



Psych Tech CEUs

Health Care Documentation: A Means to Safe and Effective Patient Care



Introduction

Adequate health care documentation can be a means to ensure the safe and effective administration of health care to patients in need. However, poor health care documentation can be quite the opposite. Poor health care documentation can lead to miscommunication among health care professionals, inaccurate patient records and, ultimately, patient adverse events and even patient mortalities. Thus, it is imperative for health care professionals to complete adequate and effective health care documentation. This course will review the roles, importance and impact of health care documentation, while providing health care professionals with an understanding of how to complete adequate and effective health care documentation.

Section 1: The Roles, Importance and Impact of Health Care Documentation

Case 1

A 27-year-old male patient presents to a hospital emergency department with several fractured ribs and a broken left arm. Due to the extent of the patient's injuries the patient is admitted into the hospital. Before the patient is transferred to a unit he reports to his nurse that he is allergic to non-steroidal anti-inflammatory drugs (NSAIDs). Twenty-four hours after the patient is transferred to a unit, he reports he is in pain. The patient is ordered ibuprofen, as needed, for pain. A dose of ibuprofen is administered to the patient. Upon taking the ibuprofen, the patient experiences an allergic reaction which impacts his ability to breathe and includes hives. The patient's symptoms are treated and the patient recovers from his allergic reaction. However, due to the incident the patient loses confidence in his health care team and becomes highly agitated when members of his health care team attempt to administer care. Additionally, the patient becomes anxious every time medications are administered to him. Eventually, the patient's anxiety begins to extend to all

aspects of his health care and the patient becomes very resistant to any form of therapy, making his recovery increasingly challenging.

Case 2

A 69-year-old female patient is admitted into a nursing facility. Seven days later, the patient develops flu-like symptoms. The patient's symptoms are treated; however, the patient becomes increasingly weak and her mobility becomes very limited. Eventually, the patient does not want to leave her bed. Twenty-four hours later the patient reports cramping in her right leg and pain in her right heel. The next day, the patient's right leg is swollen. Due to the swelling of the patient's leg, the patient's nurse performs a Homan's test. The patient's nurse observes a positive Homan's sign and verbally informs another member of the patient's health care team. The patient's nurse believes the other member of the patient's health care team will inform the patient's physician. The other member of the patient's health care team believes the patient's nurse will inform the patient's physician. Twenty-four hours later, the patient dies.

Case 3

A 67-year-old male hospitalized patient has to have an endotracheal (ET) tube inserted into his trachea. After the ET tube is inserted, the patient reports to a member of his health care team that he is having a difficult time breathing. Several hours later the patient reports he is experiencing further breathing problems. The patient's ET tube is suctioned once before a shift change. Four hours later the patient is gasping for air due to a mucus plug at the end of the ET tube. Several minutes later the patient dies from cardiac arrest.

Case 4

A 72-year-old female hospitalized patient is initiated on warfarin therapy with a target international normalized ratio (INR) of between 2 - 3. A few days after the warfarin therapy is initiated, a member of the patient's health care team observes bruising on the patient's body. Forty-eight hours later the same member of the patient's health care team observes the patient's bruising has become darker and more intense. Seventy-two hours later an INR level is ordered for the patient. The patient's INR level is reported to be above 9. An emergency dose of vitamin K is immediately administered to the patient and eventually the patient's INR comes down to 2.8. Due to the urgent and trying nature of the aforementioned incident, the 72-year-old patient is left in an exhausted and terrified state.

Unfortunately, scenarios like the ones presented in the previous case studies occur all too often in today's health care climate. With that said, the following question is posed - why? Why do so many scenarios like the ones presented above occur time and time again in health care settings? The straight forward answer is, poor health care documentation. Health care documentation can refer to a digital or an analog record detailing the administration of health care to patients^{1,2}. It has been said, that adequate health care documentation is essential to the safe and effective administration of health care and health care documentation can be the difference between positive health care outcomes and negative health care outcomes. Furthermore, health care documentation can provide valuable information to members of health care teams and it can be utilized to prevent adverse events and even patient motilities. In essence, adequate/effective documentation is the foundation on which effective health care is built upon. If completed correctly, health care documentation can be used in daily practice by health care professionals to avoid the outcomes like the ones presented in the aforementioned cases. For example, in the first case the patient reported his NSAID allergy to a nurse. Unfortunately, the nurse in the case study did not effectively document the patient's allergy. As a result, the patient was administered a NSAID medication which resulted in an allergic reaction and a poor health care outcome. Furthermore, due to the severity of incident, the patient began to suffer from anxiety which negatively impacted his recovery. Moreover, the patient lost

confidence in his health care team which could have additional negative implications on the patient's health, well-being and quality of life. Overall, the incident outlined in Case 1 dramatically impacted the patient and, furthermore, possesses the potential to alter his entire recovery process and his general attitude towards health care. That being said, the incident from Case 1 could have been avoided with adequate/effective documentation. If the nurse in the emergency department documented the patient's allergy, most likely, the patient would not have received the ibuprofen and suffered the subsequent allergic reaction. A simple lack of documentation on the behalf of a health care professional completely altered the patient's course of therapy and attitude towards the members of his health care team. The patient had to endure a terrifying experience which impacted his ability to breathe and potentially put his life in jeopardy, while he was recovering from serious injuries, all because of inadequate and ineffective documentation. Fortunately, the patient in Case 1 was able to recover from the allergic reaction before additional damage was done. Unfortunately, the same cannot be said for the patients in Case 2 and Case 3.

The patient from Case 2 was admitted to a nursing facility. Seven days after she was admitted, she began to experience flu-like symptoms which greatly affected her mobility. Due to a lack of mobility, the patient developed a blood clot. The patient exhibited signs and symptoms of a blood clot, which were observed by the patient's nurse. Due to the observations, the patient's nurse suspected a potential blood clot and then confirmed the presence of one by carrying out a Homan's test. Unfortunately, the nurse did not document any of the observations related to the presence of a blood clot or the results of the Homan's test. The nurse did verbally notify a fellow health care professional; however, due to some confusion in the communication between the two health care professionals, action was not taken and there was no subsequent documentation or further communication regarding the patient's blood clot. As a result, the patient did not receive the necessary treatment and died. The scenario in Case 2 had one of the worst possible outcomes imaginable in a health care setting; a patient died as a result of inaction by health care professionals. Initially, the patient's nurse did take appropriate steps to acknowledge and assess the presence of the patient's blood clot. However, there was no documentation to record the nurse's actions or the efforts to

inform another member of the patient's health care team. At times, it has been argued that appropriate actions are not necessary enough in a health care setting. Documentation must be completed to record the actions of health care professionals and the results of their assessments. In this case, it can be argued that if the nurse effectively documented the observations made regarding the patient's blood clot and the positive Homan's sign, other members of the health care team, including the patient's physician, could have noted the presence of the blood clot and acted accordingly, and thus the patient's death could have been avoided.

