



DOCUMENTATION FOR CERTIFIED NURSING ASSISTANTS

Introduction

Documentation for CNAs in our Center is an important aspect of providing care to our residents. Medical records are not only used as an important communication tool for the healthcare team but they are also used by the licensing agency, insurance companies, attorneys and families to assess the care that is provided to your patients. Documentation that is accurate and complete is a key to demonstrating the care provided to our patients.

Learning Objectives

1. Discuss the purposes of documentation.
2. List 3 charting tips to assure documentation is accurate and correct.
3. List 3 legal aspects of charting.
4. Describe the licensed nurse's role in CNA charting.
5. Explain the importance of using proper spelling and grammar when documenting.

MEDICAL RECORDS ARE LEGAL DOCUMENTS

Medical records are Legal records that must be documented very carefully.

Medical records tell the story of the patient's care. Important parts of that story include:

- *What care was given.*
- *Who was on the health care team.*
- *How the patient responded to the care.*

OUR CENTER'S GOAL IS FOR CNA DOCUMENTS TO BE:

- complete;
- accurate;
- timely;
- legal; and
- professional

100% of the time.

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DOCUMENTATION MUST BE COMPLETE

At our Center, we strive to make documentation efficient for our staff. For that reason, we have created charts to guide some of the documentation. You may know these documents as “ADL” or “CNA” charts or graphs.

It is important that the information on those forms is complete. Each day you provide care to a patient, you need to complete the record for the care you provided. There should be an entry for every blank on the form. If a particular type of care does not apply to your patient, you need to indicate “N/A” or not applicable. For example, if the form asks for restraints and your patient is independent without restraints, you need to write “N/A”.

The pre-printed forms are just a start. It is important that you know what else needs to be documented. For example, a patient’s refusal for any care needs to be documented. Usually, the place for this documentation is on the back of the pre-printed “ADL” or “CNA” form.

If you notice a change in the patient’s condition you need to document it and tell the charge nurse. For example, if you are turning and repositioning your patient and note an area of redness on the left hip, you document, “Redness noted on left hip the size of a quarter when turned to right side with turning and repositioning. Told charge nurse.”

DOCUMENTATION MUST BE ACCURATE

All entries in the chart must be correct. That means if you took the patient's temperature at 11:00 a.m., you note what it was at 11:00 a.m., not 7:00 a.m. If that temperature was 99.2 you should write that it was 99.2 and not 99.

It is easy to get distracted when charting and to doubt yourself if your entry is not the same as prior entries. Do not simply copy down the prior entry. You must chart your own observations and care given. If the patient was turned and repositioned on your shift, you document it, even if the prior shift indicates it was not.

(insert example graphic)

You may document only the care you provide. You may not document care provided by your team members.

You may not document that you provided care that you did not or that you saw, heard or felt things that you did not experience.

You should not make judgments about your patient or their family in your chart. You should not say that a patient is acting crazy. Instead, you should document their behavior.

Example:

Incorrect: "Joe is acting crazy today."

Correct: "Joe is talking about going to the store and shaking his fist in writer's face."

Correct: "Joe states he 'feels crazy' today. He is pacing in his room with his shoes and jacket on."

DOCUMENTATION MUST BE TIMELY

Documentation must be done on time. You must document as soon as possible after you have provided care or observed something that needs to be in the patient's record.

Medical records are an important communication tool for care providers. If important information is not in the medical record, it is not available to others who need it.

It is easy to get busy and forget to do your charting. Your memory about the care provided will never be as good as when you provided it. Do you remember what you had for breakfast last week on Wednesday or how many traffic lights were red on your way home from work? You perform many tasks throughout each and every day and it is not possible to remember them all. Do not put your charting off. It must be done timely.

Some documentation is designed to capture the care provided during an entire shift. It is important that the entries you make are accurate for that shift and that you make those entries at the end of that shift.

You may never chart care that you intend to perform in the future. That practice is unacceptable and against the law.

