Component III: Communication
Module B: Documentation
Topic 1: Written Documentation

I. **Statement of Purpose**

To enable the learner with basic principles and skills to communicate clearly and timely via written and different modes of communication including an electronic medical record.

II. Terminology

1. Electronic medical record
2. Telecommunication
3. ANA Nursing Code of Ethics
4. Nursing Minimum Data Set
5. Meaningful use
6. EMR (Electronic Medical Record)
7. Interdisciplinary plan of care documentation
8. Decision Support Systems
9. The Joint Commission
10. HIPAA (Health Information Portability and Accountability Act)
11. SBAR (Situation, Background, Assessment, Recommendation)
12. Nursing Minimum Data Set (NMDS)

III. **Performance Standards**

1. Define the terms listed in the vocabulary section.
2. Discuss the legal and professional responsibility in written communication.
3. Define the purpose and benefits of recorded documentation.
4. Discuss the legal and professional responsibility in verbal hand-off communication.
5. Define personal responsibility with system practices to ensure accurate documentation for billing and reimbursement.
6. Document appropriately and accurately in the medical record; paper or electronic.

IV. **References**

Books

Laughlin, C. (2006). Core Curriculum for Ambulatory Care Nursing, Second edition. Pitman, New Jersey: Anthony J. Jannetti, Inc.

Professional Journals

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2. Dunsford, J. (2009). Structured communication: Improving patient safety with SBAR. *Nursing Womens Health*, 5, 384-390
3. Dykes, C., DaDamio, R., Goldsmith, D., Kim, H., Ohashi, K., Saba, V., (2011) Leveraging Standards to Support Patient-Centric Interdisciplinary Plans of Care, *AMIA Annual Symposium Proceedings.* 2011: 356–363. Published online 2011 October 22.
4. Higuchi, KS, Davies BL, Edwards N, Ploeg J, Virani T. (2011). Implementation of clinical guidelines for adults with asthma and diabetes: a three-year follow-up evaluation of nursing care. *Journal of Clinical Nurse*. May; 20 (9-10):1329-38.
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6. Yocum, R. (2002). Documenting for Quality Patient Care. *Nursing*, Aug, 32, pg 58.

Websites

1. www.qsen.org
2. https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp#TopOfPage
3. Health Communication and Health Information Technology
   http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=18

Content Outline Theory Objectives	Suggested Learning Activities/Evaluation
Objective 1 **Define the terms listed in the vocabulary section.** A. Give examples of each term. B. Discuss benefits and challenges of utilizing each term or process.	Discussion: Give each dyad one –two terms. Each dyad will describe the term, give an example of the term and explain one benefit and challenge of the term in the outpatient setting.
Objective 2 **Discuss the legal and professional responsibility in written communications** A. Medical terminology that describes a patient encounter must appear as a "source document". It can be: 1. Billing forms 2. Encounter forms 3. Emergency forms B. Health care professionals are accountable for ensuring a complete, transparent documentation 1. Meet coding standards 2. Reflect service provided 3. Failure could result in fraud and/or loss of license. C. Ambulatory Patient Classifications were adopted in 2000 by CMS for outpatient. 1. Based on procedure not diagnosis 2. Can allow for severity adjustment D. Nursing Minimum Data Set (NMDS) includes 16 data elements that must be collected by nurses for all encounters (not admissions) in ambulatory settings. 1. Age 2. Gender 3. Unique patient identifier such as medical record number 4. Payment mechanism; insurance coverage or reimbursement information 5. Medical diagnosis, this is typically coded in ICD9 coding 6. Facility; facility type or provider code 7. Dates of care 8. Unique provider identification; in some situations, nurses may have their unique provider code or sign on code in a computerized documentation system 9. Nursing care provided; nursing diagnosis, intervention, outcome and intensity E. Common vocabulary is core to nursing practice and nursing informatics.	Lecture: Show examples of correct documentation. Discuss. Show examples of incomplete documentation. Ask students to identify omissions. Discuss. After NMDS section, show documentation that is missing some of the 16 elements. Ask for what is missing. Debrief. Discuss dangers of missing noted elements. Show charting examples of data collection that can be used for decision making. Examples • Pt with history of Congestive Heart Failure (CHF) has an irregular heart rate. • Pt with history of asthma exacerbation including number of times he has needed intubation • Pt with history of Chronic Obstructive Pulmonary Disease (COPD) who has

