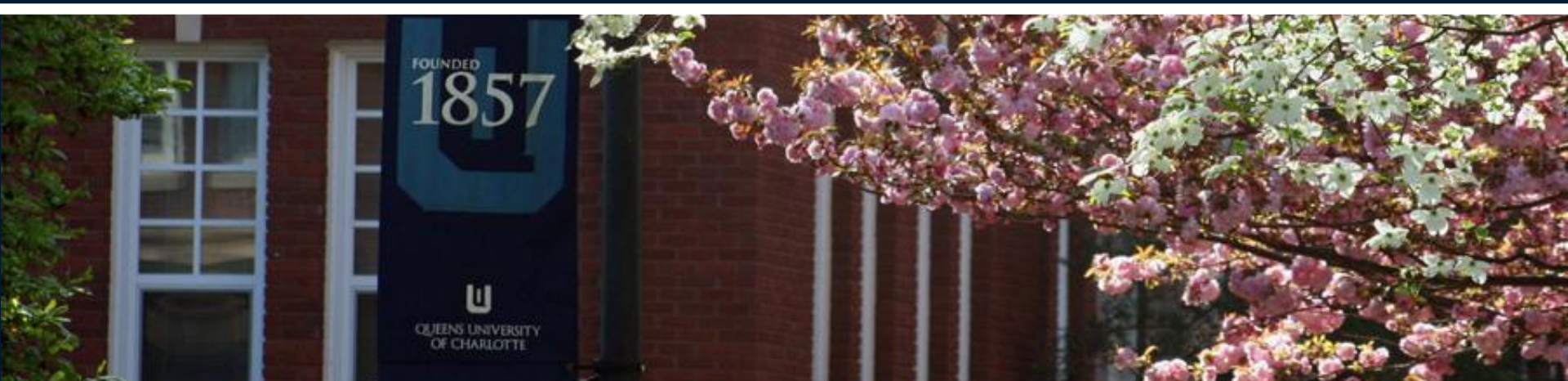


**ESSENTIALS OF LEGAL DOCUMENTATION IN  
SIMULATION SCENARIOS  
“NURSE SPEAK”**

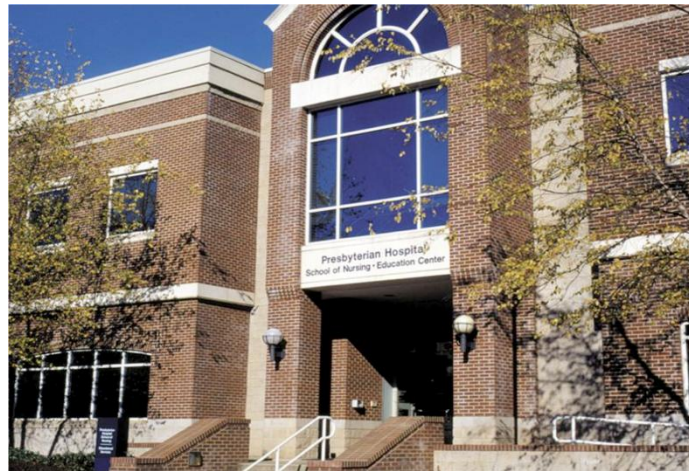
**Carey Friedrich RN MSN  
Donna Ferraro RN MSN**

**Presbyterian School Of Nursing  
Queens University of Charlotte**



## PRESENTATION OBJECTIVE

- By the end of this presentation the participants will be able to:
- Describe the benefits of assimilating legal documentation into scenarios in the PSL and student's response to this activity.



## LEARNING OBJECTIVES

- Define the methods used in the PSL to engage student's ability to critically think, speak, and write.
- Participants will understand that quality documentation must incorporate both critical thinking and the nursing process.
- The use of SBAR and DAR Notes in scenario's will improve verbal and written communication skills.
- Participants will describe the use of SBAR, DAR Note and Narrative Assessment as a strategy to articulate nursing care.

## What Does Florence Have to Say?

- “The most important practical lesson that can be given to nurses is to teach them what to observe –how to observe- which symptoms indicate improvement –which the reverse- which are of importance –which are of none –which are the evidence of neglect –and of what kind of neglect.”