As previously mentioned, the nurse from Case 2 did verbally communicate the results of the Homan's test to another health care professional; however, there was some type of verbal miscommunication between the two health care professionals and the message was not relayed to the patient's physician. Miscommunication, which can refer to the inadequate transmission of information or messages between two or more individuals^{3,4}, does occur in the health care setting, especially when it comes to verbal communication. Verbal communication can refer to the process of sharing information or messages between two or more individuals by the use of spoken word^{3,4}. Due to the fast paced nature of the current health care climate, at times verbal communication can be misinterpreted or simply lost. A health care professional may think he or she has clearly expressed something to another health care professional; however, for any number of reasons, the health care professional receiving the verbal information may not fully comprehend what is being communicated. As a result, mistakes can occur and adverse events, like the one outlined in Case 2, may transpire. One may think of the children's game "Telephone" to understand how verbal communication can be misinterpreted or lost. In the game of "Telephone," individuals pass a verbal message to each other by whispering the message into each other's ear. Often by the time the verbal message reaches the last person in the game, it is distorted and/or unrecognizable. The same can be true for verbal communication in the health care setting. When verbal information is transferred from individual to individual, much like in the game of "Telephone," the meaning or the urgency of the message can be lost, which is why it is paramount to document health care information. Clear, concise and complete health care documentation can provide a means to limit confusion and the distortion of health care related

information. Documentation can provide a complete record of information which can be referenced by various health care professionals, at almost any time, to guide actions and patient treatment. In short, effective health care documentation can ensure that a clear, accessible message or record is available for all members of a health care team, while providing a means for communication continuity among health care professionals.

A single health care professional cannot be everywhere at once and at all times. Due to the nature of varying shifts and schedules, a health care professional cannot be sure he or she will have an opportunity to verbally relay a message to relevant parties. In addition, health care professionals cannot be completely certain that their verbal communication will be correctly interpreted or effectively relayed to other health care professionals. Verbally communicating with another health care professional can be extremely valuable and has its place in health care settings; however, when appropriate, verbal communication should be backed up with effective documentation to ensure the meaning or intent of a message is not lost. In the scenario presented in Case 2, the patient's nurse verbally reported the positive Homan's sign to another member of the patient's health care team. However, due to a host of potential reasons, a communication disconnect among the health care professionals occurred and the intent of the nurse's message was lost, resulting, at least in part, to the patient's death. Had the nurse from Case 2 effectively documented the findings of the Homan's test, the information could have been available for all of the members of the patient's health care team, including the patient's physician, and perhaps action could have been taken to prevent the death of the patient. Along those same lines, if effective documentation was completed by the health care professional in Case 3, the patient's death may have also been avoided.

Case 3 involved a hospitalized patient and an ET tube. After the ET tube was inserted into the patient's trachea, the patient experienced difficulties breathing due to the presence of a mucus plug. The patient reported his breathing difficulties to a health care professional and suction was performed in an attempt to remove the mucus plug. Following a shift change, the patient developed further breathing difficulties, which eventually lead to the patient's death. Once again, in Case 3 the health care professional involved did, initially, take appropriate steps to acknowledge the patient's reports. The health care

professional effectively listened to the patient and used observations to conclude the patient was indeed having problems breathing and required action. The health care professional then took the next appropriate step and attempted to suction the patient's ET tube. Unfortunately, the health care professional's attempt to suction the patient's ET tube was not fully successful or carried out effectively enough to completely clear the ET tube. To compound the problem, the incident occurred before a shift change and the health care professional involved did not complete any documentation regarding the patient's breathing difficulties and/or attempt to suction the patient's ET tube. No other communication occurred between members of the patient's health care team regarding the patient's ET tube. Thus, the health care professional taking over the patient's immediate care had no knowledge of the patient's breathing difficulties and/or the attempt to suction the patient's ET tube. Shortly after the shift change took place, the patient died due to complications related to the ET tube. As in Case 2, it can be argued that the patient's death, was at least in part, related to poor documentation. Had the health care professional who acknowledged the patient's breathing difficulties and suctioned the patient's ET tube documented the relevant information, the patient's death may have been avoided. With effective documentation regarding the patient's difficulty breathing available to all members of the patient's health care team, the health care professional taking over the patient's immediate care could have learned about the patient's breathing problems and followed up on them with close patient monitoring and/or further suction of the patient's ET tube, leading to actions that could have prevented the patient's death.

As previously mentioned, a single health care professional cannot be everywhere at once and at all times. Due to the nature of varying shifts and schedules, a health care professional cannot be sure he or she will have an opportunity to verbally relay a message to relevant parties. As for the scenario outlined in Case 3, perhaps an incident occurred during the shift change which prevented the health care professional from verbally informing other members of the patient's health care team about the patient's complications with the ET tube, or, due to a multitude of other factors, perhaps the health care professional simply forgot to pass the information along to the relevant health care professionals. Whatever the case may be, it may be argued, that effective

documentation could have prevented the vital information from being lost. Simply put, health care settings can be incredibly unpredictable. Events can occur such as emergency codes or mechanical failures which can consume health care professionals' time and, ultimately, prevent them from communicating important patient information. Due to the unpredictable nature of health care settings, documentation should be completed in a timely manner to prevent or reduce the probability of crucial patient information being lost or simply not effectively communicated. The bottom line with Case 3 is that the health care professional should have documented information regarding the patient's breathing difficulties along with information regarding the ET tube suction attempt in a timely manner to ensure the information would be available and accessible to other members of the patient's health care team regardless of their shift or schedule. Health care information can easily be lost or the details of the information can be forgotten. Documentation can be a method to prevent health care information from being lost and a means to ensure relevant patient information reaches the necessary individuals who have the ability to directly impact and improve a patient's care, treatment and health care outcomes.

Case 4 reinforces the importance of health care documentation. In Case 4, a 72-year-old female, hospitalized patient is initiated on warfarin therapy. Several days after the patient's warfarin therapy is initiated, a member of the patient's health care team observes bruising on the patient's body, which is a potential side effect of warfarin and an indication of internal bleeding, another potential and more dangerous side effect of warfarin. The member of the patient's health care team does follow up with the patient and makes further observations regarding the patient's bruising. The health care professional noted the patient's bruising worsened over time, which may be interpreted as further complications of warfarin therapy. Unfortunately, the health care professional in Case 4 did not document any of the observations regarding the potential side effects of warfarin nor were any other attempts made by the health care professional to communicate the observations to other members of the patient's health care team. Within 72 hours of the health care professionals last observation, an INR level was ordered for the patient and reported to be above 9, which is very high and well above the targeted therapeutic range of between 2 - 3. Due to the nature of the patient's side effects, as well as the

reported elevated INR level, an emergency dose of vitamin K was administered to the patient. As a result of the urgent and trying nature of the episode, the 72-year-old patient was left exhausted and terrified that another dangerous medication side effect or adverse event may threaten her health and life. As with the other cases presented above, it can be argued that if the health care professional effectively documented the observations made regarding the patient's bruising, the entire incident could have been avoided or at least evaluated before it escalated to an emergency situation, sparing an older adult from a potentially dangerous and life-threatening situation.