An example of a unified language include is NANDA: North American Nursing Diagnosis Association's nomenclature. F. Decision Support Systems: Computerized data systems 1. An automated decision support system improves a nurse's decision- making The system contains: a. Prompts that trigger inquiries. b. Database contains expert information organized to promote decision-making c. Analytic modules can generate alterative solutions. d. Examples: "pop ups" when a visiting women's next Pap smear is due, next childhood immunization is due. 2. Benefits of an automated support system are: a. Large amounts of data can be organized and interpreted for use by professionals. b. Standardized decision making criteria result from large amounts of collected and interpreted data c. Best practices can result from large population studies G. Legal Requirement of Documentation in an EMR 1. Same as paper documentation 2. Authentic signature required 3. Secure password is required 4. "Downtime" policy and procedures required 5. HIPAA (Health Information Portability and Accountability Act) applies to all who use an electronic record	symptoms of upper respiratory infection • Pt with knee pain who recently had Total Knee Replacement (TKR) and last week had his teeth cleaned (no antibiotic coverage)
Objective 3 **Define the purpose and benefits of recorded documentation.** A. Documentation is a recorded account of care or service provided. 1. Complete, accurate and timely to improve patient safety and can minimize errors. 2. Words are clear, complete so no assumptions are made and misunderstanding is minimized. 3. Timely documentation so decisions are made with full picture of patient's care 4. Time is not lost in treatment plan 5. Documentation indicates outcomes of care and treatment. 6. Patient expectation of accountable care is met with accurate, complete, timely recorded communication of their care. B. Regulatory agency (The Joint Commission) has defined an acceptable standard for abbreviations in a medical record.	Lecture Direct students to go to The Joint Commission website and find information about abbreviations in medical records. (See handout for your reference). If students work at an agency, ask them to bring in the agency's approved list of abbreviations and policy regarding approved abbreviations. Check and discuss date last reviewed. Use any case scenario below and practice writing the documentation for the nursing encounter.

1. Any reasonable approach to standardizing abbreviations, acronyms, and symbols is acceptable. Examples include: a. Standardized abbreviations developed by the individual organization. b. Use of a published reference source. c. If multiple abbreviations, symbols, or acronyms exist for the same term, the organization identifies what will be used to eliminate ambiguity. C. Each professional is accountable for knowing the unapproved list and agency approved list of abbreviations.	
Objective 4 **Discuss the legal and professional responsibility in verbal hand-off communications** **A. Discuss RN responsibility in transferring patient centered care assessments to other health professionals.** **a. Hand-off communication occurs between all health care professionals and team members. Some examples frequent communication in the ambulatory setting include:** **i. RN- MD** **ii. RN-LVN** **iii. RN-PharmD** **iv. RN-MA** **b. Professional standards define one's responsibility to communicate effectively to ensure patient safe timely care.** **c. Standardized format for hand-offs:** **i. Ensures a clear message** **ii. Delivered in a concise format** **iii. That is complete with what is requested or recommended.** **d. SBAR is a "best practice" form that health professionals can use in their hand-off communication with each other.** **e. SBAR is a safety strategy that meets the QSEN competency of Teamwork and Collaboration (qsen.org)**	Activity: In dyads, have students review ANA standards, "Code of Ethics for Nurses with Interpretive Statements" and identify which standards define accountability for accurate communication among health care team. This is an enclosed handout, but it is a PDF and I could not label it. Refer to SBAR in Module I. Role play and use SBAR to transfer assessment and plan of care to another health professional while keeping patient involved as active member and decision maker of his/her care.

