CAVALLUZZO

DOCUMENTATION ISSUES AT THE COLLEGE OF NURSES OF ONTARIO:

Avoiding Scrutiny From Your Regulator

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College of Nurses Practice Standard: Documentation, Revised 2008

- *A nurse meets the standard by ensuring that documentation is a complete record of nursing care provided…*

Overview

Most important point in College proceedings:

- The "complete record" assists you in defending your care.
- College proceedings tend not to be focused on minor documentation errors but instead falsification or substantive issues with care.

What is the College Standard?

1. Where can you find the standard?
   - www.cno.org →Learn about the Standards & Guidelines →Documents List→Documentation, Revised 2008
   - Already revised twice – keep abreast of changes
   - eg technology

2. What is in the standard?

- The standard covers three principles relevant to documentation:

a) Communication

b) Accountability

c) Security

A. Communication

A nurse meets the standard by ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process…

What does this mean?

- err on the side of documenting -- the more you document about what you've done or what has occurred, the more easily you can prove it

Communication, cont'd

- document significant communication with family members/significant others, substitute decision-makers and other care providers
- ensure that relevant client care information kept in temporary hard copy documents (such as kardex, shift report or communication books) is captured in the permanent health record
- documenting informed consent when the nurse initiates a treatment or intervention authorized in legislation
- advocating for clear documentation policies and procedures that are consistent with the College's practice standards

B. Accountability

- documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event
- indicating when an entry is late as defined by organizational policies
- ensuring that documentation is completed by the individual who performed the action or observed the event, except when there is a designated recorder

C. Security

- maintaining confidentiality of client health information, including passwords or information required to access the client health record
- accessing only information for which the nurse has a professional need to provide care
- maintaining the confidentiality of other clients by using initials or codes when referring to another client in a client's health record (for example, roommate)
- understanding and adhering to policies, standards and legislation related to confidentiality

College Process

- Members come to attention of College by complaints or reports
- Professional Misconduct includes "contravening a standard of practice of the profession or failing to meet the standard of practice of the profession".
- Generally complaints and reports are not made due to documentation alone
- Documentation can be part of it and, in any event, helps you defend yourself

College's Investigation

- You will respond to allegations against you using the client chart
- Your documentation is how you present your story

Typical Example

- **Complaint:** The Member did not provide one-on-one care to the client, as was the policy in the Critical Care Unit. The family had difficulty locating the member and she would disappear for significant periods of time.
- **Response:** A review of the Member's charting shows how closely she was attending to the client. The Member charted on the client at 0800, 0900, 1000, 1100, 1145, 1320, 1530, 1730, 1800, 1900 and 1930.

Examples of Documentation Gone Wrong

Example A

- The Member wrote on the client's worksheet "designed a time machine, got wasted on mushrooms, beat up [X] and got stoned with [Y] on pot!..."
- This was intended as a joke for the charge nurse coming on shift and member planned to delete the information immediately thereafter.
- Member admits this was professional misconduct in failing to meet the standard of practice of the profession and also that he engaged in conduct that having regard to all of the circumstances would reasonably be regarded as dishonourable and unprofessional.

Examples of Documentation Gone Wrong, cont'd

Example B

- Client in special care home had history of behavioural symptoms such as wandering, socially inappropriate behaviour, agitation and aggression.
- Client was exhibiting some difficult behaviours, including reaching around the member from behind to try to grab her phone.
- Member tried to move away and client continually trying to grab.
- Member forcefully pushed client away – both fell on the floor and the Member was holding the client down.

Examples of Documentation Gone Wrong, cont'd

- Member charted the incident but failed to chart that she has pushed the client and restrained him on the floor.
- She admitted to committing an act of professional misconduct in that she failed to accurately and adequately document her interactions with the client.

Examples of Documentation Gone Wrong, cont'd

Example C

- Obstetrician, Dr. R., saw client in hospital on October 12 due to client's concerns that baby not moving.
- Two days later a c-section was performed and baby was born without a heartbeat.
- Dr. R. did not chart October 12 visit until three weeks later.

Examples of Documentation Gone Wrong, cont'd

- Dr. R claimed that she advised the client to follow up with her obstetrician the following day to arrange a biophysical score.
- "Concerning her documentation of the patient's case, Dr. R. acknowledged that she was several weeks late in completing it. She stated that she simply forgot to make the note at the time of the examination, but added that the contents of the note were accurate."

Examples of Documentation Gone Wrong, cont'd

- "In the usual circumstances, a physician's notes would provide contemporaneous information that would shed light on the circumstances, but in this case, Dr. R.'s notes were not made until November 4, and by this time, she was aware of the tragic outcome of the case."
- "The complaint concerning Dr. R. is not simply that she failed to chart the October 12, 2009 visit. It is that she did not advise the Applicant and the patient to arrange a biophysical profile with the patient's obstetrician and that her late chart note is not an accurate record of what transpired."

Examples of Documentation Gone Wrong, cont'd

Lessons about charting from this case:

- Dr. R. could not prove that she advised a biophysical score
- Dr. R. was considered to have falsified the chart
- When is a late entry too late?

Conclusions

- The College will be most concerned with intentional misconduct around documentation.
- But, document fully and accurately to protect yourself!