, 2009	

### **Case Study**

You are taking care of a 50-year-old male with HIV he is listed to be on strict intake and output. He vomited twice after breakfast. You failed to report these findings to the primary nurse or record this observation. You planned on completing all of your documentation at the end of the shift. Later in the day, he begins to deteriorate (His blood pressure drops and he begins to have cardiac arrhythmias).

### **Could this the deterioration of this have been prevented?**

The deterioration may have been prevented if the nursing assistant had reported and recorded these findings: The patient condition could have been:

- a. Reported to the Doctor
- b. Order would have been given for possible better outcomes
- c. Medication could have been provided for the vomiting
- d. The patient could have been monitored more closely

### **What should the nursing assistant have done differently?**

All findings and facts about a patient that are NOT normal must be reported to the primary nurse orally, directly, immediately, and then documented in the patients' medical record.

### **Documenting Aspect of Care**

The aspects of care that must be documented should demonstrate that the care provided was in the patient's best interest. Entries must be legible, clear, accurate and comprehensive (Ellis and Bentz, 2007). Everything that was done for the patient should be documented. Treatments, and care should be documented. If the patient was given a bed bath, denture care, back rub, turned every hour, meal intake, had a bowel movement (color, consistency, and amount), foot care, hair washed, shaved, oral care, Foley care, family at bedside, etc..... Must be documented in the patient medical records. Anything that is not normal must reported and documented e.g.

- a. Changes in patient condition
- b. Inappropriate behavior
- c. Becoming violent

Do not write anything in the medical record that could possibly slander the patient for example, "the patient is lazy. The patient may have a change in his or her condition that is resulting in weakness, or lethargy. These are additional reportable findings that should be reported and documented.

### **Confidentiality**

Patients expect that all of information about them will be confidentially maintained. All information gained while patient is under the car of the health care organization (this may

include information about the person's observations assessments and treatments) should be considered confidential and as such is protected by law (Dimond, 2008). Health care organizations have policies and procedure in place regarding the HIPAA (the federal Health Insurance Portability and Accountability Act of 1996). The primary goal of the HIPAA law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the healthcare industry control administrative costs. Health care organization take the HIPAA law very serious. Therefore you should not discuss or disclose any information about the patient's condition without seeking prior consent/release from the patient unless the person is a part of the health care team caring for that patient. According to Peate, (2009) health care providers and assisting personnel must seek guidance prior to releasing information about any patient to any other party. In addition Records must never be left in places where unauthorized staff or members of the public can see them; this will include paper records or records left on a computer screen.

## **Conclusion**

It is important to remember that a documentation remains a part the patients' permanent medical records. It is imperative that these record are not alter in any way. According to Gutheil, (2004), the primary pitfall in documentation is attempted alteration. The most critical advice in documentation is that one should never attempt to change, alter, or falsify an existing record. Always keep in mind documenting in the medical record guidelines and adhere to those guidelines.

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