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DOCUMENTATION TIPS

1. Chart in the **RIGHT** chart.
2. Write neatly and **LEGIBLY** with blue or black ink.
3. Provide **ALL** significant details.
4. Chart **ALL** changes of conditions and report to the charge nurse.
5. If checking boxes on a form, make certain they are **ACCURATE**.
6. Sign and date **EVERY** entry.
7. Use only **AUTHORIZED** abbreviations.
8. Make certain patient's name is on **EVERY** page.
9. Correct an error by drawing a single line through the error and chart your initials (No erasing, blacking out or white out.)
10. Do **NOT** document "Incident Report Completed".
11. **AVOID** tattling and finger pointing.

SAMPLES OF INACCURATE DOCUMENTATION

The following are true examples of charting errors noted in CNA flow sheets:

- Patient ambulating (is comatose).
- Patient incontinent (Foley catheter in place).
- Patient showered (is at hospital).
- Patient is turned and repositioned (patient expired).
- Heels floated (patient had amputation).

WHEN COMPLETING FORMS, NOTES AND OTHER RECORDS

Record your full name, credentials and job title in the appropriate section on forms. Your signature must be in cursive. Take the time to sign your name legibly.

More Charting Tips

Document the resident's refusals for interventions including treatment, medication, therapy, splinting, eating, toileting, repositioning, etc. Report refusals to the charge nurse.

Chart as soon as possible after giving care.

Include important information remembered later as a "late entry", noting the date and time of the late entry.

If information on a pre-printed form does not apply to your client, write NA for "not applicable" rather than leaving it blank.

NEVER chart ahead of time.

DO NOT record staffing problems or conflicts.

NEVER chart care that was not done.

Fill in the lines or spaces. Do not leave extra lines without drawing a single line to prevent charting by someone else.

NEVER alter a resident's record. Do not squeeze information in at a later date. Do a proper "late entry." Do not date an entry so it appears it was written at an earlier time. Do not add inaccurate information. Do not re-write records or destroy records.

DO NOT use shorthand or abbreviations that are not approved.

DO NOT chart what someone else said, heard, felt or smelled unless the information is critical and then, use quotations and give credit to the individual who experienced it.

DO NOT CHART OPINIONS or SPECULATION.

DO NOT use language that suggests a negative attitude towards the resident, family or another health care worker.

DO NOT write in the margins.

DO NOT chart words associated with errors like "accidentally", "unintentionally", "miscalculated," "by mistake".

DO NOT put other resident's name in the charting of this resident. Use initials or room and bed number.

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Post Test

Question 1

All of the following **basic** information should be included in chart entries *except*:

- A. the date
- B. the time
- C. your name and title
- D. the patient's admission date

Question 2

Which of the follow is a false statement?

- A. You should document that an incident or accident report was completed
- B. Do not use "white out" or erase if you make a mistake
- C. Reasons care was not given should be documented
- D. Document ahead of time is not allowed.

Question 3

If you fail to char in the box on the flow sheet next to the word "Breakfast" then it may be presumed that:

- A. The resident was not given breakfast.
- B. The resident only ate 50% of his breakfast
- C. The resident received breakfast but ate nothing.
- D. The resident refused breakfast.

Question 4

Neither the CNA nor the licensed nurse should document when a resident refuses care.

- A. True
- B. False, both should document refusals
- C. False, only licensed nurses document refusals
- D. False, only CNAs document refusals

Question 5

When you later remember important information to be charted you should

- A. consider it unimportant since you did not remember it earlier
- B. Go back and write when you forgot in the margin of the page when you already documented
- C. document it tomorrow using the notation "late entry" along with the time and time you are writing it.
- D. call your place of employment and ask someone else to document it for you since you aren't there to do it yourself

Question 6

Charting care that has not been given is against the law.

- A. True
- B. False

Question 7

To save time when you are extremely busy, you should document care on everyone before you provide care to everyone.

- A. True
- B. False