AWHONN MN Section Conference

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Topic of Discussion

Mindful Documentation:

What to document and what not to document……..

That is the Question?

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Before we get started……

- Review background and history so as to understand my experience and why/where my information is coming from

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Healthcare Organizations Maintain medical records for several Key Purposes:

- Patient Care. Patient records provide the documented basis for planning patient care and treatment.
- Communication
  - Make the description as objective as possible
  - Describe so someone else can understand what you meant
  - If another caregiver misunderstand or misinterprets, it increases likelihood of error
- Legal Documentation
- Billing and reimbursement
- Research and Quality Management
- Continuity of care and communication between providers and the care team

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Legal Documentation:

1. Date and time
2. Patient's name
3. Nurse's name
4. Clinical Assessment – check your policy
5. Details of incidents
6. Conversations with Family, provider whether in person of phone
7. Late Entries
8. Use proper grammar/spelling and medical terminology rather than shorthand or texting type verbiage

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What Not to include in your Documentation

- Personal Opinion
- Rumors or speculation
- Care provided by other providers
- Defensive documentation – issues with providers/other care givers
- Incident Report or Risk Management
- Judgements or interpretations outside scope of responsibility
- Copy and paste notes
- Staffing issues

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Secondary Use of Documentation: Defense of Medical Malpractice Cases

- Record of events that have been forgotten
- Refreshes memory
- Supports and validates recollection and testimony
- Information in writing is more persuasive – Use of quotes
- Get credit for good care that was provided
- Establish alternative causation theories and determine damages

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Legal Perspective on Documentation

- Not Documented = Not done
- Poorly documented = Poorly done
- Incorrectly documented = potentially fraudulent

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Medical Malpractice Basics Elements of Negligence

- **Duty to the patient** . Duty is established when you accept care of a patient under your scope of practice, licensure and employment. It requires you to provie the standard of care that a reasonably prudent nurse would provide for a similar patient in similar circumstances. Factors that define the standard of care include the scope of nursing practice under your state's nurse practice act, nursing accreditation bodies, policies and procedures of the facility where you work, nursing certification, and acceptable treatment standards as outlined in current nursing journals and textbooks.
- **Breach of Duty:** Care rendered was not consistent with what a prudent nurse would do in similar circumstanace. The plaintiff must prove that care provided by a nurse was substandard and fell below the Standard of Care (C-).
- **Causation/The patient was injured:** a nurse may perform duties to a patient in a manner that falls below the standard of care required but, even though an incident occurs with the patient, the patient isn't injured.
- **Damages/The injury was directly caused by the breach of standard of care**. The plaintiff must prove a direct connection to the nurse's failure to provide care within the recognized standard (for example, that missing the dose of the antibiotic set back the patient's recovery from infection).

In a professional negligence lawsuit, the plaintiff is required to prove all four elements through an expert witness unless a written standard of care speaks for itself. Typically the expert is another nurse with a similar skill set or similar expertise in the standard of care as that of the defendant nurse. The expert will look at the nursing documentation for clues and evidence that the care rendered wasn't consistent with appropriate nursing care in order to form an expert opinion.

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Review of Cases

- OB Case
- Pediatric/ER Case
- Falls Case

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Minnesota State of Limitation, Medical Malpractice

- Adults {18 years +}:
  - Injuries other than death: 4 years
  - Wrongful death: 3 years (from death)
- Minors
  - Limitation period suspended for 7 years, then runs as though minor is an adult {up to 11 years}

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Review

A well-documented medical record:

- Protects the patient
- Demonstrates that you are a competent nurse to:
  - Board of Nursing
  - Medicare
  - Attorneys and other third-party stakeholders
- Minimizes the potential of being drawn into a malpractice lawsuit
- Greatly assists with defense of a malpractice lawsuit
- Does not leave opportunity for anyone to question or doubt the great care you provided!

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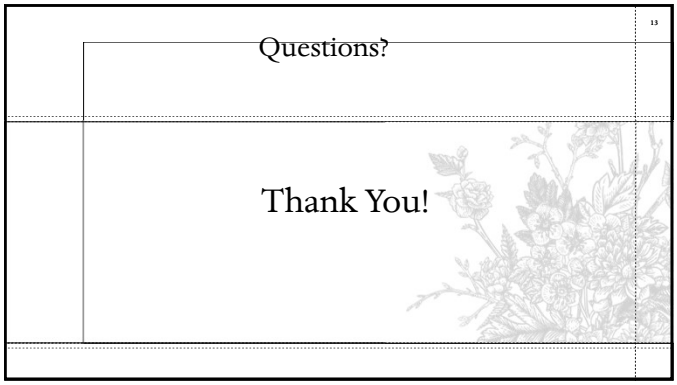

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