

Documentation in long-term care

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Importance of excellent documentation

- Documentation is the foremost source of reference and communication between nurses and other health care providers.
- Nursing documentation makes up a critical aspect of the patient's record and is the written evidence of nursing practice.
- The primary purpose of documentation is to ensure continuity of care for residents.
- (Martin, Hinds & Felix, 1999)

College of Nurses standards

- CNO states: “Documentation should provide a clear picture of the needs or goals of the client, the actions of the nurse and the outcomes” (CNO Documentation Standard, 2004).
- CNO standards are available on-line or by phone order: www.cno.org or 1-800-387-5526 ext. 6125 and ask for Marjory.

What do we need to chart?

- For the most part, charting by exception is the rule to follow in long-term care homes.
- What does charting by exception mean?
- Examples of charting by exception would be PRN medications, changes in behavior or any change in the residents condition that is unusual. If the resident has had a recent fall, or unusual occurrence such as difficulty with another resident or if they have had a medical procedure done outside of the Home, this requires your documentation in detail.

What to chart (continued)

- Residents in long-term care often have a family member voice a concern and this also needs to be documented in an objective way.
- Perhaps the resident has gone to see a specialist, such as a dentist, EENT physician or eye doctor. These appointments need to be recorded.
- Whenever the resident is out on an LOA, this must be noted on the chart.
- If it is out of the ordinary, it needs to be recorded for the multidisciplinary team to duly note.

Methods of charting

- There are numerous methods of charting
- Examples of charting methods are:

PAR	DAR	SOAPE
Problem	Data	Subjective
Action	Action	Objective
Response	Response	Assessment
		Planning
		Evaluation

- Helpful to use the nursing process as a firm base for your charting. (Assessment, nursing diagnosis, planning, implementing and evaluating.)

Core standards for documentation

- These are the minimum standards of documentation
- A nurse maintains documentation that is:
- Clear, concise and comprehensive
- Accurate, true, honest
- **RELEVANT**
- Reflective of observations, not of unfounded conclusions

Core standards (continued)

- Timely and completed only during or after giving care
- Chronological (in the order that the event happened)
- A complete record of nursing care provided, including assessments, identification of health issues, a plan of care, implementation and evaluation (a nursing process approach)

Core standards (continued)

- Legible and NON-ERASABLE (most institutions require a black ink ballpoint pen for a permanent record—no pencil)
- Permanent, retrievable
- Confidential
- Client-focused
- Completed using forms, methods and systems provided (as your LTC home specifies) (CNO, Practice Standard, 2004)

A nurse's documentation

- Includes date and time of care or event
- If a late entry include present time and date and time and date the event occurred
- Identifies who provided the care
- Contains meaningful information—avoid meaningless phrases such as “good night” or “usual day” or “up and about”

A nurse's documentation (continued)

- Includes what was observed and avoids statements such as “appears to” and “seems to” when describing observations
- Includes signatures or initials, and professional designation
- Avoids duplication of information in the health record
- (CNO, Practice Standard, Documentation, 2004)

Transcribing orders

- Basic competency of nurses who administer medications.
- Other individuals may do the actual transcribing, but nurses are accountable for validating the accuracy and completeness of the transcription.
- Consider scheduling to ensure medications are given at the same time(s) each day to ensure dosage and stability of the medication level.

Transcribing orders (continued)

- Medication absorption rate and action is affected by food intake or there are contraindicated foods such as grapefruit juice or dairy products (eg. when taking Lipitor for high cholesterol)
- Drug interactions may affect scheduling when clients are on multiple regimens
- Whenever possible incorporate client choices and preferences in the schedule
- (CNO, Practice Standard, Medication, 2004)

Don't assume!

- When the nurse is unable to read the writing of the order, or is unsure of the dosage or knows of a possible contraindication—ASK!
- When a resident has seen a specialist it is very important to let the family or in-house physician know of a new order and to have him/her confer with that order. Although all doctor's orders are valid, the resident is much better known by the family physician and can be alerted to a change in medications or routine.

Orders (continued)

- When a resident comes back from a specialist appointment, out of courtesy to the family physician and as a safeguard for your resident, give the family physician a call so that he/she is aware of any new orders. The family or in-house physician knows the resident best
- Leaving a prescription fastened to the chart until the family physician comes in is setting the nurse up for a further complication if the order is lost or misplaced

Orders (continued)

- When the order(s) have been transcribed from a specialist appointment and the family physician has been notified, remember to have the physician sign that order when he/she is next attending at the home
- (This information validated by MOHLTC Compliance Advisor—Ottawa, Ontario, November, 2006)

Questions, comments?

- Let's take a few minutes now and discuss what we have just learned and find out if you have any specific concerns at your LTC Home.
- Thank-you.