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# Charting Practices to Optimize Resident Safety

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## Clinically Pertinent Documentation

*"Quality of Care is determined by facts in the medical record.*
*Excellent quality of care, not documented, leaves room for questions and speculation."*

### Significant Resident Event

Mr. George Johnson is an active octogenarian that lives in assisted living with his wife. George's wife has severe arthritis, and she has limited mobility. George loves to socialize and is frequently seen walking the halls visiting with staff, family members, and residents. George is mentally alert and enjoys completing the daily tabloid crossword puzzle and frequently shares current events from the news.

One-day George's wife calls for help and George is found lying on the floor of the shower. He has a large gash above his right temple that is bleeding, and he is complaining of significant pain on the right side of his chest. George is confused and does not recall what happened.

An ambulance is called, and George is transferred to the emergency room. Documentation in George's health record notes the following:

*7/14/2023 10 a.m., Resident is found lying on his right side in the shower in his room. A large gash is noted above his right temple that is bleeding. Pressure is applied with gauze. The resident is complaining of significant pain on the right side of his chest and has some shortness of breath. Respirations are 24, pulse is 90 and BP is 140/106. The resident has difficulty moving; an ambulance is called.*

## Is the noted documentation complete, accurate, and clinically pertinent?

The documentation does provide some pertinent details related to finding the resident in the shower and observed and reported injuries. Clinically pertinent documentation would also include:

- A description of the gash including measurements (e.g., length, width, and depth) and quantity of bleeding

- A description of pain (e.g., sharp, stabbing), location (e.g., head, chest, other areas), and intensity (e.g., mild to severe or pain scale)
- Neuro checks for an unwitnessed fall (facility policy may direct calling 911)
- Actions taken for the resident's shortness of breath and pain
- Assessment and observation of other injuries
- Communication provided during handoff with the ambulance team (e.g., new onset of confusion)

## What Should Documentation Include After a Significant Resident Event? (Recommendations for Skilled Nursing and Assisted Living Facilities)

**The Facts** – Document accurate information about the event, including assessment/observations, monitoring, interventions, actions, communications, and resident response. Include relevant comments from the resident and family regarding the event (e.g., "My family brought my new glasses yesterday. I have been having balance issues since I started wearing my new glasses").

**Timeline of Care** – Document the timeline of care and treatment during and after a significant adverse event including vital signs, neuro checks (for witnessed and unwitnessed reports of head injury), acute symptom management (e.g., complaints of shortness of breath or difficulty breathing after a fall) and pain management. Document the transition of care if the resident is transferred to the emergency room or an acute care facility, including hand-off report to the accepting nurse.

**Clear, Concise, Complete** – Ensure that documentation regarding the event is factual, concise, and complete. Avoid assumptions, opinions, or accusations about the care and treatment. Do not blame or criticize the resident, family, other care team members, the facility, or other healthcare organizations.

**Communication** – Clearly document communication with the primary care physician, the resident (as appropriate), and the family (as appropriate). Assign responsibility for post-event follow-up communication with the resident and family.

**Interventions** – Ensure an updated assessment of risk is conducted after an event (e.g., fall risk, skin integrity risk, elopement risk). Current interventions should be evaluated for effectiveness and new interventions implemented to manage the risk (e.g., physical therapy assessment). A multi-disciplinary assessment of resident risk is recommended, including a medication review as appropriate. Update the resident's care plan.

## Documentation Best Practices [1]

- Chart assessments and care concurrently
  - Avoid end-of-shift charting
- Document clinical decision making, nursing process, and plan of care
  - Document clinically pertinent assessment, monitoring, interventions, and communication
  - Use specific terminology including measurements and descriptions (e.g., wound and injury size, color, location)
  - Avoid imprecise descriptions (e.g., bed soaked, large amount)
- Use approved abbreviations
- Use correct spelling, grammar, and punctuation
- Sign, date, and time all entries
- Ensure late entries are following facility policy and procedures
  - Ask the following questions – Does the missing information impact resident care? Is the missing information necessary to communicate clinical care that was provided?
  - Use a late entry to document a legitimate non-defensive clarification/addition regarding resident

care. A late entry should not be about covering yourself after an event occurred.

- Follow facility security protocols for logging in and out of the record.
  - Confirm you are in the correct record
- Document follow-up care – confirm resolution of the issue and/or changes in the plan ofcare
- Document communication – physician, other disciplines, and family
  - To whom you spoke and details regarding the conversation
- Document resident and family teaching
- Document discharge planning
- Document a resident's refusal to take a medication or allow a treatment
- Document resident non-compliance with their plan of care
  - Document the instruction/treatment that was not followed
  - Use quotes, when possible, to illustrate the non-compliance
  - Make objective statements – avoid labeling the resident
  - Note who you informed about the noncompliance
  - Document all incidences of not following the plan of care (Demonstrates a pattern). This is especially important with repetitious events like getting out of bed without notifying you.
- Read-back and confirm all verbal orders

## Documentation Don'ts [2]

- Electronic Medical Record – Avoid copying and pasting critical resident information. Copying and pasting creates a potential for error if the information is not reviewed in its entirety. Copying and pasting can also give the impression of a cloned record.
- Don't make excuses in the medical record, such as "Medication not given because not available." A medication or treatment that is not available requires action (e.g., provider notification)
- Don't chart care ahead of time--something may happen, and you may be unable to actually give the care you have charted.
- Don't chart a symptom, such as "c/o pain," without also charting what you did about it.

## Sources


1. *Nurse Service Organization. Do's and Don'ts of Documentation.* Do's and don'ts of nursing documentation | NSO [Accessed August 20, 2023]
2. *Ibid.*