

MEDICAL RECORD DOCUMENTATION AND LEGAL CONSIDERATIONS FOR THE CERTIFIED NURSING ASSISTANT

The patient's medical record contains all of the important information about the patient's health and progress. The medical record is also the place where health clinicians communicate to each other about patient care outcomes. The basic purpose of patient care documentation is to produce a clear, concise, and accurate record that allows everyone involved on the health team to know what has happened, what is planned, and what needs to be done. Proper documentation is essential because if this information and those events are not recorded, no one on the health team caring for the patient will know what has happened and patient care and outcomes will suffer.

Learning Goals:

1. Identify three aspects of proper documentation.
2. Identify three things that a CNA may document about his/her patients.
3. Identify the proper way to document a note that is entered late.
4. Identify what is important to document when performing a therapeutic activity.
5. Identify a CNA note that is an example of good documentation.

Introduction

Learning to document in the proper way on a patient's medical record is absolutely vital for all members of a health team. Hospitals, clinics, skilled nursing facilities, and other healthcare facilities can be very busy and hectic. Many interventions and changes can be occurring surrounding patient care, and the pace of the environment can be very fast and sometimes overwhelming. There is simply no way that safe and appropriate patient care can be delivered without proper documentation by all members of the health team related to health interventions. For patients to receive the best care possible, all of the information on the medical record must be properly documented.

Patient Care Documentation: The Basics

All of the important information and events that pertain to patient care must be recorded on the patient's medical record. The patient's medical record is the only place where all of the important information about the patient can be found. It is also the place where health clinicians communicate to each other about the patient's care outcomes. The basic purpose of patient care documentation is to produce a clear, concise, and accurate record that allows everyone involved on the health team to know what has happened, what is planned, and what needs to be done. Proper documentation is essential because if this information and those events are not recorded, no one on the health team caring for the patient will know what has happened and patient care and outcome will suffer.

Documentation would be simple if every task, observation, or discussion related to patient care were written in the chart. Only the important tasks, observations, and conversations have to be

documented. When the responsibility of documentation is looked at in that manner, documentation can seem like an overwhelming and difficult task because 1) the amount of information to document may appear great, and 2) the CNA may be unsure whether an event was important and needed to be documented.

Some healthcare workers begin with the idea "*if it isn't documented, it wasn't done.*" This adage is not new and many health clinicians have heard it before. It embodies the principle that without accurate documentation a patient intervention cannot be said to have occurred. All of the information about the patient - what is done for the patient, what the plan of care is, how the patient responded to this care, what needs to be done on the patient's behalf, what the future plans for the patient are, amongst other things - must be documented.

While the phrase "*if it wasn't documented, it wasn't done*" is often stressed, if clinicians were to consider everything important, and documented everything, documentation would be a never-ending task. If a person followed the adage, "*If it wasn't documented, it wasn't done,*" without reasonable limitations, documentation would be endless; a CNA, however, does *not* have to include every detail of everything seen, done, and said during the course of patient care. With regard to documentation, the CNA should use professional judgment about what to include and what to leave out and use this standard to decide: *is what I am documenting important in terms of patient care?*

Medical record documentation is a skill that must be learned and practiced. After time, documenting the correct way will become second

nature, and CNA members of the health team will instinctively know when to document, what to document, and how to document. The following examples will help to illustrate the process and why it is important.

Example #1

A patient has an in-dwelling urinary catheter and catheter care is scheduled to be done once a day. The CNA has been delegated the duty to perform the catheter care, and to follow the proper care specified by hospital policy. The CNA has performed the procedure many times before. After the CNA has finished the catheter care, documentation of the procedure is done. If the concept of “not documented, not done” is taken to an extreme the patient care note might appear as such:

