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Clinical Documentation—Putting the House in Order

Background

Clinical documentation is one of the most basic professional responsibilities, yet the importance of documentation, while acknowledged, is often not reflected in practice. Maintaining good standards of clinical documentation by practitioners in all care settings is problematic in spite of years of continued and consistent advice from professional bodies and liability carriers. The most often mentioned reasons for poor documentation practices by practitioners are lack of time and a reliance on verbal communication.

This newsletter discusses some of the issues that may arise from poor quality documentation and the need for improvement and the establishment of basic minimum standards for documentation. The term "documentation" is used to mean any paper-based or electronically-generated information (including e-mail) generated information about a client (e.g. patients and residents) that describes the care or service provided to that client.

Purposes of Clinical Documentation

All practitioners are accountable for maintaining health records as an inherent responsibility within their duty of care[1,2]. Documentation is an integral part of safe and appropriate clinical practice and is a record of the judgment and critical thinking used in professional practice. The clinical record supports quality client care by facilitating communication among care providers serving the client. Objective, contemporaneous and relevant documentation promotes consistency in client care and effective communication between members of the care team.

1 College of Nurses of Ontario, "Nursing Documentation Standards", 2002.

2 Ministry of Health and Long-Term Care, "A Guide to Better Physician Documentation", November 2006.

The clinical record is an overall indicator of clinical and service quality, and serves as a basis for planning care and for service continuity. Increasingly, the quality and content of health records are being used as an indicator of the standard of care given to an individual client. Clear, comprehensive, and accurate clinical documentation demonstrates that a client's condition was properly assessed, that the problems being treated were clearly identified, that the care plan specifically addressed those problems, and that the client's status was continually evaluated.

The key purposes of clinical documentation are:

- **to document clinical care**—by recording what was done, by whom, to whom, when, where, why, and with what results;
- **to serve as the basis for care planning and continuity of care by an individual practitioner**—by recording clinically relevant information about the client's response to treatment/services including any problems experienced during the course of treatment;
- **to serve as the basis for continuity of care by the care team**—by recording clinically meaningful data regarding the assessment, treatment, and progress in and response to treatment so other members of the care team have sufficient information to provide continuity of care/services to the client;
- **to facilitate coordination of clinical care**—by communicating with members of the care team thereby facilitating coordinated, rather than fragmented, treatment/service delivery;
- **to comply with legal, regulatory, and institutional guidance and standards**—by demonstrating through documentation that a practitioner has applied clinical knowledge, skills, and judgment in accordance with professional standards;
- **to facilitate quality assurance and utilization review**—by serving as a basis for analysis, study, and evaluation of the quality of health care services rendered to clients, and providing data for educational planning, policy development, program planning, and research; and
- **to provide risk management and malpractice protection**—by providing documentary evidence of a client's care and treatment that supports the adequacy of clinical assessments, the appropriateness of the treatment/service plans, and the application of professional skills and knowledge in the provision of professional services.

Elements of Good Clinical Documentation

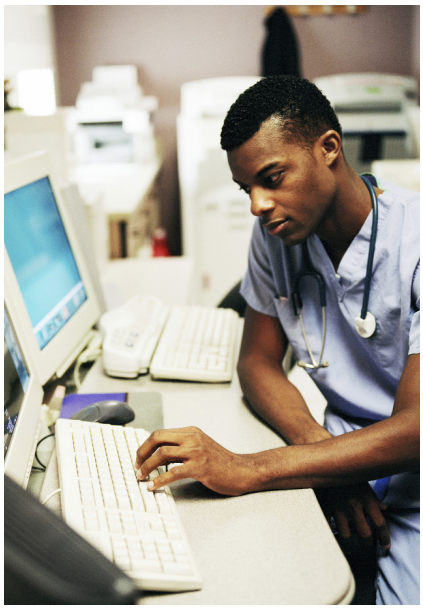
Documentation, whether electronic or paper, must provide a record of the client's needs, care provided, and clinical outcomes.

While there is no single model or template for a record, the key principles that underpin good documentation practices as it relates to style and content are common across all care settings. A client record should: [3,4,5]

- be factual, internally consistent, concise, and accurate and not include editorial comments, speculation, or meaningless phrases;
- be written concurrently, or as close as possible, to the time care was given;
- be written from first-hand knowledge except in an emergency where one practitioner may be designated as the recorder;
- be written legibly in ink using correct spelling and grammar and be readable on any photocopies;
- be written such that any necessary corrections or additions are dated, timed, and signed, and the original entry can still be clearly read. Entries should never be corrected by erasing or obliterating (e.g., with correction fluid) the original entry. Annotations should never be made in the margins or between the the lines.;
- have entries written in chronological order without any blank space between entries;
- be signed with the first initial, last name, and professional designation (e.g., MD, RN);
- include the date and time for all entries; charting in blocks of time should be avoided as the timing of specific events cannot be determined;
- use only facility-approved abbreviations and symbols;
- adhere to the charting format adopted by the facility; and
- be written on the appropriate, approved facility forms.

In addition to the above, practitioners have a professional accountability to clients, and their documentation should reflect safe, competent, ethical care that meets the requirements expected of their role in a particular practice setting. Documentation should be able to demonstrate:

- an assessment of the client's health care status and the care that has been planned and provided;
- significant events during a care episode;
- the interventions used to respond to a client's goals/needs;
- the client's response to interventions taken and any subsequent action taken;
- assessments of the client prior to and following the administration of PRN (pro re nata) medication;
- any teaching provided to the client and/or family; and
- discharge planning including instructions given to the client and/or family.



