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Ask a Practice Consultant About Documentation

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QUESTION:

I work in a long-term care facility where documentation is done twice a week on flow sheets. Other than the flow sheet we only document "by exception." In other words we only write a note on the integrated progress note if there is something unusual to report. A nurse recently hired at our facility has been questioning this practice and has been documenting each shift on most of her patients in the progress notes. Is there something wrong with the way we have been documenting?

ANSWER:

The CRNM nursing practice consultants are frequently asked questions about documentation in specialized settings. The good news is the basic principles of documentation hold true across all care settings. The patient record should paint a clear picture of what happened to the patient from the time they entered the system/facility until the time they left. While flow sheets can provide a quick overview of the resident, and act as a checklist for activities of daily living and treatments, details of the condition of the resident and care provided can be missed.

In long-term care settings changes to a resident's condition can be subtle and may not seem important on one shift. However, when viewed over several shifts or days the changes can be substantive. For this reason, in long-term care it is also important to complete and document admission and baseline assessments.

If nothing was documented it would be assumed that no nursing assessments or interventions occurred. The Canadian Nurses Protective Society document *Quality Documentation: Your Best Defence* states "Omissions will generally work against you unless there is other credible evidence to demonstrate that your nursing care was indeed given."

The type or format of the documentation does not matter, whether it is narrative or a format like subjective objective assessment plan (SOAP). Rather it is the quality of the documentation that is important. Nursing documentation should be a reflection of the standards of practice and the nursing process. There should be evidence of critical thinking reflected in the

documentation and evidence of assessment of the client and the response to problems or health promotion needs. The documentation should provide evidence of nursing interventions with a client-centered focus and evidence of assisting clients to make knowledgeable decisions. The focus or plan of care should be evident and the documentation should include an evaluation of the interventions and revisions to the plan.

While flow charts and charting by exception have the potential to reduce the amount of documentation, there are risks to patient safety. For example, if a nurse writes "no change" in a check box for a wound, there is no evidence of a wound assessment and critical thinking. If the wound did not change, why is it not improving? Who was notified? Was the plan of care altered?

In summary, the documentation system should be user-friendly and avoid duplication; however, it should be integrated in such a way that patient safety is the focus.

Resources

- Contact a practice consultant for information or support at 774-3477 or visit www.crnmb.ca/resources-askapracticeconsultant.php
- CRNM documents available on the web www.crnmb.ca
 - *Documentation*
 - *Documentation System Requirements*
 - *Standards of Practice for Registered Nurses*
- Canadian Nurses Protective Society documents available at www.cnps.ca
 - *infoLAW: Quality Documentation: Your Best Defence*