Warfarin possesses the potential to cause serious, life-threatening, side effects and drug interactions. Much like other medications, warfarin requires patient monitoring and observation. Documenting observations regarding serious medication side effects or drug interactions can be extremely valuable in health care settings, especially when it comes to older adult patients. An older adult can refer to any individual 65 years old or older⁵. Older adults represent a specific patient population with specific needs. Older adults are often more susceptible to illness, infection, exhaustion and medications can affect older adult patients in different ways when compared to other patient populations. Thus, it is highly imperative that health care professionals effectively document potential medication side effects, drug interactions and observations when caring for older adult populations and/or other patient populations with specific requirements. Effective documentation in special patient populations can be the difference between positive health care outcomes and negative health care outcomes and in some cases, effective documentation can be the difference between life and death. As previously highlighted, due to the urgency of the scenario outlined in Case 4, the older adult patient was left in an exhausted and terrified state. The final state of the patient from Case 4 is relevant because of the patient's age. Exhaustion could have a further negative impact on the patient's overall health and well-being. In addition, if the patient remains terrified about impending treatment and her overall health care, perhaps anxiety or depression could develop, which could have further negative consequences on the patient's health. If anxiety or depression were to develop, the patient's ability to eat, sleep and care for herself could become greatly diminished, increasing her time in the hospital and, potentially, placing her health and life in jeopardy. In this case, if the health care professional

documented the observations made regarding the patient's bruising, perhaps other health care professionals, including the patient's physician, could have acknowledged the presence of the potentially dangerous side effects and immediately assessed the patient and/or adjusted the patient's warfarin dose or other medications before the side effects worsened and put the 72-year old patient through a harrowing episode that could have future negative implications on her health. Special patient populations require special attention and effective documentation must be completed to ensure their needs are met. That being said, due to the increasing amount of responsibilities placed on health care professionals and the ever increasing patient populations, at times, specific patient details, like lab values, may be overlooked or simple missed.

Typically, when warfarin therapy is initiated for a patient, a baseline INR and a subsequent INR is ordered to monitor the patient's progress on the medication and to ensure therapeutic levels are reached and maintained. For any number of reasons, an initial INR was not ordered for the patient in Case 4, making the lack of documentation regarding the patient's bruising that much more relevant. If the health care professional in Case 4 effectively documented the observations regarding the patient's bruising, perhaps the lack of an INR would have been noted and an INR could have been ordered much sooner to evaluate the patient's warfarin status. Documentation made by health care professionals regarding observations and the results of patient assessments can draw attention to patient medications, potential side effects, drug interactions, test results and important lab values, which may have been otherwise overlooked or missed. Adequate/effective health care documentation can prove to be an effective means to review patient cases and ensure all aspects of an individual patient's health care are noted and evaluated to maximize therapeutic outcomes. The bottom line when it comes to health care documentation is very simple and straightforward. Health care documentation must be done, and it must be done for two very specific reasons - the first of which is to strengthen and reinforce communication among health care professionals.

Communication Among Health Care Professionals

Effective communication between health care professionals is vital to the health care process. Without effective communication, it would be incredibly difficult for health care professionals to administer health care to patients. The majority of communication between health care professionals which occurs in health care settings is known as interpersonal communication. Interpersonal communication can refer to the transmission of information, messages and/or ideas between two or more individuals^{3,4}. Interpersonal communication can occur between two or more individual via verbal communication and nonverbal communication. As previously mentioned, verbal communication can refer to the process of sharing information or messages between two or more individuals by the use of spoken word^{3,4}. Nonverbal communication, on the other hand, can refer to the process of sharing information or messages between two or more individuals by the use of gestures, facial expressions, visual cues and body positions, otherwise known as body language^{3,4}. Together, verbal and nonverbal communication are used in conjunction to express and transmit information in order to obtain meaning and understanding between two or more individuals. Interpersonal communication is the primary way individuals connect, express emotions and achieve collectivism. Individuals rely on interpersonal communication in their personal life and professional life to achieve goals and a commonality among their peers. Furthermore, interpersonal communication is essential to obtaining and maintaining relationships in and out of the work place. Without interpersonal communication, it would be hard to imagine carrying out a functional partnership or obtaining a high level of team work with other individuals. In short, interpersonal communication is essential for individuals to initiate and maintain individual relationships. That being said, problems can occur when relying solely on interpersonal communication in the workplace. Researchers estimate that only a percentage of information is obtained and/or retained when individuals communicate on an interpersonal level- meaning that, intricate or specific details may be lost in an interpersonal exchange between two or more individuals. On a personal level, that may be okay. If two or more individuals interact at a party or at sporting event and not every detail is understood or retained, it may not prove to be significant or have any further implications or impact. However, when details are lost in the workplace, and

especially in a health care setting, it can prove to have great significance. The following example will highlight the previous concepts. During a shift change, Nurse 1 and Nurse 2 engage in a discussion regarding their 80-year-old male patient. Nurse 1 verbally informs Nurse 2 that the patient was initiated on a new medication, which is only currently available in tablet form. Nurse 2 verbally acknowledges the new medication and the discussion regarding the patient's new medication continues. During the discussion between the two nurses, a physician interrupts Nurse 1 to ask unrelated questions about the patient. Right before the physician is about to speak Nurse 1 quickly tells Nurse 2 that the patient's new medication must be crushed because the patient exhibited difficulties swallowing it. Nurse 2 does not acknowledge the information regarding the need to crush the new medication and the physician begins to ask Nurse 1 questions. After the physician leaves, no further information regarding the new medication is provided to Nurse 2 and the topic is not revisited. Furthermore, Nurse 1 did not complete any documentation regarding the need to crush the patient's new medication. Nurse 1 and Nurse 2 disengage from their interpersonal communication exchange, with Nurse 1 believing Nurse 2 received, understood and will retain all of the relevant information regarding the patient and the need to crush the patient's new medication. Nurse 2 leaves the interpersonal communication exchange with the belief that all of the relevant information from Nurse 1 has been adequately obtained. Several hours pass and it is time for the patient's new medication. Nurse 2 looks for documentation regarding the patient's new medication and cannot find anything of note. Nurse 2 administers the medication to the patient. Because the medication is administered in a small paper cup, the patient does not get a good look at the size of the tablet. The patient attempts to swallow the new medication. Within seconds he is choking. Nurse 2 attempts to offer the patient an additional cup of water to aid his choking. Unfortunately, before Nurse 2 can do so, the patient's choking intensifies and the urgency of the situation increases. It quickly becomes obvious to Nurse 2 that the patient will not be able to stop choking on his own. Nurse 2 takes action and administers the Heimlich maneuver to the patient. Fortunately, Nurse 2 is able to dislodge the tablet from the patient's airway. Eventually, the urgency of the situation dissipates and the patient begins to recover - although, he is visibly shaken by the ordeal.