“I entered the patient’s room at 13:00 hours and advised him I was going to perform catheter care. I removed the bedding and lifted the patient’s gown in order to expose the area. I examined the meatus and the skin around the area: I did not observe any redness, swelling, or drainage. I checked all of the catheter connections, and ensured that the catheter was firmly secured to the patient’s leg and that there was no tension on the catheter tube that would affect or irritate its insertion site. The urinary collection bag was secured to the bed with two hooks, and it was approximately 12-14 inches below the level of the bladder. There were no kinks or loops in the collection tube. The urine color was pale yellow; I did not observe any blood or sediment in the tube or the bag. I washed my hands using soap and water, scrubbing for 2 minutes. I dried with paper towels, and then put on disposable gloves. I washed the area around the insertion site of the catheter with soap and water and a gauze pad, moving from the inside

to the outside in a circular manner. This took approximately two minutes, and the patient did not complain of pain or discomfort during the procedure. After discarding the gauze and the disposable gloves in a hazardous waste container, I repositioned the gown, replaced the bedding, and made sure the patient's call light could be reached. The procedure was completed at 13:10."

Example #2:

A CNA has been checking the temperature, blood pressure, pulse, and respirations of a patient. The blood pressure, pulse, and respirations are within normal limits and they are normal for the patient; the patient, however, has a temperature is 100.9°F. The patient is awake, alert, and oriented, and does not have any specific complaints. The patient's skin color and temperature are normal and there is no diaphoresis observed. The vital signs are charted in the appropriate place, and the CNA reports to the immediate supervisor of the patient's elevated body temperature. A patient care note with unnecessary detail might read as follows.

"I entered Mr. F's room at 12:00 to check his vital signs. I checked his pulse by palpating his left radial artery for 30 seconds and multiplying the result by two: the pulse rate was 80. After making sure that the patient had not had recently anything to eat or drink, I placed the thermometer probe under his tongue and held it in place until a reading was obtained: the temperature was 100.9°F. Respiratory rate was obtained by counting the number of breaths for 30 seconds and multiplying times two: the respiratory rate was 20. The patient's skin color was normal, no cyanosis noted. The respiratory rhythm was regular and no respiratory accessory muscles were used. The blood pressure cuff was assessed to make sure it was the proper size, and

the cuff was applied to the left arm with the leading edge approximately one inch above the brachial artery. The patient's arm was positioned at the level of the heart, and the blood pressure was measured: the blood pressure was 128/70. The patient was noted to be awake, alert, and oriented, his skin color and temperature were normal and no diaphoresis was noted. He had no specific complaints. I notified the nursing supervisor, Susan L., R.N., at 12:15 of the elevation of body temperature, 100.9°F, and of my other observations. Susan L. stated that she understood that the patient had an elevated body temperature."

All of the information in the notes *could* be considered important because the use of proper technique when performing procedures such as good infection control is a critical part of patient care. But these notes are very long and difficult to maintain in everyday practice. The first note is 249 words and the second is 224 words. Also, a lot of the information that the CNA included is not important in terms of communicating the vital facts about the patient to other staff members, which is the purpose of documentation.

The specific reasons why the examples above are *not* good notes relate to aspects of patient preparation, observation and performance.

Patient Preparation

Patient preparation before a procedure is important but a CNA cannot perform catheter care if the area is under the blankets and covered by a gown, so writing "I removed the bedding and lifted the patient's gown in order to expose the area" is not needed.

Observations

Other clinicians who may read a CNA note of patient care knows what to look for related to performance of catheter care, *i.e.*, abnormalities around the insertion site, color and appearance of the urine, and the proper positioning of the collecting system. If a CNA has been assigned to do catheter care, it can be assumed by other healthcare professionals that the CNA knows what is normal and what is abnormal, and the CNA would write the note on catheter care accordingly.

Performance

Anyone reading a CNA's note may assume that the CNA is an experienced healthcare worker and has been assigned to perform catheter care because the CNA knows how to do such a procedure. Other medical professionals can also assume that the CNA understands proper handwashing and hazardous waste disposal protocol, so it is not necessary to document every single step of what was done when the CNA was performing the procedure, in this case catheter care.

When a CNA is documenting patient care, he or she must simply keep in mind the *reason for why documentation is being done* and should therefore not need to be burdened by the concern of "not documented, not done."

The following examples help to elucidate a better way to write notes for the two scenarios that were raised above. If these examples are followed, the documentation would take much less time and anyone reading the notes would have all of the information needed.