3 See note on page 1.

4 Registered Nurses Association of British Columbia, "Nursing Documentation", 2003.

5 College of Registered Nurses of Nova Scotia, "Documentation Guidelines for Registered Nurses", 2005.

The frequency of documentation and amount of detail documented are determined both by a practitioner's professional judgement and the facility's policies and procedures. More frequent entries are generally required based on: [6,7]

- the complexity of the client's presenting health problems;
- the acuity of the client's condition (e.g., unstable vital signs, confusion, disorientation);
- the degree of risk involved in the proposed care or treatment; and
- the need for more intensive care than the norm.

Consequences of Deficient Documentation

It has been argued that the quality of care a client receives is reflected in the quality of the documentation of the care, and that a direct relationship between the two exists. There is also substantial evidence to indicate that when documentation concerning client care is poor (incomplete, inaccurate or even inappropriate) and the care team is unsure as to the care required (or provided), potential negative consequences for clients may occur from: [8,9]

- inability to provide continuity and consistency of care;
- the omission or duplication of treatment;
- inappropriate care decisions;
- inability to evaluate the effectiveness of care/treatment; and
- responding ineffectively to deterioration in a client's health status.

6 College and Association of Registered Nurses of Alberta, "Documentation Guidelines for Registered Nurses", September 2006.

7 Nursing and Midwifery Council, "Guidelines on Documentation and Record Keeping", 2002.

8 See note 6 above.

9 Ontario Ministry of Health and Long-Term Care, "A Guide to Better Physician Documentation", November 2006.

Case Studies—Common Documentation Deficiencies that Cause Adverse Outcomes:

1 Failure to Document Medications that Have Been Administered

Scenario: A diabetic was ordered a STAT dose of insulin at shift change; the day nurse administered the drug but did not chart the medication on the medication administration record (MAR) before she went off duty. The evening nurse saw the order but no indication that the dose had been given. She gave the client the insulin and he subsequently became hypoglycaemic and collapsed.

Lesson Learned: It is the responsibility of every practitioner to record every medication when it's given—including the dose, route, and time. The day nurse should have recorded that she had given the dose, and the evening nurse should have been suspicious when she saw the STAT order but no evidence that it had been given. As a further check, she could have asked the client if he'd received the medication.

2 Failure to Record Allergies

Scenario: A client's penicillin allergy was not recorded on the admission assessment or flagged on her medical record. Because the medical resident was not aware of the client's allergy, he prescribed intravenous penicillin which was administered by the nursing staff. The client went into anaphylactic shock and suffered irreversible brain damage.

Lesson Learned: On admission, each client must be asked about allergies including foods, medications, latex, or any substance that may come in contact with a person. Each client allergy must be listed on the admission assessment, documented in the allergy section on the MAR and entered into the computer profile for each client. An allergy bracelet should be applied to all clients with known allergies.

3 Failing to Document Clinical Care

Scenario: A client has frequent dressing changes over a 24-hour period. None of the staff on either the day or night shift documented that the dressing had being changed or the amount of drainage.

Because nothing had been documented, the staff were not aware that the client's condition had deteriorated due to significant fluid loss until he went into shock. All of the staff who changed the dressing thought that the amount of drainage was normal for their shift.

Lesson Learned: Every treatment should be recorded as soon as possible after it has been done with sufficient detail to allow the next practitioner taking over care to assess whether the client's condition has improved or deteriorated. Where appropriate, standard flow sheets and charts should be used as documentation tools.

4 Recording on the Wrong Record

Scenario: Two residents, with similar last names, were admitted to the same nursing unit. One, Ms. J. McMillan, had terminal breast cancer and the other, Mrs. J. MacMillan, had congestive heart failure. Mrs. J. MacMillan's physician wrote admission orders for digoxin, captopril, and furosemide.

The charge nurse inadvertently transcribed the orders onto Ms. J. McMillan's chart and the team leader administered the medications. Several hours later, Ms. J. McMillan collapsed and died.

Lesson Learned: When two or more clients are admitted with the same or similar name, a facility must have a protocol to distinguish between these clients. This may include flagging the clients' charts and medication records with 'same name alert' and the use of photographs in addition to the standard wristband checks before medications are given.

5 Failing to Document a Discontinued Medication

Scenario: A client with a long history of taking high doses of aspirin for arthritis developed indigestion and upper abdomen pain. Her physician suspected that she had developed a gastric ulcer so he wrote an order to discontinue the aspirin. The charge nurse forgot to transcribe the order on the medication administration record, and the staff continued giving aspirin. The ulcer perforated the stomach and the client required an emergency partial gastrectomy.

Lesson Learned: To help ensure that new orders are not missed, a facility should have a system to flag new orders and the physicians' orders should be double-checked with the medication administration record to ensure they are up-to-date.

6 Transcribing Incorrect Orders

Scenario: A physician wrote an order for 5.0 units of Insulin, however, she did not write the decimal point clearly. The nurse transcribed the order as 50 units and, although he did not think the order seemed correct, he did not clarify it with the prescribing physician. The client became hypoglycaemic after receiving a 10-fold overdose of insulin.

Lesson Learned: A nurse is responsible for recognizing and questioning an order that looks incorrect. To further prevent this type of error, a facility should have a policy that trailing zeros are not to be used and an independent double-check should be performed by another practitioner before high-alert medications like insulin are given.

Summary

A client's health record should provide clear evidence of the care planned, the decisions made, the care delivered, and the information shared. The degree to which this has been accomplished may be readily evaluated by answering the question "if care had to be transferred to another practitioner, does the record provide sufficient information for the seamless delivery of safe, competent care?"

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For further information please contact:

Ruth Stewart, M.H.A., CHE
Marsh Canada Limited, 161 Bay Street, Suite 1400, Toronto, Ontario M5J 2S4
Telephone: 416 868 2771 Fax: 416 868 2692

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