In the previous example Nurse 1 and Nurse 2 engaged in an exchange of interpersonal communication to share and receive information regarding their patient. Unfortunately, due to the physician's interruption and the resulting confusion, the relevant information regarding the patient's new medication was lost. Nurse 1 was unable to effectively transmit the information to Nurse 2 and Nurse 2 was unable to receive the information with enough clarity to acknowledge the message or retain the importance of it. To compound the problem, Nurse 1 did not document any information regarding the need to crush the patient's new medication. Due to the failure in communication between Nurse 1 and Nurse 2, Nurse 2 administered the new medication to the patient without crushing it, resulting in the choking incident experienced by the patient. The previous example illustrated how the specific details of critical information can be lost in an interpersonal communication exchange. Nurse 1 was able to effectively communicate the information about the patient receiving a new medication to Nurse 2, which was acknowledged by Nurse 2 - although, the specific detail regarding the need to crush the medication was lost in the confusion and/or the noise of the surroundings.

Interpersonal communication can be an efficient method to exchange information, messages and instructions between two or more individuals; however, it does have flaws when used as the primary means to share information in a health care setting. As highlighted in the previous example, for any number of reasons, including interruptions and background noise, information can be simply lost among health care professionals engaging in interpersonal communication in health care setting - thus, revealing the importance of health care documentation and how it can be used to strengthen and reinforce communication among health care professionals. In the previous example, documentation could have been used by Nurse 1 to reinforce the messages that were exchanged with Nurse 2 to strengthen the overall exchange of information. If Nurse 1 effectively documented the need to crush the patient's new medication then, most likely, Nurse 2 would have observed the necessary medication note when the patient's information was reviewed prior to the new medication's administration, and therefore avoiding the choking incident. In the previous example, the patient's life was placed in jeopardy due to a breakdown in communication between Nurse 1 and Nurse 2. If effective documentation was completed by Nurse 1, it may be argued, that the whole

incident could have been prevented. As previously mentioned, health care professionals should not solely rely on verbal communication to exchange important health care information at all times. Health care professionals cannot always be sure the intent of their messages will be fully understood or received by other health care professionals. Therefore, it is best for health care professionals to complete documentation regarding the necessary information to backup what was said so it may be used as a reference material for other health care professionals to obtain the information they may require. Had documentation been completed in the previous case, Nurse 2 would have been able to reference the material to obtain the information regarding the need to crush the patient's new medication. Effective communication, where all parties involved obtain the desired meaning of the messages being exchanged, is one of the most important aspects of health care. Therefore, health care professionals must do all they can to ensure their messages and/or instructions are received, understood and acknowledged by intended parties. The goal of communication between two or more individuals exchanging important health care information should be to obtain meaning and a shared understanding of the exchanged information. Effective documentation can be a means to ensure the previously mentioned goal is achieved by reinforcing messages and strengthening the overall flow of communication between two or more health care professionals in order to provide clarity and a reference source for the optimal administration of health care to patients in need.

Professional Responsibility

Effective health care documentation must be completed to maximize the flow of communication between health care professionals. Without effective health care documentation, communication within health care settings can become stunted and eventually breakdown, leading to potentially negative health care outcomes for patients. Due to the importance of communication between health care professionals, it is the professional responsibility of individuals working in health care settings to complete effective health care documentation, which is the second major reason why health care professionals must effectively document health care related information - it is their

professional responsibility to do so. That being said, why is the completion of effective health care documentation a professional responsibility of health care professionals? Health care professionals have many responsibilities to their patients when administering health care and completing effective health care documentation is one of them for a few key reasons. The first key reason is related to the oaths health care professionals take upon graduation. When health care professionals take their respective oaths, they agree to adhere to a specific ethical code and the specific ethical concepts of beneficence and nonmaleficence while administering health care. Beneficence and nonmaleficence have specific meanings when applied to health care. Beneficence can refer to the act of doing what is best for the patient, while nonmaleficence can refer to inflicting no harm to patients - do no harm to patients⁶. When health care professionals take their respective oaths, they agree to abide by the aforementioned ethical concepts when administering health care to patients. Therefore, health care professionals must do what is best for the patient and do no harm to the patient while administering health care. As previously mentioned and highlighted by the case studies presented above, poor documentation can negatively affect a patient and lead to negative health care outcomes including death. Thus, if health care professionals fail to complete effective documentation, then they are not doing what is best for the patient nor are health care professionals doing what they can to avoid harm being brought to the patient, putting them in direct violation of their respective oaths. As a result, health care professionals must complete effective documentation when administering health care to patients in order to uphold and honor beneficence, nonmaleficence and, ultimately, their professional oaths.

The next key reason why health care professionals must complete effective health care documentation is related to the standards set forth by professional organizations such as the American Nurses Association (ANA). Professional organizations, like the ANA, have developed specific standards of practice for health care professionals. Standards of practice may refer to the authoritative statements of duties that all health care professionals, regardless of role, population or specialty are expected to perform competently⁷. In other words, standards of practice provide a guideline for health care professionals to follow in order to administer safe and effective health care. Standards of practice

were established by the ANA and other professional organizations to provide a means for the consistent administration of health care across the various health care settings found in the current landscape of health care. It is highly recommended that all health care professionals follow the standards of practice set for by their professional organization in every aspect of health care administration to ensure they are in accordance with the necessary requirements for safe and effective health care.

Another key reason why health care professionals must complete effective documentation may lie in individual health care organization's policies and procedures. Typically, each health care organization, such as a hospital or a long-term care facility, has their own distinct policies and procedures, which outline the rules, codes, protocols and standards of the specific organization. Almost everything a health care professional needs to know and understand about how to effectively administer health care in his or her own given facility can be found within the organization's policies and procedures. Much of what is covered within an organization's policies and procedures centers around the safe and effective administration of health care. Therefore, often health care organizations will have specific policies and procedures regarding documentation. There are many different forms of health care documentation including a patient's medical record, therefore a health care organization's policies and procedures should reflect and inform health care professionals on how to proceed when completing any form of health care documentation. Health care professionals should take the time to become familiar with their individual organization's policies and procedures to ensure they are meeting the requirements set forth by their respective facility.

In addition to the aforementioned reasons, health care professionals have a legal responsibility to complete effective health care documentation when administering health care to patients. Federal and individual state laws may apply to health care documentation. Thus, health care professionals must be aware of the existing laws regarding health care documentation, especially when it comes to specific state laws. Every state possesses the potential to have different laws relating to health care; therefore, every state may have distinct laws when it comes to health care documentation. Furthermore, each state may have explicit laws outlining the requirements of health care documentation for each particular type of health care professional, such as

nurses. For example, the state of California has specific requirements for nurses when it comes to health care documentation. An example of California's health care documentation laws can be observed in Figure 1. It is highly recommended that health care professionals consult their respective individual state laws to understand what their regulatory responsibilities are when completing health care documentation.

