Managing and Evaluating Students in Clinical Settings: Documentation

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1

OBJECTIVES

1. Explain the importance of student documentation in the clinical setting.
2. Discuss the student responsibilities for documenting in the clinical setting.
3. Describe principles of legally defensible and ethical documentation.
4. Describe principles of legally defensible and ethical documentation.
5. Develop strategies to teach students clinical documentation in all learning settings (classroom, lab, simulation, clinical).
6. Delineate appropriate faculty feedback for student documentation.
7. Describe principles of legally defensible documentation of clinical incidents and clinical failures.

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LET'S BEGIN WITH THE END IN MIND

- What documentation skills should students from your program have upon graduation? (THINK-PAIR-SHARE)
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NCLEX TEST PLAN

- 5 Integrated Processes
  - Communication and Documentation
  - How many tasks are on the NCLEX Detailed Test Plan? (WEBSITE REVIEW)

3

21

8

18

11

10

15

HOW DO WE IMPRESS UPON STUDENTS THE IMPORTANCE OF DOCUMENTATION IN THE CLINICAL SETTING?

WE BEGIN IN FOUNDATIONS/FUNDAMENTALS

- FOUNDATIONS/FUNDAMENTALS
  - Standards-based documentation
    - ANA Standards of Practice
    - The Joint Commission
    - HIPAA/Protected Health Record (PHI)
    - IOM
    - QSEN
    - Policies and Procedures (institution's legal standards)
    - Personal stories of medical errors
      - Josie King
      - Sue Sheridan

ANA STANDARDS OF PRACTICE

- ASSESSMENT
  - Collects comprehensive data…in a systematic and ongoing manner…
  - Documents relevant data in a retrievable format
- DIAGNOSIS
  - Documents diagnoses or issues in a manner that facilitates the determination of expected outcomes and plan
- OUTCOMES
  - Documents expected outcomes as measureable goals
- PLANNING
  - Documents the plan in a manner that uses standardized language or recognized terminology
- IMPLEMENTATION
  - Documents implementation and any modifications, including changes or omissions, of the identified plan
- EVALUATION
  - Documents results of evaluation

(ANA, 2010)

THE JOINT COMMISSION

- Collects and analyzes data related to seminal events
  - Oral, written, and electronic communication leading root cause of sentinel events
- National Patient Safety Goals
  - Developed to focus on frequently occurring seminal events
  - NPSG: use at least 2 ways to identify patient
  - NPSG: Record and pass along information about patients medications
  - http://www.jointcommission.org/standards_information/npsgs.aspx

HIPAA AND PERSONAL HEALTH INFORMATION (PHI)

- HIPAA (ATI Skills Module: HIPAA)
  - Protects privacy and security of patient information
- Personal Health Information (PHI)
  - Maintaining integrity of patient data
  - Maintaining confidentiality of patient data
  - Restricts access to patient information
  - Electronic signatures, passwords, encryption

TEACHING TOOL: Skills Module: HIPAA

TEACHING TOOL: Skills Modules have practice challenges that evaluate student learning and application of content

IOM

- IOM Report (1999), To Err is Human
  - 98,000 patients die per year due to medical error

  (A STUDY DONE IN 2013 FOUND THAT HOW MANY DEATHS PER YEAR ARE DUE TO MEDICAL ERRORS?)
- James (2013), A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care
  - >_____ patients die per year due to medical errors
  - http://www.ncbi.nlm.nih.gov/pubmed/2386019
- IOM Report (2003), Health Professions Education Report: A Bridge to Quality
  - 5 core competencies for health professionals

    Provide patient-centered care
    Work in interdisciplinary teams
    Employ evidence-based practice
    Apply quality improvement
    Utilize informatics

QSEN

Clean, accurate and accessible documentation is an essential element of safe, quality, evidence-based nursing practice.

