

# DOCUMENTATION TIDBITS



## ❖ WHO

- Patient Name!
  - Be sure patient name and account number are present on all paper and handwritten forms.

## ❖ WHAT

- Signature!
  - If you provide a service or treatment, such as hanging an IV bag, please document by signing or making a note in the patient record.

# ◆ WHEN

## ➤ Date and Time!

- Be sure date and time are present on all paper and handwritten forms.
- Be sure correct date and time are present on your documentation entries.
- Some items are chargeable by hour, such as observation hours, recovery time, and infusions.
  - If a patient comes from the ER with an IV, document that in the appropriate area of the patient record in a timely manner.
  - -Example: If a patient arrives from ER at 2 pm with an IV infusing, and there is no documentation of that IV until 6 pm, those 4 hours between are not chargeable. So please include continuing IVs in your initial assessment.
  - Admission and discharge times are very important when charging for observation and post surgical patients.

# ◆ HOW

- Drug Route!
  - Be sure that all medications ordered have a specified route.
  - If a drug is ordered to be given “PO” or “IV”, or “PO” or “IM”, document which route given so the pharmacy or the charge entry staff will know which one to charge.

**GOLDEN RULE:**

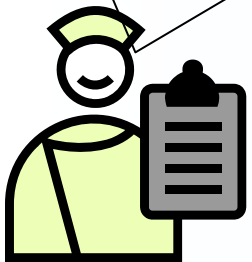
**IF IT IS NOT DOCUMENTED, THEN IT WAS NOT DONE**

# POOR PAPER DOCUMENTATION EXAMPLE

Allergies:	PCN
Permit for:	Right & Left Common femoral artery bypass
Type of Anesthesia:	<input checked="" type="checkbox"/> GEN <input type="checkbox"/> MAC <input type="checkbox"/> CHOICE <input type="checkbox"/> SPINAL <input type="checkbox"/> EPIDURAL <input type="checkbox"/> NONE <input type="checkbox"/> MODERATE SEDATION <input type="checkbox"/> LOCAL <input type="checkbox"/> OTHER REGIONAL
Tests:	<input checked="" type="checkbox"/> CBC <input type="checkbox"/> HCG <input checked="" type="checkbox"/> EKG <input checked="" type="checkbox"/> CHEST X-RAY <input checked="" type="checkbox"/> UA <input checked="" type="checkbox"/> CMP <input type="checkbox"/> BMP <input checked="" type="checkbox"/> PT <input type="checkbox"/> PTT <input type="checkbox"/> Type & Screen <input checked="" type="checkbox"/> Type & Crossmatch for <u>2</u> units <input checked="" type="checkbox"/> PFT <input type="checkbox"/> Magnesium <input type="checkbox"/> Other
M & D:	
Assisting Surgeon:	

Was PFT ordered?

Be sure that all documentation is clear. →



# MEDITECH PCS

- **MEDITECH's Patient Care System (PCS)** is an electronic documentation system offering care providers interdisciplinary Plans of Care required for a patient-focused care delivery system. Automated worklists allow care providers to document care using a point-of-care-device. PCS display panels provide the ability to observe up-to-date patient information.

<http://www.meditech.com/ProductBriefs/Pages/ProductBriefsCSPCS.htm>

# MEDITECH PCS

## Documentation of Patient Information

- PCS allows care providers to electronically view, update, and process relevant patient information components of a Plan of Care. PCS supports the delivery of a patient-focused care system and offers a means to capture clinically significant data on the patient's progress. PCS documentation features enable care providers to document:
  - Interventions and assessments on a worklist. A worklist contains the interventions or tasks that the care provider will perform for the patient.
  - Spreadsheet Documentation, used as a tool for simultaneous data review and data entry, allows for:
    - care providers to document assessments, intake and outputs, medications, laboratories, and wave forms to be included for review and documentation
    - drag and drop capabilities for rearranging data for care providers viewing preference
    - graphing upon demand
    - data documented to enter EMR in real-time.

# MEDITECH PCS

## Documentation of Patient Information Continued...

- Outcome evaluations, including EMR data review capabilities.
- Variances from a Critical Path indicating source, subtype, and status.
- Free text notes and templates that may be linked to a problem, outcome, intervention, or order.
- Medication Administration Record (MAR). The on-line MAR documents activity related to patient medications such as:
  - administration, entering a comment, entering reason medication wasn't given, and adjusting actual dosages
  - changing a medication's order, viewing a medication's order and dose instruction
  - clinical indicator, monograph, and associated data for a specific medication
  - Allergy Management, and the patient's Enterprise Medical Record.

<http://www.meditech.com/ProductBriefs/Pages/ProductBriefsCSPCS.htm>





# POOR MEDITECH DOCUMENTATION EXAMPLE

Diphtheria/Tetanus/Acell Pertussis				
Adacel				
Date	Time	Dose	Queries	Recorded by
	06:28	0.5 ML IM	Influenza Injection Site: <input type="checkbox"/> Expiration Date: 20110423 Lot Number: UF500BA	

Which medication was administered?  
Make sure that the documentation is  
correct and consistent.



# POOR DOCUMENTATION EXAMPLE

Date	Time	Dose	Queries
	12:44	See Dose Instructions UNITS SC	Injection Site: 
	08:58	6 UNITS SC	Injection Site: 
	22:18	See Dose Instructions UNITS SC	Injection Site: 
	17:34	See Dose Instructions UNITS SC	Injection Site: 

Be sure to document the dose given. An unknown dose of medication is not chargeable.



# KNOW YOUR RIGHTS

- **Remember the 5 Rights of Medication Administration**
  - Right med
  - Right dose
  - Right route
  - Right time
  - Right patient
- **The 6<sup>th</sup> Right**
  - **Right Documentation**

# REMINDER

- If it wasn't documented, it didn't happen and we can't get paid for it

# IF IN DOUBT...

- **Check with your supervisor or call your facility's nurse auditor.**
  - **Herrin Hospital:**
    - Carolyn Johnson ext: 36139
  - **Memorial Hospital of Carbondale:**
    - Linda Walkup ext. 65498
    - Janice Brewer ext. 65406
  - **St. Joseph Memorial Hospital:**
    - Sarah Gill ext. 55335