Figure 1: California Code of Regulations Title 22; Section 702158

70215. (a) (1) A registered nurse shall directly provide:

Ongoing patient assessments as defined in the Business and Professions Code, Section 2725(d). Such assessments shall be performed, and the findings documented in the patient's medical record, for each shift and upon receipt of the patient when he/she is transferred to another patient care area.

The following concept builds on the aforementioned legal reasons why health care professionals must complete effective health care documentation: health care documentation, such as a patient's medical record, may be considered and viewed as a legal document. That being said, what are the implications of the previous concept? Essentially, what the previous concept means is that health care documentation may come into question in the case of litigation or legal actions against or pertaining to a health care professional. In other words, if a health care professional's actions are legally called into question, their health care documentation may be used as a means to scrutinize and judge their actions - leading many health care professionals to view documentation as their worst enemy or as their biggest ally. If health care documentation is not adequately/effectively completed or simply not done at all, it may be considered a health care professional's worst enemy. Evidence to support the previous notion can be obtained by revisiting the four case studies presented above. In each of the four case studies, documentation was not effectively completed by health care professionals leading, at least in part, to negative health care outcomes for the patients involved in the cases. The negative

health care outcomes for the patients highlighted in the case studies ranged from an allergic reaction brought on by a medication to death. As previously mentioned, it can be argued that if effective documentation was completed by the health care professionals in each case, the negative health care outcomes experienced by the patients could have been avoided - thus, opening the door for potential legal action against the health care organizations and the health care professionals involved in each case study. If legal action were to be brought upon the health care professionals in each case, the first thing that may be examined is health care documentation. Unfortunately, for the health care professionals in each case, effective documentation was not completed, leaving them vulnerable to medical liability claims. Even though some of the health care professionals in the case studies took appropriate actions to either monitor, observe or administer health care to their patients, nothing was documented to shed light on what transpired or to provide evidence of the appropriate actions of the health care professionals. Therefore, because nothing was documented it may be concluded that nothing was done and the health care professionals were at fault in each case.

In the previously mentioned four cases studies, documentation could prove to be the health care professionals worst enemy because the lack of effective documentation may be used against them to solidify their negligence. To avoid scenarios like the ones presented in the above case studies, health care professionals should work to make documentation their biggest ally by completing effective documentation to outline their appropriate health care actions. Had the health care professionals in the four case studies documented their actions, they would have evidence to support their actions and thus may not be found liable in the cases of potential medical liability claims. In short, effective health care documentation can be used as a means to communicate vital patient information to fellow health care professionals, and it may also be used as a means for health care professionals to protect themselves against medical liability claims and/or malpractice claims. Effective health care documentation must be completed by health care professionals for their protection and, perhaps most importantly, the protection of their patients' overall health, well-being and quality of life.

Section 1: Summary

Health care documentation can refer to a digital or an analog record detailing the administration of health care to patients^{1,2}. It has been said that documentation is the foundation on which safe and effective health care is built upon. If completed effectively, health care documentation can be used in daily practice by health care professionals to communicate vital patient information to other health care professionals in order to facilitate positive health care outcomes and to decrease the potential for negative health care outcomes, such as adverse events and patient mortalities. In essence, effective health care documentation can be used as a method to review patient cases and to ensure all aspects of an individual patient's health care are noted and evaluated to maximize therapeutic outcomes.

Effective health care documentation must be completed by health care professionals to ensure their messages and/or instructions are received, understood and acknowledged by intended parties. The goal of communication between two or more individuals exchanging important health care information should be to obtain meaning and a shared understanding of the exchanged information. Effective documentation can be a means to ensure the previously mentioned goal is achieved by reinforcing messages and strengthening the overall flow of communication between two or more health care professionals in order to provide clarity and a reference source for the optimal administration of health care to patients in need. Additionally, due to a host of different reasons including professional oaths and regulatory requirements, health care professionals must complete effective health care documentation because it is their professional responsibility to do so. When a patient is admitted into a health care facility, his or her health, overall well-being and quality of life, often rely on the safe and effective administration of health care - health care documentation can be a means to ensure patients receive the safe and effective health care they rely on.

Section 1: Key Concepts

- *Health care documentation is essential to the safe and effective administration of health care.*
- *Health care professionals should document relevant patient information, observations, assessment results and special requirements to facilitate positive health care outcomes and decrease the potential for negative health care outcomes such as adverse events and patient mortalities.*
- *Health care documentation can be a method to prevent health care information from being lost and a means to ensure relevant patient information reaches the necessary individuals who have the ability to directly impact and improve a patient's care, treatment and health care outcomes.*
- *Effective health care documentation must be completed by health care professional to reinforce, strengthen and ensure their messages and/or instructions are received, understood and acknowledged by intended parties.*
- *Effective health care documentation must be completed by health care professionals because it is their professional responsibility to do so.*

Section 1: Key Terms

Health care documentation - a digital or an analog record detailing the administration of health care to patients^{1,2}

Miscommunication - the inadequate transmission of information or messages between two or more individuals^{3,4}

Verbal communication - the process of sharing information or messages between two or more individuals by the use of spoken word^{3,4}

Nonverbal communication - the process of sharing information or messages between two or more individuals by the use of gestures, facial expressions, visual cues and body positions, otherwise known as body language^{3,4}

Older adult - any individual 65 years old or older⁵

Interpersonal communication - the transmission of information, messages and/or ideas between two or more individuals^{3,4}

Beneficence - the act of doing what is best for the patient⁶

Nonmaleficence - inflicting no harm to patients; do no harm to patients⁶

Standards of practice - the authoritative statements of duties that all health care professionals, regardless of role, population or specialty are expected to perform competently⁷

Section 1: Personal Reflection Question

What roles can effective health care documentation play in the administration of health care?

Section 2: Effective Health Care Documentation

It has been well established that effective health care documentation must be completed by health care professionals; however the following question remains - what makes health care documentation effective? Health care documentation may be considered effective when its two major objectives or functions are achieved. The first objective or function of health care documentation is communication. As previously highlighted, communication is essential to the administration of health care and health care documentation can be a means or a method of communication among health care professionals. The goal of communication is to convey information and an understanding of information in a manner which achieves a shared meaning

among two or more individuals^{3,4}. If health care documentation achieves the previous goal of communication, then it may be considered effective.

The second major function of health care documentation is to establish a detailed record of health care administration, which can be easily accessed and/or understood by intended parties. In other words, health care documentation must provide an accessible account of health care administration, which can be used to track and/or obtain information regarding the administration of health care to patients. If health care documentation is clear, easily understood and can be used to establish continuity among necessary health care professionals over time, then it may be considered effective.

