VAALER
A Marsh & McLennan Agency LLC Company

Documentation to Optimize Resident Safety

Documentation Best Practices

- Chart assessments and care concurrently, avoid end-of-shift charting
- Know and follow facility policy and procedures related to documentation, assessments, and care planning
- 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, drainage)
- Avoid imprecise descriptions (e.g., bed soaked, large amount, pool of blood)
- Document the effectiveness of interventions
- Document follow-up assessments and monitoring based on the resident's clinical condition and facility policy and procedures (e.g., charting every shift for 72-hours after a fall with injury, skin injury, change in condition)
- Use approved abbreviations, correct spelling, grammar, and punctuation
- Sign, date, and time all entries

Late Entries

- Ensure late entries are following facility policy and procedures
- Note the date and time of the entry and the date and time of the resident information that is being added
- 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.
- Review late entry information with a supervisor if in doubt about documentation content.

Communication

- Document communication with physicians and other providers. Note with whom you spoke, resident information provided, and orders received.
- Document communication with family members or other legally responsible parties (e.g., Power of Attorney). Note with whom you spoke, and information shared.
- Document resident and family teaching
- Document discharge planning
- Document complete transfer communication, a structured format such as SBAR (Situation, Background, Assessment and Recommendation) is suggested. (Source – Institute for Healthcare Improvement, SBAR Tool)

Resident Refusal of Care and Non-Compliance

- Document a resident's refusal to take a medication or allow a treatment. Obtain information about why they are refusing, if possible. Ensure interventions are in place to support resident-centered care. Document provider and family communication about the refusal (as applicable).
- Document resident non-compliance with their plan of care
- Document the instruction/treatment that was not followed/allowed (e.g., resident smoking while on oxygen)
- Make objective statements. Do not criticize or label the resident.
- Be consistent in documenting non-compliance with the plan of care (demonstrates a pattern).
- Document who you informed of the non-compliance
- Document interventions and new actions to support resident safety

Incident and Injury Documentation

- Document accurate information about the event, including assessment, 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.")
- 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.
- 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.

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