FLORENCE NIGHTINGALE/NOTES ON NURSING  
(1859).

## Adding to Florence's Practical Advice:

- Our goal in simulation is for our students to not only observe and assess, but to document their data appropriately.



## WHY DOCUMENT?

- Legal Requirement and Nurse Protection
  - NOT DOCUMENTED → NOT DONE
- Financial Reimbursement
- Quality Assurance and Quality Improvement
- Research
- Monitoring and Auditing
- Communication and Continuity of Care
- Education and Evaluation of Patient Care
- Provides a Baseline

» (Potter and Perry ,2009).

# Who Regulates Medical Records?

State and federal laws

Accrediting organizations (JCAHO)

Case Law

Licensing Statutes

Statute of limitation is 2 years

# What does the Joint Commission have to say?

- “Nursing care data related to patient assessments, nursing diagnoses and/or patient needs, nursing interventions, and patient outcomes are permanently integrated into the medical record.”
- We are responsible for what we document today, tomorrow, and in the future.

» (Doengens & Moorehouse, 2008).

## WHAT INSPIRED US ?

- Course in Legal Documentation
- Not enough emphasis in the curriculum
- Concerns regarding spelling and grammar
- Diverse student population
- Lack of required medical terminology

# Student Spelling Samples From Two Nursing Programs:

- Pholey
- Apindix
- Meninjitis
- Needlesporin
- Pnemomia
- Soar for sore
- Cerserians
- Stimulation lab

## OUR APPROACH

- Faculty Input- Identified Concerns
- Informal Survey of Faculty
- Developed a Student Survey
- Yes and No Questions/One short answer
- Targeted our student population
- Two Groups:
  - Seniors about to graduate
  - First Med-Surgical course

## STUDENT SURVEY RESULTS

- 1) Do you have a good grasp of Nursing Documentation?  
Med Surg 1: 15 YES, 20 NO  
Seniors: 9 YES, 25 NO
  - 2) Can you chart accurately and chronologically  
Med Surg 1: 18 YES, 17 NO  
Seniors: 19 YES, 14 NO
  - 3) Does CBE help you develop good charting habits?  
Med Surg 1: 20 YES, 15 NO  
Seniors: 18 YES, 16 NO
  - 4) Would you like more information regarding documentation?  
Med Surg 1: 35 YES  
Seniors: 32 YES, 3 NO
  - 5) Do you want to do more verbal reporting thus improving your ability to speak like a nurse?  
Med Surg1: 33 YES, 2 NO  
Seniors: 31 YES, 3 NO
- 35 STUDENTS PER GROUP

## SHORT ANSWER QUESTION:

### ■ 1) WHAT ARE YOUR BIGGEST CONCERNS REGARDING NURSE DOCUMENTATION?

- Abbreviations
- Accuracy
- Spelling
- Unable to present a “clear picture”
- Medical terminology
- Unable to protect
- What to document
- What not to document
- Afraid of being vague
  - Omitting pertinent data

## What is the challenge in the PSL?

Nursing students will develop into holistic thinkers by performing scenarios, documenting appropriately by using the Nursing Process and critiquing each other's documentation during debriefing.

**GOAL: IMPROVE STUDENT NURSES' WRITTEN AND VERBAL COMMUNICATION**

# Nursing Process

1. To teach students to think, problem solve, and organize their thoughts.
2. Guide for documentation regardless of the method utilized.

Paper vs. Electronic



# THE CORRELATION: CRITICAL THINKING AND LEGAL DOCUMENTATION

- □CLEAR
- □ACCURATE
- □PURPOSEFUL
- □DEFENSIBLE - relevant to legal documentation

(Paul and Heaslip,1995).

# HOW DO WE GET STUDENT NURSES IN SIMULATION TO CRITICALLY THINK? *HOLISTIC APPROACH-IT'S NOT JUST THINKING*

- Critically Listen
- Critically Write
- Critically Read
- Critically Speak
- Critically Think

(Paul and Heaslip.1995).