In short, in order for health care documentation to be considered effective it must be a viable form of communication as well as a means to establish a detailed record of health care administration. That being said, how can health care professionals ensure their health care documentation is effective? There are many different forms of health care documentation; however, if health care professionals include specific characteristics in their documentation, they can ensure that no matter what form of health care documentation they are completing, it may be used as a viable form of communication and as a means to establish a detailed record of health care administration, and thus be considered effective.

Objectivity and Accuracy

The first major characteristic of effective health care documentation is objectivity. Objectivity can refer to the process of obtaining meaning or information that is true outside of an individual's judgment, bias and/or opinion^{9,10}. In other words, objectively is the process of determining fact and/or reproducible/measurable data; when something is objective, it is widely accepted as fact. For example in a health care setting, lab values such as a patient's white blood cell count or red blood cell count would be considered objective information. A white blood cell count or red blood cell count is information that is produced by scientific lab equipment. The data can be

reproduced and, moreover, the counts or lab values are not based on any one individual's judgment, bias or opinion. Blood is drawn from a patient. The patient's blood is taken to a lab. The patient's blood is then analyzed and the information is reported. There is very little or no human analysis of the information. It is simply reported as is. When information or data is obtained in such a manner, it is objective.

Objectivity can also be understood by reviewing subjectivity. Subjectivity can refer to the process of forming an opinion and/or judgment based on one's own point of view or perspective^{9,10}. When something is subjective, it is an opinion or point of view. Subjectivity derives from one's own view point, meaning subjectivity is an interpretation based on individual perspective. For example, one individual may believe an object is beautiful while another individual may completely disagree and find the same object repulsive. The object remains the same independent of the individual's view point; however, the interpretation of the object differs depending on the individual's point of view/perspective. Essentially, subjectivity is opinion based. Subjective information is not typically based on reproducible or measurable data - it is almost purely based on an individual's bias or judgment. For example, Nurse 3 may report to Nurse 4 that a patient is difficult. The information Nurse 3 reported to Nurse 4 is subjective. It is purely based on opinion. There is no scientific method to measure the information or determine whether or not it is fact. The information is simply a judgment, based on Nurse 3's point of view or perspective. When information is rooted in judgment, bias and/or opinion it is subjective. In other words, one can, typically, view subjectivity as the opposite of objectivity. Subjectivity is based in judgment while objectivity is based on reproducible and/or measurable fact. With that said, why should health care documentation include objective information?

As previously mentioned, the two main objectives or functions of health care documentation are to communicate and record information. In order for information to be communicated and/or recorded effectively, it must be clear, complete, concise, comprehensible, accessible and, perhaps most importantly, accurate, especially in health care settings. Accurate information is essential to health care documentation. After all, other health care professionals will be basing their health care and/or treatment strategies on the information included in a patient's health care documentation. Thus, accuracy is of the

upmost importance. To return to the previously posed question, why should health care documentation include objective information - the simple, straightforward answer is accuracy. The bottom line is, health care documentation must be accurate. Often, there is very little room for error when administering health care to patients. The individual patient's health, overall well-being and in many cases, life depends on the safe and effective administration of health care. Therefore, health care documentation must be accurate to ensure patient safety and the best way to keep health care documentation accurate is to include objective information. Incorrect or erroneous information included in a patient's medical record or related health care documentation could have dire consequences for the patient. The following example will highlight the aforementioned concepts. A 52-year-old male patient admitted to a psychiatric facility for alcohol addiction is administered a pass to leave the facility. Upon the patient's return, Nurse 5 observes the patient exhibiting some signs and symptoms of intoxication such as lethargy. Nurse 5 immediately documents the observations. Nurse 5 includes the following statement in the patient's related health care documentation: "patient returned from pass drunk." No tests are ordered to obtain the patient's blood alcohol level and the nurse does not even attempt to ascertain if the patient smells like alcohol or admits to being intoxicated. Nurse 5 documents the aforementioned note and continues to observe the patient. After some time, the patient simply enters his room and goes to sleep. Upon reading Nurse 5's note, the patient's physician cancels all future passes and outside privileges for the patient until further evaluation. The patient becomes aware of his physician's actions and becomes anxious. The patient was hoping to obtain another pass so he could attend his brother's upcoming birthday party. With no hope of future passes coming, the patient becomes increasingly agitated and enraged. Eventually, the patient begins to aggressively act out and has to be physically restrained, sedated and placed in a quiet room until further notice. The patient's physician learns of the events and investigates the situation. As it turns out, the patient was not intoxicated at all when he returned from his pass. He was simply exhibiting some side effects of a recently initiated medication. However, due to Nurse 5's documentation, the patient was labeled as drunk, which led to a chain of events culminating in the patient's restraint, sedation and sequestering - all of which could have detrimental long-term effects on the patient's recovery, treatment, health,

overall well-being and quality of life. Due to inaccurate documentation, the patient suffered a trying ordeal which possesses the potential to negatively impact his therapy and, ultimately, his life.

The previous example highlighted the importance of accuracy when completing health care documentation. Essentially, Nurse 5's documentation regarding the patient was inaccurate, which led to negative consequences for the patient. Thus, health care documentation must be accurate to avoid scenarios like the one presented in the previous example from occurring. That being said, the best way to maintain accuracy when completing health care documentation is to include objective information. The information Nurse 5 included in the patient's documentation was subjective. It was based on the nurse's opinion and judgment as opposed to reproducible, measurable data. Initially, Nurse 5 acted appropriately by observing the patient; however, Nurse 5 inappropriately rushed to judgment and documented the patient was drunk before any tests were initiated to confirm or refute the validity of the suspicions. If Nurse 5 genuinely believed the patient was intoxicated based on the observations that were made and that information was essential or beneficial to the patient's treatment, health and overall well-being, then Nurse 5 could have documented the information but in a more objective manner by simply noting what was observed without including judgment, bias, opinions and/or labels, such as "drunk." If Nurse 5 observed the patient acting lethargically, then Nurse 5 should have documented that observation versus the judgment or opinion as to why the patient was acting lethargic. In the previous example, Nurse 5 fell into a classic pitfall of health care documentation. Nurse 5 documented a subjective opinion, which turned out to be inaccurate. As previously mentioned, inaccurate documentation can be detrimental to patient care. It can lead to negative health care outcomes and even patient mortalities. Inaccurate documentation must be avoided at all times in health care settings and the best way to avoid inaccurate documentation is to document objective information. With that said, how can health care professionals avoid the pitfalls of inaccurate information and ensure they are documenting objective information? To avoid the pitfalls of inaccurate documentation, health care professionals may follow the "See Rule."

