

# Nurse Documentation: Not Done or Worse, Done the Wrong Way—Part I

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**Purpose/Objectives:** To focus on nursing documentation and expanding technologies (e.g., facsimile, telephone, e-mail, computer charting) that offer different ways to record, deliver, and receive patient records and avoid nursing liability for inadequate or inaccurate documentation.

**Data Sources:** Nursing, non-nursing healthcare, legal journals, case law, and related Internet sources.

**Data Synthesis:** To avoid liability for inadequate or inaccurate documentation, nurses must be aware of the major issues involved in documentation litigation. New technology is altering how healthcare documentation is done and raising new confidentiality issues.

**Conclusions:** Nurses should follow their facility's guidelines and principles for documentation of patient care, especially when using more advanced technologies.

**Implications for Nursing Practice:** Educating nurses about the principles of documentation and the importance of implementing risk-reduction practices will help guard against liability and ultimately improve patient care.

## Key Points . . .

- ▶ New technology offering different ways to record, deliver, and receive patient records (e.g., facsimile, telephone, e-mail, computer charting) poses serious documentation and legal issues for nurses.
- ▶ Nurses must be knowledgeable about the risk factors associated with the emerging electronic technologies related to nursing documentation and confidentiality expectations and implement risk-reduction practices when using these new methods of communication.
- ▶ Various intrinsic and extrinsic reasons account for why healthcare professionals do not adequately document care.
- ▶ Nurses who follow their facility's guidelines on documentation are more likely to provide an accurately documented patient record and, as a result, better patient care.

**A**lthough the medical field has progressed significantly in detecting and treating cancer, more work needs to be done. Oncology nurses play a vital role in cancer prevention, detection, and treatment. Their responsibilities include working directly with the patients and providing documentation in patient records. In past years, documentation may not have been considered a very important part of a nurse's job. Today, what a nurse writes on a medical record or types into the computer in regard to the patient's care is important to more than just the patient.

Oncology nurses in the healthcare system, which is becoming more sophisticated, are not only concerned that patients receive proper care but also have to consider liability resulting from improper documentation. The number of negligence and malpractice lawsuits that name nurses as defendants because of their failure to adequately document patient care has increased in recent years. Nurses are under a great deal of scrutiny, regardless of the healthcare setting. For example, in the clinical trials setting, where documentation is critical to the evaluation of the experimental treatment, a greater emphasis is placed on correct documentation procedures and the increased role of risk managers as a result of litigation concerns. The work of the oncology nurse, whether in the hospital, home, or clinical trials setting, involves a great deal of documentation, such as charting the patient's history, physical changes, medications, treatments, chemotherapy administration, side effects, complications, family concerns, and tele-

phone conversations. The demand for oncology nurses involved in these activities can leave a paper trail that would take others months, or even years, to follow and understand. Nurses need to understand the laws as they apply to documentation and be familiar with the issues that have a substantial impact on their nursing role.

Adding the increased use of and reliance on technology in the nursing setting complicates matters even further because liability can result from the nurse's improper documentation when using these new technologies. Changing technology is stretching the parameters of documentation and the concerns related to adequately documenting care. Fortunately, oncology nurses can do several things to ensure effective patient care and proper documentation.

This article discusses the various methods and forms of documentation used by nurses and provides guidelines for the proper documentation of a patient's chart. Reasons why some nurses do not adequately document care also are discussed. The article focuses specifically on the widespread use of emerging technology and its impact on patient charting and

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