	Debrief and give feedback to team mates on role play. Was the message clear, concise and complete? If pt is present, was patient included in the communication? Assign students to look up QSEN competency on Teamwork and Collaboration (qsen.org). Select one knowledge, skill and attitude they will practice when transferring information to other health professionals. Handout 5 Develop own plan of action to perfect SBAR communication technique for verbal transfer of information.
Objective 5 **Define personal responsibility with system practices to ensure accurate documentation for billing and reimbursement.** A. **Documentation is the written/visible method of communication.** **a. Meets professional standards of assessment, plan, implementation** **b. Meets professional and regulatory standards (DMS, CMS, TJC)** **c. Meets QSEN standardized competency of teamwork and collaboration. (qsen.org)** **d. Demonstrates adherences to approved protocols, orders, standards of care, evidence based guidelines.** **e. Records the level of service provided and who provided the care** **f. Enables health care organizations to seek reimbursement for services given** **g. Provides transparency and accountability to the public. Documentation must be accurate and complete in order to bill fairly and measure outcomes for the public's information.**	Lecture Activity: Each nurse will bring his/her agency's policy and procedures for documentation: EMR, paper, email Share documentation methods and documentation policy used at own agency. In dyads, review the policies to see how the agency ensures accurate, complete and timely documentation to meet state and regulatory standards. Identify any gaps in documentation policies and explain the risks of identified gaps.
Objective 6 **Document appropriately and accurately in the medical**	With given scenario, (Handout 6) and guide students to document

record; paper or electronic. **A. SBARE is a format for documenting action and outcomes, which are required for billing and reimbursement.** **a. S= Situation,** **i. Concise statement of problem, "What is happening"** **b. B=Background** **ii. Pertinent data/database that paints the context of the situation** **c. A= Assessment,** **iii. Your assessment of the date/situation.** **iv. Begins with "I think".** **v. This part of SBAR is done by MD, RN** **d R = Actions, Interventions & Recommendation** **vi. What you did** **vii. Recommendations to be done** **e. E = Outcomes and evaluation** **viii. What outcomes were reached** **1. response to treatment** **2. patient understanding of plan** **3. patient's willingness to follow plan** **Critical pathways/protocols are seen in electronic documentation. (Computerized Decision Support System)** • **Interdisciplinary approach to capture patient centric interventions for managed care services** • **Based on use of critical pathways or protocols to structure documentation** • **Standard MD or other order sets are included in pathways and are automatically processed.** • **System can track variances from the standard or anticipated critical pathway** • **Provides a feedback loop and information is used to improve care and patient outcomes.**	their care in SBARE format. Debrief, use answer sheet (in Handout 6) to guide teaching. Create additional scenarios and have students practice documentation in SBARE format. Share and debrief. Solicit an example from one of your affiliate agencies. Review with class and discuss if each pathway/protocol is evidence based, prompts safe quality practice, creates inter-professional communication and coordination. Discuss benefits, precautions and problems if any. Discuss article, Leveraging Standards to Support Patient Centric Interdisciplinary Plans of Care. This article has a futuristic approach on how the nursing care plan can individualize patient care across all disciplines.

SAMPLE CASE STUDIES

Case Study-Adult Medicine

Maria, a 28-year-old female, presents to your office approximately 5 weeks pregnant. Her first language is Spanish and she speaks only broken English. Her cousin came with her to translate. This is her first pregnancy. She believes she is current on her shots but has no vaccine or previous health records. She is living with a cousin and has good extended family support, but limited financial support and no transportation or phone. She is excited about the pregnancy and the prospect of being a mother. She reports having a few sexual partners with intermittent use of protection. Maria did mention that her previous doctor had her watching her diet and trying not to eat a lot of sugar but she is unclear as to why.
Vital signs: BP 124/82, Pulse 84, Resp Rate 12, Height 63", Weight 190 pounds. Blood sugar done in office was 174

1) Identify primary health concerns for Maria.
   (Pregnancy; potential STDs; elevated blood sugar-potential diabetes…)
2) What tests do you anticipate being ordered?
   (HCG, fasting blood sugar, hemoglobin A1C, CBC, Chem panel, STD screening including HIV; varicella titer, rubella titer, Hep B antibodies)
3) Identify Maria's barriers to receiving medical care.
   (Health literacy challenges; language barrier; lack of transportation; limited income; limited communication means i.e.-no phone)
4) Identify teaching needs.
   (Pregnancy; expectations, s/s of concern-when to seek care/call office, visit intervals, need for prenatal vitamins, when to repeat blood work, weight gain expectations, medications to avoid, etc.; blood sugar management – possible meds, diet, checking blood sugars at home; safe sex practices)
5) Develop a teaching plan, including: consideration of learning barriers, time allotted for each teaching point, learning activities, and how to measure teaching success/retention.