The See Rule advises health care professionals to document what they can see. In other words, health care professionals should document what they can

physically see a patient doing or what they can see on a patient's body, patient monitor or lab report. The See Rule can help health care professionals avoid documenting subjective opinions and/or inaccurate information by focusing their attention and, subsequently, their documentation, on data which can be verified by another health care professional. When data or information can be verified by two or more individuals then it is less likely to be viewed upon as subjective information and more likely to be viewed as objective information. The more sources that can verify data or information, the greater the probability the data/information is objective and thus not a subjective opinion or, most importantly, inaccurate. By focusing their attention on data which can be seen, health care professionals can ensure they are documenting objective, accurate information. The following example will highlight the previous concepts. Nurse 6 observes a 47-year-old male patient's right knee. Nurse 6 notices the patient's right knee is inflamed and red. Nurse 6 also observes, on the patient's monitor, that the patient's blood pressure is 140/90 mmHg. Nurse 6 immediately documents the observations. Nurse 6 describes the patient's right knee as inflamed and red. Nurse 6 also notes the patient's elevated blood pressure and provides the exact reading as: 140/90 mmHg. Nurse 6 does not include any additional information. Nurse 6 only documents what was observed. Several minutes later the patient's physician reads Nurse 6's documentation regarding the patient's right knee and elevated blood pressure. Due to the clear, concise nature of the documentation, the patient's physician immediately understands the information included in the documentation. Upon examination, the patient's physician concludes the patient's right knee is indeed inflamed and has a reddish appearance. The patient's physician also observes the patient's blood pressure is elevated, verifying the information contained in Nurse 6's documentation. Based on the documentation and observations, the patient's physician adjusts the patient's therapy. Subsequent observations by the patient's physician reveal the patient's right knee is less inflamed and the patient's blood pressure is within normal limits. In the previous example, Nurse 6 made some important observations regarding the patient's right knee and blood pressure. Nurse 6 then documented the data/information in a clear and concise manner, documenting only what was seen. Nurse 6 did not include any subjective opinions nor was the documentation bias or judgmental in any way. Nurse 6 simply documented what was seen in a detailed manner. Nurse 6 did not include any other subjective information,

which could have detracted from the information's relevance or distorted the data in any way. The data/information was presented in a straightforward manner as to communicate a message and record data/information. The documentation was not convoluted by unnecessary details or subjectivity. It was clear and to the point. Due to the clarity of the documentation, the patient's physician was able to immediately grasp the meaning of Nurse 6's notes and use the information to evaluate the patient. The physician verified the information contained within the documentation was accurate and then used the information, as well as observations, to adjust the patient's therapy to effectively manage the patient's right knee inflammation and elevated blood pressure, ultimately improving the patient's health-related state. By following the See Rule and documenting what was seen or observed Nurse 6 was able to avoid the pitfalls of inaccurate documentation. Moreover, by following the See Rule, Nurse 6 was able to ensure the documentation regarding the patient was effective. The two main objectives of health care documentation are to communicate and record information. Due to the clear, concise, objective and accurate nature of the documentation, Nurse 6 was able to achieve those objectives. Data/information was recorded and communicated to the patient's physician, who was able to use the information to evaluate the patient, make adjustments to the patient's treatment and improve upon the patient's care, which furthers the following point of interest: health care professionals rely on health care documentation to obtain vital information about their patients; therefore, health care documentation must be accurate. By following the See Rule and by documenting objective data/information in a straightforward manner, devoid of subjective judgments, bias and opinions, health care professionals can ensure their documentation is accurate and effective.

Clarity and Completeness

The second characteristic of effective health care documentation lies within the two Cs of effective health care documentation: Clarity and Completeness. Clarity, as it relates to health care documentation, can refer to a quality which enables multiple health care professionals to obtain meaning from recorded data and/or information relating to health care. Completeness, as it relates to

health care documentation, can refer to a state where all of the necessary components and/or parts are present. If health care professionals view health care documentation as a means of communication between two or more health care professionals and as a method to record data/information, then it should be no surprise that Clarity and Completeness are essential to the health care documentation process.

To achieve Clarity in health care documentation, health care professionals must always keep in mind that other health care professionals will be reading their documentation with the intent to obtain meaning. Thus, health care professionals must complete their documentation in a manner which facilitates or promotes meaning. If more than one health care professional cannot obtain meaning from health care documentation, then it may not be considered to be clear or effective. To ensure Clarity in health care documentation, health care professionals should be as concise as possible, only stating relevant information. For example, if a patient experiences a rash on his or her left arm, then the health care professional should document that information exactly as it is observed without adding any irrelevant details. In other words, the health care professional should be as brief and comprehensive as possible. Health care professionals may also obtain Clarity in health care documentation by using universally accepted abbreviations. Organizations such as The Joint Commission have established acceptable abbreviations which may be used when completing health care documentation. The Joint Commission approved abbreviations are, typically, universally accepted throughout health care. Thus, by adhering to Joint Commission approved abbreviations, health care professionals can ensure other health care professionals will be able to obtain meaning from abbreviations. Lastly, to obtain Clarity, health care professionals should follow the specific policies and procedures of their respective health care setting regarding documentation. A specific health care facility or organization may have unique guidelines relating to health care documentation Clarity. Health care professionals should be aware of their organization's policies and procedure regarding health care documentation to maximize health care documentation Clarity.

To achieve Completeness in health care documentation, health care professionals must always remember that health care documentation is a means to create a record of health care administration to patients. Records of

health care administration can be very valuable to health care organizations such as hospitals. Hospitals and other health care facilities often use health care documentation, such as patients' medical records, to observe trends in health care, identify patterns of infection or disease, obtain information which can be used to increase patient safety and to secure financial reimbursement, payment and/or funding. Without complete health care documentation, a health care organization may lose out on important information which may be used to increase patient care and/or obtain funding. Additionally, health care professionals must also understand that Completeness also impacts the Clarity of health care documentation. Clarity and Completeness go hand and hand, and often without Completeness there can be no Clarity. For example, if it is documented that a patient is scheduled to receive a dressing change at specific time and there is no additional documentation completed to confirm or indicate the dressing change was completed, then it is not clear if it indeed occurred.

Without complete documentation to record health care administration, there can be no clear indication or record that any health care was administered, leading to potential gaps in patient care and confusion among health care professionals using patient medical records or related health care documentation to determine patient care. Thus, health care documentation must be complete. To ensure Completeness is achieved in health care documentation, health care professionals must document any and all forms of health care administered to a patient and any health care outcomes which are relevant to the patient's treatment and overall health. For example, if a patient is scheduled to receive a medication, then a health care professional must document that the patient received the medication. Furthermore, if the patient experienced a reaction to the medication, that too must be documented. In addition, changes to a patient's condition or status should also be documented by health care professionals. In certain health care settings, such as a hospital, a patient's condition may change dramatically or rapidly. Any change to a patient's condition or status must be documented to accurately reflect and record the patient's status throughout his or her admission. Finally, to ensure Completeness health care professionals must not leave sections of health care documentation blank or empty. Only when all of the necessary components and/or parts of a health care document are present, including a

signature, may it be considered complete. When sections of a health care document are left blank or empty, it may not be considered complete and thus it may not be viewed as effective.