Example 1:

“Catheter care was performed at 13:00 hours. The patient tolerated the procedure well. No abnormalities were noted at the catheter insertion site, nothing abnormal was noted in the urine, and all parts of the system were properly positioned. The patient’s call light was left within reach.”

Example 2:

“Mr. F’s temperature at 12:00 was 100.9. All other vital signs were normal. The patient had normal skin color and temperature, no diaphoresis noted, and the patient had no complaints. S.L., nursing supervisor, was notified at 12:15 of the patient’s elevated body temperature.”

In contrast the earlier examples, these notes are quick, simple and easy to understand, and they are also complete. The first example is 45 words and the second example is 43. Everything that is important in terms of patient care has been included and nothing that is unessential is entered into the documentation.

Guiding Principles Of Patient Care Documentation

The primary reason that documentation is important is to ensure good patient care. This was mentioned in the introduction but is worth further emphasis here. The patient’s medical record is the only place where all of the important information about that person’s care can be found. The medical record is where health professionals communicate to each other about a patient’s condition and what has been done for the patient. So the goal of documentation is to produce a clear, concise, and accurate document that allows everyone involved in the

care of a patient to know what has happened, what is planned, and what needs to be done.

Documentation on the medical record clearly helps to ensure good patient care but there are specific reasons why this is true. Whenever a CNA is documenting a patient's medical record, the following points must be kept in mind. Remember that good documentation leads to complete records that will avoid medical errors, such as dangerous duplications of treatment, or an omission of necessary treatment. This will lead to good care and will help the CNA avoid liability issues.

Dangerous Duplication

If someone does not document that a medication has been given or someone does not document that a treatment or a therapy has been performed, it is possible that the medication could be given twice or the treatment or therapy could be repeated - and this could be dangerous.

Example:

A CNA is assisting a patient for a walk of a specific distance down the hall as part of the patient's post-operative rehabilitation after knee surgery. Midway through the walk, the patient becomes very weak and tired and despite every best effort, falls to the floor, hitting the surgical knee. The suture line breaks open. The CNA finds out later that another CNA, trying to be helpful, had gotten the patient up and walking just one hour ago but the other CNA did not document the event. The patient did not mention to the CNA that someone had already walked him or her just an hour before. A CNA cannot depend on the patient to inform the CNA of duplication of a medical treatment

or patient care intervention. Generally, patients will assume that the health staff are doing their jobs correctly.

Dangerous Omissions

It can be just as serious to document something that has not been done. It may seem, at times, efficient to document a task that you are going to do but this is never correct. It is also very important that all observations of patient care outcomes are documented. The care that a patient receives will often depend on what is observed.

Example:

The CNA is assigned to irrigate a patient's PEG (**P**ercutaneous **E**ndoscopic **G**astrostomy) tube. A PEG tube is a short, soft rubber tube that is inserted through the wall of the abdomen into the stomach. It is used to deliver food and medications to patients that cannot swallow. PEG tubes must be irrigated periodically with water or saline so that they do not become clogged. The CNA working the 7 am - 3 pm shift decided to document that irrigation of the patient's PEG tube was done *before* actually performing the task in an effort to save time but then forgot to do the irrigation.

The CNA arriving on the next shift reads the patient's medical record and sees that according to the CNA who worked the previous shift, the PEG tube was irrigated at 12:00 hours. That is what was documented so the CNA reading the care note waits until 20:00 hours to perform the scheduled irrigation. However, at this point the PEG tube has actually not been irrigated for 16 hours and has become clogged, and cannot be cleared; consequently, the PEG tube has to be removed and replaced. PEG tube removal and replacement is relatively simple but the replacement should not have been needed and because of this

erroneous documentation the patient missed receiving PEG tube feedings and some scheduled medications.

Liability

A CNA may be a very good and conscientious caregiver but if for some reason there is legal action involving a patient's care, the courts are far more inclined to believe a written record of what was done than what the CNA remembers. If there is no documentation that something was done or there is no documentation that something has happened, the courts will likely conclude that the event did not occur, or the care was not provided.