Case Study – Staff Education Need

It has come to the attention of the office that there are inconsistencies in how blood pressures are being taken by all the medical staff. Cuff size, not taking BP on bare arm, using alternative extremity, and inability to perform proper orthostatic blood pressures are all items of concern. You have 25 medical assistants to educate, from very new to 18 years in practice. Two of the medical assistants have already stated they are not concerned with changing anything as they feel what they are doing is working.
You have a 30-minute slot at the staff meeting later this week to perform this education.

1) How will you prepare for this? (Printed materials, supplies, etc.).
2) How will you manage the resistance?
3) How will you organize your teaching? (Time breakdown, learning station, lecture, demo, etc.)
4) How will you assess effectiveness of education?

Case Study – Adolescent Medicine

Sam is a healthy 16-year-old athlete. He is having increasing reactions to bee stings including significant site swelling, site itching, and facial swelling with his most recent bee sting. Sam is

being referred to an Allergist for workup and possible allergy shots for bee sting allergy. At his visit today, the PCP just prescribed an EpiPen 2-Pack to carry at all times. You have been given the job of educating Sam and his father about the EpiPen. Sam and his father are in a hurry to get back to school for practice and seem pre-occupied.

1) What information does Sam need to hear before he leaves the office?(How to recognize signs and symptoms of anaphylaxis; when to use EpiPen; how to use EpiPen)
2) What teaching tools could be used?
3) How will you measure the success of your teaching?

Case Study- Pediatric Medicine

Scenario #1

Call received from mother of 3-year-old child, stating that she is being "so bad". When asked what behavior the child was showing, mother stated that she was having little urinary accidents in her panties for the last week and was got getting to the bathroom in time to void. Was also having night time accidents. Child had been completely trained (day and night) for over 6 months without accidents. Child was only having urinary accidents and no trouble with bowel movements, was also complaining of "tummy pain".

1) What additional questions would be appropriate to ask mother regarding her concern?
2) What would be your considerations for the differential diagnosis for this patient? Mother was encouraged to make appointment to rule out urinary tract infection as children in this age group have atypical presentation, often with urinary accidents and tummy pain. On evaluation, urinalysis showed 4+ glucose as well as bacteria. Blood glucose found child's blood sugar to be 389. Child was immediately admitted to the hospital with the diagnosis of Type I diabetes.
3) Upon learning that her child would be admitted to the hospital, what information about the need for hospitalization would be important for the mother to have?
4) What emotions might the mother be experiencing upon learning the diagnosis and what an appropriate strategy is for the ambulatory care nurse.
5) What information could be provided to mother regarding expected toddler behavior vs. illness symptoms?

Scenario #2

Call from mother who reports that 15-month-old child had been seen in Urgent Care three nights previously for "bad cough". Was told there were no abnormal findings on examination at that time and he had a viral illness. Mother calls because she thinks "cough is getting worse".

1) What assessment questions would be important to ask to determine if this child is currently in any respiratory distress? (length of illness, fever, description of cough, s/s of increased work of breathing, color, level of activity, counted respiratory rate while on phone with Advice Nurse)
2) What additional information would be important to know about the child's medical history? (any concurrent medical diagnoses, immunization status)
   Child is reported by mother to be having nasal flaring and substernal retractions. Mother was able to provide a counted respiratory rate of 60. Child had been having

fever 103-104 degrees for past 24 – 48 hrs. Poor feeding, only one wet diaper in last 24 hrs. Mother advised to take child to nearest Emergency Room. Child in ER had O2 saturation of 88%, respiratory rate of 64, mild dehydration, chest x-ray showing bilateral pneumonia. Started on nebulizer treatment, IV antibiotics and admitted for evaluation. Discharged home after 72 hours improved and stable.

3) What education to mother would have been important regarding follow-up for continued concerns after initial evaluation in Urgent Care? What parameters could be given to mother to evaluate worsening condition?