The two Cs of effective health care documentation, Clarity and Completeness, must be achieved in health care documentation in order for it to be effective. Health care professionals must be able to obtain meaning from health care documentation and they must be able to use health care documentation as a means to link patients' symptoms, diagnosis, treatments and outcomes by following an intact record of health care administration. By confirming their health care documentation achieves both Clarity and Completeness, health care professionals can ensure their health care documentation is effective.

Time/Date

Finally, effective health care documentation must include accurate times and dates of health care administration. Health care data and information should be documented in a timely fashion and health care professionals should include accurate times and dates of health care administration. Accurate times and dates of health care administration are typically required to establish an orderly, chronological sequence of data/information. **As previously mentioned, the two main objectives or functions of health care documentation are to communicate and record information, which means the data/information included in health care documentation must be accessible.** In other words, individuals must be able to locate and identify the data/information they require from a patient's health care documentation with relative speed and ease. For example, if a health care professional needs to know what medications were administered to a patient at 9:00 AM on a specific date, he or she should be able to obtain that information from the patient's health care documentation effortlessly. The health care professional should not have to sift through data/information for hours on end to acquire the necessary information. The health care professionals should be able to simply follow an orderly, chronological flow of information to obtain what he or she requires. Also, in emergency situations, health care professionals should be able to

quickly access data/information contained in a patient's health care documentation to respond rapidly and administer the required health care.

The data/information found in health care documentation is there for others to access in order to obtain relevant information and maximize patient health care. Therefore, health care documentation must be kept in an orderly, chronological sequence to ensure accessibility. Thus, health care professionals must include accurate times and dates of health care administration when completing health care documentation to facilitate the availability of health care information and to ensure their health care documentation is effective.

Section 2: Summary

Health care professionals must complete effective health care documentation. In order for health care documentation to be considered effective, it must function as a viable form of communication as well as a means to establish a detailed record of health care administration. There are many different forms of health care documentation; however, if health care professionals include specific characteristics in their documentation they can ensure it is effective.

The first characteristics of effective documentation are objectivity and accuracy. Health care documentation should include objective information free of subjective judgment, bias or opinion. Health care documentation should also be accurate - meaning it should include information which can be measured or verified by another individual. To ensure the information included in health care documentation is both objective and accurate, health care professionals may follow the See Rule. The See Rule encourages health care professionals to document what they can physically see on a patient's body, monitor and/or lab report.

Additional characteristics of effective health care documentation lie within the two Cs of effective health care documentation: Clarity and Completeness. Clarity, as it relates to health care documentation, can refer to a quality which enables multiple health care professionals to obtain meaning from recorded data and/or information relating to health care. Completeness, as it relates to

health care documentation, can refer to a state where all of the necessary components and/or parts are present. Only when Clarity and Completeness are achieved can health care documentation be considered effective.

Finally, the information found within health care documentation should be readily accessible and available to all those who require it. Thus, health care professionals must include accurate times and dates of health care administration when completing their health care documentation to further its effectiveness.

Section 2: Key Concepts

- *Health care documentation has two major objectives or functions. The first objective or function of health care documentation is communication. The second major function of health care documentation is to establish a detailed record of health care administration, which can be easily accessed and/or understood by intended parties.*
- *Health care documentation may be considered effective when its two major objectives or functions are achieved.*
- *Characteristics of effective health care documentation include objectivity, accuracy, Clarity, Completeness and the inclusion of accurate times and dates of health care administration.*

Section 2: Key Terms

Objectivity - *the process of obtaining meaning or information that is true outside of an individual's judgment, bias and/or opinion; the process of determining fact and/or reproducible/measurable data^{9,10}*

Subjectivity - the process of forming an opinion and/or judgment based on one's own point of view or perspective; when something is subjective, it is an opinion or point of view^{9,10}

The See Rule - advises health care professionals to document what they can physically see a patient doing or what they can see on a patient's body, patient monitor or lab report; encourages health care professionals to document data/information which can be verified or reproduced by two or more individuals

Clarity (as it relates to health care documentation) - a quality which enables multiple health care professionals to obtain meaning from recorded data and/or information relating to health care

Completeness (as it relates to health care documentation) - a state where all of the necessary components and/or parts are present

Section 2: Personal Reflection Question

How can health care professionals ensure their health care documentation is effective?

Course Review

The following questions are presented to further review the concepts found in this course. By reviewing these questions health care professionals can obtain knowledge which may be used to complete effective health care documentation.

What is the primary goal of communication in health care settings?

There are many goals of communication; however, it has been said that the primary goal of communication in health care settings is to obtain meaning and

a shared understanding of information and/or messages exchanged between two or more individuals.

What is the difference between objective information and subjective information?

Objective information is true or valid outside of an individual's judgment, bias and/or opinion. Objective information can typically be verified, reproduced and/or measured by two or more individuals. Subjective information is often an opinion and/or judgment based on one individual's point of view or perspective.

Why is it important for health care professionals to avoid "labels" when completing health care documentation?

Labels such as "difficult," "needy" or "unpleasant" should be avoided when completing health care documentation because they may represent subjective information based on judgment, bias and/or opinion, and thus may prove to be inaccurate. Health care professionals must do what is in their power to avoid documenting inaccurate information. Inaccurate information included in health care documentation may lead to miscommunication among health care professionals and, ultimately, patient adverse events, and perhaps even patient mortalities. Health care professionals should focus on documenting accurate information when completing health care documentation to ensure patient safety.

Why should health care professionals complete health care documentation in a timely fashion?

Health care professionals should complete health care documentation as close to the administration of health care as possible to foster accurate, up-to-date information. Accurate, up-to-date information is essential to the administration of health care. Waiting hours after health care administration to complete documentation may lead to inaccuracies due to an inability to recall events as they actually occurred. Moreover, waiting to document health care data can deprive fellow health care professionals of vital information which they may

require to make important decisions regarding a patient's treatment and overall health. Health care professionals must have accurate, up-to-date health care data/information to maximize patient care. Thus, health care documentation must be completed in a timely fashion.

Conclusion

Health care documentation can refer to a digital and/or analog record detailing the administration of health care to patients^{1,2}. It has been said that documentation is the foundation on which safe and effective health care is built upon. If completed effectively, health care documentation can be used in daily practice by health care professionals to communicate vital patient information to other health care professionals in order to facilitate positive health care outcomes and to decrease the potential for negative health care outcomes, such as adverse events and patient mortalities. Health care professionals must complete effective health care documentation to strengthen and reinforce communication among health care professionals and because it is their professional responsibility to do so.

In order for health care documentation to be considered effective it must function as a viable form of communication as well as a means to establish a detailed record of health care administration. There are many different forms of health care documentation; however, if health care professionals include specific characteristics in their documentation they can ensure it is effective. Characteristics of effective health care documentation include: objectivity, accuracy, clarity, completeness and the inclusion of accurate times and dates of health care administration.

Finally, health care documentation is essential to health care. When a patient is admitted into a health care facility, his or her health, overall well-being and quality of life often rely on the safe and effective administration of health care - effective health care documentation can be a means to provide patients with the safe and effective health care they rely on.

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