(ANA, 2010)

QSEN

Quality and Safety Education for Nurses

http://qsen.org/

(WEBSITE REVIEW)

INSTITUTIONAL POLICIES AND PROCEDURES

- Sets standards of practice for institution
- Reflects federal, state, and local laws
- Accreditation standards

- Healthcare quality organization recommendations
- Critical to familiarize self with unit's policies and procedures
- Supports legally defensible documentation

JOSIE KING STORY / SUE SHERIDAN (TeamSTEPPS)

- Josie King Story – YouTube; QSEN
  - Lost 18 month child recovering from burns to medical errors
  - https://www.youtube.com/watch?v=Mp8Kq3ajv3w
- Sue Sheridan – YouTube; TeamSTEPPS
  - Healthy newborn son
    - Kernicterus was not treated due to medical errors
    - Now lives with multiple handicaps
  - Husband
    - Tumor removed from spine was not identified as malignant due to medical errors
    - Malignancy was discovered 6 months later after metastasized
    - Died 9 months later
    - https://www.youtube.com/watch?v=Hgug-ShbqDs

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HOW DO WE TEACH STUDENTS THEIR RESPONSIBILITIES FOR DOCUMENTING PATIENT CARE?

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DOCUMENTATION: TWO TENETS TO LIVE BY

IF IT ISN'T CHARTED…. IT WASN'T DONE

DOCUMENTATION" PRINCIPLES OF CHARTING

- Chart holds the record of patient care
  - Legal
  - Confidential (TEACHING TOOL – Media Library: Confidentiality)
  - Permanent
  - Clear, concise, complete
  - Legible

  TEACHING TOOL - Fundamentals Review Module - Information Technology; Media Library)

- Charting maintains a record of:
  - Patient assessment data / changes in condition / trends
  - Medications administered
  - Treatments given and patient's response
  - Patient education

DOCUMENTATION" PRINCIPLES OF CHARTING

- Types of charting
  - SOAP (subjective, objective, assessment/analysis, plan)
    - Organizes charting
    - May or may not include "acronym" (S-O-A-P)
  - PIE (problem, intervention, evaluation)
    - Assessment (found on flow sheets) not included on narrative – decreases duplication of charting
    - Problems may be numbered
  - DAR (data, action, response) used in focus charting
    - Focus is nursing diagnosis, patient concern, change in condition
    - Charting follows nursing process
- Medical Terminology
- Military time

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DOCUMENTATION" PRINCIPLES OF CHARTING

- Approved abbreviations
  - Institution specific (policy/procedure manual)
  - Official "Do Not Use" List of Abbreviations (TJC)
    - EXAMPLE: IU – Mistaken for IV or 10 – write out "International Unit"

    COMPLETE "DO NOT USE" TABLE
    http://www.jointcommission.org/facts_about_do_not_use_list/
  - List of Error-Prone Abbreviations (Institute for Safe Medication Administration – ISMH)
    - Avoid using these abbreviations

    http://www.ismp.org/Tools/errorproneabbreviations.pdf
    CHANGE ABBREVIATIONS TO ACCECPTABLE TERMS
  - Tall man letters (ISMH)
    - Look-alike drug names

    http://www.ismp.org/Tools/tallmanletters.pdf
    MATCH SELECTED DRUGS SPELLED SIMILARLY

HOW DO WE TEACH STUDENTS THEIR RESPONSIBILITIES FOR DOCUMENTING PATIENT CARE IN THE CLINICAL SETTING?

STUDENT: DOCUMENTING IN CLINICAL SETTING

- Patient assessment
- Individualized patient-centered plan of care
- Medication administration
- Documentation
  - Care provided
  - Client condition/changes in thereof
  - Discharge teaching
  - FACT – factual, accurate, complete, timely
  - EMR/MAR

PATIENT ASSESSMENT: TYPES

What types of assessments must students be taught to complete? (THINK-PAIR-SHARE)

1.

2.

3.

4.

5.

6.

7.

PATIENT ASSESSMENT: STUDENT SKILLS

- What process and resources are used to support development of student's assessment skills?
- TEACHING TOOL – Skills Modules: Physical Assessment – Adult (includes documentation)
- What tools are available to support assessment of assigned patients?
- What methods can faculty use to evaluate student competency?

INDIVIDUALIZED PATIENT-CENTERED PLAN OF CARE

- Nursing Process
  - Evidence-based, individualized, patient-centered plan of care (rubric)
  - Systems Template (rubric)

  TEACHING TOOL: Systems Disorder Template
- Institutional care plans
  - Individualize
  - Interprofessional

MEDICATION ADMINISTRATION

- Medication Administration Record maintains record of medication prescribed, administration schedule,
- Steps of Nursing Process guides safe administration of medications
- Document
  - Assessment data if relevant
  - Dose, route, time, and date
  - Reason if withheld
  - Evaluation of medication effect

