Nursing Documentation

Legally proven Strategies to Keep You Out of the Courtroom

Monday, August 29, 2011

San Juan Regional Medical Center

Location of Training:
Center for Workforce Excellence

Registration: 7:30am • Time: 8:00am – 4:00pm
Lunch: 12:00noon – 1:00pm (on your own)

Target Audience: Registered Nurses

Speaker

RACHEL CARTWRIGHT, RN, MS, CNS, LHRM, FNC, LNCC, has over 24 years of clinical, management and consulting experience. As a critical care nurse, she currently works in a level II trauma center and an acute care facility. Her nursing experience includes managing critical care units, renal transplant, and dialysis, as well as directing surgical services departments. Rachel continues to be an adjunct clinical instructor at a local university. As the Vice President of a Florida-based consulting firm, Rachel has helped hospitals prepare for and exceed the regulatory requirements of JCAHO as well as state and federal agencies. Rachel owns her own legal consulting business, Medical Legal Concepts, LLC. Through her business, she works with attorneys, law firms and healthcare organizations reviewing and evaluating medical records for adherence to standards of care and compliance with regulatory requirements. Rachel has been as an expert witness for both the plaintiff and defense on medical negligence cases. Rachel is licensed as a Healthcare Risk Manager and has a forensic nursing certificate. She is also certified by the American Association of Legal Nurse Consultants. From her involvement in litigation regarding medically related issues, Rachel has learned the legal pitfalls nurses can face. She is a firm believer in prevention. Rachel has the passion to bring new and tangible information that can be applied immediately to your professional practice of nursing. She makes this seminar fun, exciting, and definitely applicable to the current healthcare practices.

Learner Objectives

At the end of this class the participant will be able to:

1. List 10 ways to keep your documentation notes and charts out of the courtroom.
2. Summarize the common documentation mistakes and how to avoid and/or correct them.
3. Integrate the correct practices into your documentation notes to keep your license unblemished.
4. Utilize actual medical malpractice cases to learn how to improve your documentation.
5. Review and learn documentation tips from actual transcripts of nurses' testimony.
6. Demonstrate how to document precisely and completely when situations are sensitive and/or stressful.

Seminar Topics

Legal and Ethical Implications of Documentation
- Standards of documentation are not negotiable
- Get it right the first time
- What is timely communication?
- Deviating from standards of care
- Record errors appropriately to avoid the perception of tampering
- Omissions can be deadly to your documentation and may be perceived as substandard care
- Make corrections and alterations correctly to avoid misinterpretation

Risk Management and Documentation
- Compliance requirements
- JCAHO
- Facility policy and procedures
- CMS (Centers for Medicare and Medicaid Services)
- Sentinel events and the evaluation of documentation
- Does everything "out of the ordinary" go on a variance report?
- What to do when routine care turns into an adverse event

Admissible Forms of Nursing Documentation
- Guidelines to keep you protected
- Legally sound documentation
- Proper and concise grammar
- Common documentation mistakes
- How to correct mistakes
- Physician orders
- Assessment
- Plan of care
- Medications
- Interventions
- Difficult situations
- Patient education and response
- Documentation for the home care nurse, float, per diem, agency or traveling nurse

Nursing Charting Systems (Good and Bad Samples of each)
- Narrative charting
- Focus charting
- CBE (charting by exception)
- Computerized charting Avoid Legally Risky

Documentation (Good and Bad Samples of each)
- Credible evidence
- Record events objectively
- Factual
- Avoid ambiguity
- Avoid bias
- Avoid words associated with errors or mistakes
- Abbreviations to avoid

Maintain Integrity of the Medical Record
- Consequences of missing records
- Record critical and extraordinary information
- Precise and complete
- If you don't record it, it can hurt you
- Countersignatures

Malpractice and Documentation
- Duty to render quality of care
- Nurses at higher risk for litigation
- Damages will be determined by the court

Actual Case Scenarios

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This educational activity is being provided by PESI HealthCare for San Juan Regional Medical Center.

Contact Information:

Education Department 609-6430

Registration deadline: August 19, 2011

Tuition:

- $80 for SJRMC Employees
- $150 fee for others

Cancellation policy: You must cancel by August 19 to receive a refund.

Registration Information:
For SJRMC employees, turn in completed Education Benefits Request Form to pay and register in HealthStream. Others please call the Education Department to register and pay.

Credit Information

Nurses/Nurse Practitioners/Clinical Nurse Specialists: CMI Education Institute Inc. is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Nurses in full attendance will earn 6.3 contact hours. No partial contact hours will be issued for partial attendance.

The following individuals contributed to the planning of this educational event: *Content Expertise:* Rachel Cartwright, RN, MS, CNS, LHRM, FNC, LNCC; *Nurse Planner:* Mary Meyers, RN, MSN; *Activity Planner:* Steve Isaacson, MS; *Target Audience Consultant:* Joyce Harris, RN, CLNC

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