Safe and Appropriate Patient Care Documentation

Documenting patient care correctly is not difficult but it does require some training and conscientious, consistent effort. Three key aspects of proper documentation are timeliness, accuracy and objectivity.

Timeliness

In a perfect world, a CNA would be able to document everything right away or shortly afterwards but a CNA's job can get extremely busy, and it is not unusual for CNAs to wait many hours after an event to document what they did or observed. Each workplace will have different rules pertaining to documentation but if a CNA finds that he or she is documenting something hours after the fact, notation should be made that clearly indicates a late entry was made.

Example:

"Late Entry, 18:00 hours, 11/15/2009. Assisted patient in range of motions exercises of the hips and knees, left and right hips and knees, 10 flexions and extensions, at 15:00, 11/15/2009." However, the

longer the CNA waits between “doing and documenting,” the greater the risk that he or she will forget to document or will forget something that is important to document. *This last point is very important.*

Accuracy

It seems obvious that accuracy is a very important part of good documentation. Nonetheless, mistakes can be made when documenting patient care. It pays to always review patient care notes before entering them in order to make sure they are correct and complete. When documenting a patient’s health record, all health team members should make sure that everything is spelled correctly, especially words that may sound alike but are actually very different. Patient notes should include numbers or figures such as body temperature, pulse, the amount of urine emptied from a collection bag, *etc.*, and that the numbers are correct. These points are quite simple but making a seemingly small mistake can have consequences.

Example:

A CNA documents that the patient seemed to have left leg pain while being assisted from the bed to a chair but the pain was actually in the right leg. The physician examines the patient’s left leg based on the erroneous documentation and concludes that there is nothing wrong and misses diagnosing a right leg blood clot.

Example:

A CNA documents that from 10:00 to 14:00 hours there was 25 cc of urine in the patient’s collection bag but had meant to write 250 cc. In response to that the RN increased the infusion rate of the patient’s

intravenous (IV) infusion and notified the MD, who ordered several unnecessary laboratory tests and medication.

The CNA should always review patient care notes after writing them. Imagine a CNA who wrote a long, comprehensive, and very well done entry in a patient's chart; everything in the note was done perfectly, except that the note was written on the *wrong* chart. This may sound unlikely; however, it happens more often than one would want to believe. Reviewing patient care notes upon completion of writing them should always be done because it can be very easy to make mistakes or forget something.

Accuracy is especially important when a CNA is documenting what a patient says. It can be difficult to remember the word-for-word details of what someone said but if it is important the CNA should make a good faith effort to do so. The key to safe and appropriate patient care documentation is to use professional judgment. A CNA cannot be expected to write down everything that was said verbatim. A CNA does need to assess each situation and determine what is important and document it.

Objectivity

What does it mean to be objective when documenting patient care? It is important to document what is objectively seen, measured, *etc.* This means that another person providing the same patient care would see and note the same information. Objectivity excludes personal opinions. It is very important to avoid documenting one's opinions about patient care outcomes. Whatever is written down should be factual. Not only will being objective help with a patient's care, it can protect the CNA, as well.

Imagine if someone documented that they thought “a patient was intoxicated” but did not provide any objective data to support this observation. Being objective also includes avoiding humorous, judgmental, or profane comments.

Example:

A CNA who was previously caring for a patient documented: *“Surgical dressing of incision site changed. Patient was whining and crying during the procedure. Dressing change completed without difficulty.”*

There are several reasons why this is bad documentation. First, the word “whining” is demeaning and it serves no purpose for patient care. Also, stating that someone is whining is a value judgment, not a fact. If someone perceives that a patient is whining it is likely that the patient was experiencing discomfort or pain, and it is the responsibility of the CNA to find out if this is true. If there was an indication that the patient was experiencing pain or discomfort during a procedure, the CNA should write down what was noticed that made the CNA arrive at such a conclusion. The CNA should try to have the patient explain why he or she was in pain and how much pain was being experienced.

Second, there is nothing in the note about the condition of the incision site or the presence or absence of any drainage, or whether or not there was blood or pus on the dressing.

Third, there is no documentation of where the surgical dressing is; the patient could have more than one.