TEACHING TOOL: Documentation follows skill presentation in most textbooks

TEACHING TOOL: Skills Modules: Medication Administration 1,2,3,4

TEACHING TOOL: Fundamentals Review Module

DISCHARGE TEACHING

- Begins upon admission
- Ensure continuity of care between healthcare settings
- Includes clients and families/significant others
- Promote communication between health care providers
- Use nursing process as a guide to plan teaching

TEACHING TOOL: Review Module: Admissions, Transfers, Discharge
TEACHING TOOL: Video Library – Discharge Teaching
TEACHING TOOL: Active Learning Template – Systems Disorder

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HOW CAN WE TEACH AND EVALUATE STUDENTS' CLINICAL DOCUMENTATION SKILLS FOR PATIENT CARE SETTINGS (classroom, lab, simulation, clinical)?

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TEACHING DOCUMENTATION

- Classroom
  - Case studies
  - Role play hand off communication including documentation
  - Ticket to Class (Skills Modules Practice Challenges; Review Modules Application Exercises)
  - Patient teaching care plan (classroom, simulation lab, clinical - rubric)
- Skills Lab - Assessment
  - Focused assessment labs with documentation of findings (program assessment tool - rubric)
  - Evaluation of findings and use of correct terminology
  - Head to Toe assessment with summary documentation of findings (program check off document - rubric)
  - TEACHING TOOL: Skills Modules Checklists – Physical Assessment: Adult Head to Toe with Documentation

TEACHING DOCUMENTATION

- Skills Lab – Skills
  - Demonstrate skills
  - Document intervention, patient tolerance, other relevant information

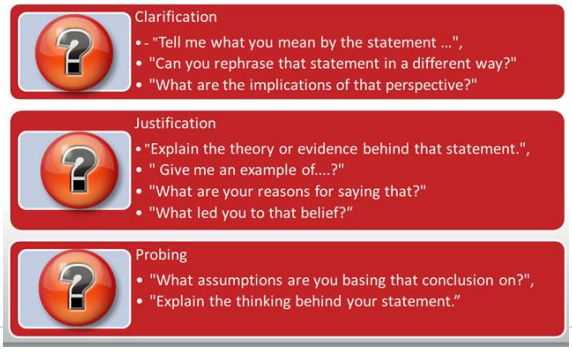
  TEACHING TOOL: All Skills Modules have a Documentation component
- Skills Lab – Safe Practice
  - Little Room of Errors
  - Identify errors
  - Document findings and intervention taken to rectify unsafe situation (rubric)
- Skills Lab – Electronic Documentation
  - Familiarize students with EMR and MAR
  - Using Docucare, have students document electronically client assessment, narrative notes, flow charts, routine procedure checklists, medication administration

TEACHING DOCUMENTATION

- Clinical
  - Orient to EMR/MAR and related documents (may need to participate in institution orientation session)
  - Discuss with unit manager/charge nurse opportunities for students to chart
  - If students allowed to chart:
    - Have student chart on a blank document and review prior to posting in EMR
    - When completing/charting assessment personally supervise or have nurse supervise documentation
    - Monitor for proper use of ID/PW, maintenance of confidentiality, and logging off after use
  - If charting is not allowed
    - Have students chart on a blank document and provide feedback for improvement

TEACHING DOCUMENTATION

- Clinical
  - Have students complete program required documents prior to/during clinical and review prior to care (pre-conference)
  - Have students discuss patients using program required documents during post-conference
  - Have students turn in at end of clinical for grading (rubric)
  - Use Socratic questioning to prompt students to defend their documentation



TEACHING DOCUMENTATION

- WHAT ADDITIONAL OPPORTUNITIES CAN YOU RECOMMEND THAT PROVIDE STUDENTS THE OPPORTUNITY TO CHART? (THINK-PAIR-SHARE)

Principles of Legally Defensible and Ethical Charting

- If it wasn't charted….
- F.A.C.T. – Avoid value judgment (HANDOUT)
- Follow Policies/Procedures

- What are common errors made related to documentation (THINK-PAIR-SHARE)
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Principles of Legally Defensible and Ethical Charting

- Incident/unusual occurrence report
  - Date/time/place of incident
  - Names of persons involved
  - Names of witnesses
  - Facts about incident
  - Injuries or other consequences
  - Personal response to incident
  - Name of provider notified and when

- Provide case study for students to practice writing report

TEACHING TOOL: NURSES' TOUCH – THE LEADER (MODULE 2)

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