An alternative, more appropriate and accurate way to write a note documenting care for the above scenario would be as follows:

On 13:00 hours, 12/25/2009: *"Patient was noted to be sweating, grimacing, and gripping bedclothes tightly during change of surgical dressing on right knee. When asked, patient stated that he was experiencing pain when surgical dressing was changed. When asked, patient stated that the pain was at a level of 7 on a scale of 1 to 10. There was redness and swelling that extended approximately 3 centimeters out from the incision on all sides. No drainage or blood was observed at the incision site or on the dressing. New dressing applied. John Doe, RN notified of patient's discomfort at 13:30. Jane Doe, CNA."*

Other aspects of documentation that are important are outlined below.

- Use approved abbreviations:
Abbreviations are very useful. They save time and allow for clear and accurate communication. Any institution that a CNA works in will have – or should have – a list of approved abbreviations, and those are the *only* ones the CNA should use.
- Never document for someone else:
It may seem like a nice thing to do, especially if a co-worker is very busy and appears to need help but a CNA should only document what he or she actually sees or does.
- Never change what has been written:
Electronic records are becoming the standard everywhere, but if a CNA is still writing care notes on paper, he or she should never attempt to change a note after it has been written. If a clinician

makes a mistake, *do not use erasers, do not use correction fluids, and do not cross out a note and write over it.* The health institution should have a policy in place that can inform how to correct a written mistake. The CNA should ask the nurse manager or supervisor about questions of policy related to editing a patient care note. By example, an institution may have a policy that it is acceptable to cross out an incorrect note with a single line, write "Error" immediately after the note, and then enter the date, the time, and initial next to edition.

If a note on a medical record has been altered, this can raise a concern about the truthfulness of the documentation and the honesty of whoever has made the change. If there is legal action, it would be almost impossible to defend against suspicions of dishonesty with documentation and that there was something to hide.

- Document important conversations with other CNAs, nurses, physicians, and healthcare professionals:
A CNA may observe something crucial about a patient he or she cared for before. Perhaps a patient informs the CNA that a certain medication was causing uncomfortable side effects, or perhaps the CNA notes that the patient's temperature was elevated. Naturally, the CNA would relay this information to a nurse or a physician. Is it enough that the CNA simply tells someone? It is not enough. Although the CNA should certainly mention important issues to the RN or MD, the first rule of documentation (if it wasn't documented, it wasn't done) should be followed. This is especially important when it involves what

the CNA communicated to someone else. A person may later deny that they were told important information about a patient's condition, especially when the patient's condition may have worsened. In other instances, the person may simply forget what was said or not remember what was said correctly.

It was mentioned before that it can be difficult to remember word-for-word details of what someone communicated or what was said to another person. But if the conversation was important, the CNA should make a good faith effort and use professional judgment when deciding what to document.

While these recommendations appear to be a lot, after a little practice, good documentation becomes easy and is not as time-consuming. The CNA can break down and simplify the process by remembering the four basic "dos" and three basic "don'ts" of documentation.

The Four Basic Dos-

1. *Do* be objective.
2. *Do* be complete.
3. *Do* be accurate.
4. *Do* be timely.

The Three Basic Don't-

1. *Don't* be subjective.
2. *Don't* change an entry after it has been written.
3. *Don't* document for someone else.

What Is Appropriate Documentation?

The CNA will be spending a lot of time with patients, perhaps more time than anyone else, so documentation of patient care is very important. It has already been stressed that a good CNA will document everything that is important. But what exactly does that mean? The following lists what the CNA may be entering in a patient's chart.

- Level of consciousness
- Temperature, blood pressure, heart rate, and respiratory rate
- Fluid intake
- Urinary output
- Bowel elimination patterns
- Food intake
- Color and condition of the patient's skin
- Important things that the patient says or does
- Important conversations with other members of the healthcare team
- Height and weight
- Therapeutic activities that have been performed. These could include range of motion exercises, assisting the patient to ambulate, application of cold compresses or hot packs, urinary catheter care, bandage changes, turning and positioning patients who are confined to bed, and many other activities.
- The patient's response to those therapeutic activities.

Good and Bad Examples of Documentation

Example of Bad Documentation: Patient Ambulation

"Got patient OOB this am. Patient seemed very unhappy; I don't know why. Walked short distance and patient was complaining. Returned to bed."

First, OOB (referring to **O**ut **O**f **B**ed) may or may not be an approved abbreviation. Writing an opinion, that “Patient seemed very unhappy,” without providing some evidence of this conclusion is incorrect and it is not objective. The CNA also made himself or herself look careless by admitting - through lack of documentation - that there was no attempt to find out why the patient was uncooperative.

The distance and the amount of time the patient walked was not recorded; instead the CNA recorded an opinion that the distance was “short.” The patient’s complaints were not documented: What did he say? What was he complaining of? There was no mention of the quality of the patient’s gait. There was no documentation of when all of this happened, the note was not signed, and if someone was notified about the patient’s complaints, what was reported and to whom it was reported cannot be determined from the note. The note is not accurate, complete, or objective.

Example of Good Documentation: Patient Ambulation

“11:00, 12/25/2009. Assisted patient out of bed. Patient stated that he did not want to ambulate as he was tired and he was afraid to get out of bed so soon after his hip surgery. I advised patient that T.I.D. ambulation was ordered by his physician, and that he would not be expected to ambulate if it was too painful/tiring. Helped patient walk from entrance of room to end of hall and back several times, total time 10 minutes. During this time, patient complained again of feeling tired and of pain in his right hip. The patient reported the pain to be 3 on a scale of 1-10. Offered patient the option of stopping ambulation, but he declined and stated the pain was tolerable and less than the pain experienced during ambulation the previous day. No abnormalities of

gait were observed. The patient's blood pressure and pulse were checked immediately before and after ambulation: normal on both occasions. Surgical incision line was inspected before and after ambulation; no abnormalities noted. Returned patient to bed at 11:10. Advised Jane Roe, RN, of patient's fear of ambulation and his complaints of pain in right hip. Jane Doe, CNA."

The above patient care note is accurate, complete, and objective.

Example of Bad Documentation: PEG Tube Irrigation

"PEG irrigation performed at 13:00. Approximately 300 cc was put through the tube. It does not appear as if the CNA from the previous shift had irrigated the tube. RN notified."

The problem with writing "approximately" when performing a procedure is obvious. PEG tube irrigation is not a procedure that requires an extremely high level of precision but the amount that is instilled should be measured to the cc and this is simple to do. In addition, the CNA would never irrigate a PEG tube with 300 cc. The CNA certainly meant to write 30 cc but added an extra zero and did not review the note before entering it.

There was no documentation about the position of the PEG tube or what the skin around the PEG tube insertion looked like and this is always important to note. It is not known if the patient tolerated the procedure because this information was not included. The CNA wrote that the CNA who worked previously did not irrigate the PEG tube, but what is that observation based on? Finally, an RN was notified: Who was the RN, when was the RN notified, and what was she or he told?

Example of Good Documentation: PEG Tube Irrigation

“PEG irrigation performed at 13:00. The PEG tube was noted to be in the proper position, the skin and the area around the insertion site appeared normal. 30 cc of water instilled through the tube; there was a slight resistance to the instillation when the procedure was started. The patient appeared comfortable during the procedure and he had no complaints. Jane Doe, RN, notified at 13:20 of the difficulty in initiating the PEG tube irrigation.”

The above patient care note is accurate, complete, and objective.

Summary

All of the important information and events that pertain to patient care must be recorded on the patient’s medical record. The patient’s medical record is the only place where all of the important information about the patient can be found.

Some clinicians begin with the idea *“if it isn’t documented, it wasn’t done.”* It embodies the principle that without accurate documentation a patient intervention cannot be said to have occurred. While the phrase *“if it wasn’t documented, it wasn’t done”* is often stressed, if clinicians consider everything important, and document everything, documentation would be a never-ending task. With regard to documentation, use professional judgment should be used about what to include and what to leave out.

For patients to receive the best care possible, all of the information on the medical record must be properly documented. Key aspects of proper documentation should be observed such as timeliness, accuracy and objectivity.