# METHODS USED TO DOCUMENT/COMMUNICATE IN SCENARIOS

- WRITTEN NARRATIVE (inclusive)
- FOCUS NOTES (DAR/DARP)
- SBAR (communication tool)

## Charting by Exception (CBE)

Does not provide enough information

Hard to recreate what happened

Increased liability

Does not show nurse attentiveness

Guido, pg 187.

# Role of the Facilitator

Facilitators- assist and guide student's to think, speak and write like nurses using the nursing process and critical decision making.

Analyze and critique the student's verbal and written skills by using narratives/DAR/SBAR and focus on this in debriefing.

# TEACHING STRATEGY

According to Billings and Halstead there are 23 different strategies. We choose FIVE:

- 1) Cooperative Learning- team and individual assignment
- 2) Imagery
- 3) Problem based learning- how to resolve problems
- 4) Reflection
- 5) Writing exercises in debriefing



# FACULTY TECHNIQUES

Assign Roles to facilitate teamwork and collaboration:

Student recorder

Assessment

Medication

Treatments

Communicator

Introduce Narrative Charting by Use of Whiteboard

Instruct students in SBAR and DAR Notes

**EMPHASIZE: FACT**

**FACTUAL, ACCURATE, CONSISE AND TIMELY**

# Form Used for Assessment

Presbyterian School of Nursing at Queens University of Charlotte  
NURS 191 Fundamentals of Nursing  
Physical Assessment Narrative

General

survey: \_\_\_\_\_  
\_\_\_\_\_

Skin:

\_\_\_\_\_

Head:

\_\_\_\_\_

Eyes / Vision:

\_\_\_\_\_

Ears / Hearing:

\_\_\_\_\_

Neck:

\_\_\_\_\_

Chest & Lungs:

\_\_\_\_\_

Heart & Pulses:

\_\_\_\_\_

Abdomen / GI:

\_\_\_\_\_

Musculoskeletal:

\_\_\_\_\_

Mental Health:

\_\_\_\_\_

Urinary:

\_\_\_\_\_

## Head to Toe Physical Assessment

1. Skin: Assess skin color, temperature, turgor, presence of hair. Is the skin dry or moist? Is the skin intact? Are mucous membranes pink, moist, intact? Describe any lesions, incisions, wounds, dressings, drains. Assess for bruises, rash, pressure ulcers, scars. **Complete Braden Scale.**
2. Respiratory: Assess for regular / irregular respirations and note the rate. Assess for labored / unlabored breathing. Does the chest expand symmetrically? Assess breathing sounds. Are nail beds and mucous membranes pink? Note any coughing. Is it productive or unproductive? Note amount, color, consistency, smell of secretions. Is client on oxygen? How much and what mode of delivery? Are chest tubes present?
3. Cardiovascular: Assess heart rhythm for regularity / irregularity. Are there extra heart sounds (S3 or S4) or murmur? Palpate precordium for thrill. Assess pulses according to scale. Note edema according to scale. Note any cyanosis. Check capillary refill in fingers and toes. Is patient on telemetry? Listen for bruits over carotid arteries and abdominal aortic artery.
4. Gastrointestinal: Listen for bowel sounds in all 4 quadrants. Are they hyper / hypo active; diminished? Assess client's abdomen – soft / firm; flat / distended; tender? Is there nausea, vomiting, constipation, diarrhea? Is the patient passing flatus? **When was last BM?** Is this patient's normal pattern? If ostomy present, describe location and color of stoma. Note any tubes, drains, tube feeding. Is the patient continent of stool?
5. Genitourinary / Reproductive: Is patient voiding at least minimum amount? Urinary catheter present? Pain, urgency, burning, difficulty with urination? Assess for bladder distention. Describe urine color, clarity, odor. Describe stoma color of ileal conduit, if present. If warranted, assess penis for circumcision; scrotum for edema or hernia. If warranted, assess for vaginal discharge and note color, consistency, odor. Assess perineum for redness, edema, bruising, or skin breakdown.
6. Neurologic: Assess level of consciousness. Does patient follow commands? Is patient alert, drowsy, lethargic, unresponsive, combative? Orient patient to person, place, time, situation. Assess for comprehension of speech and clarity of speech. Is patient's behavior appropriate for age & situation? Assess mood, affect & emotional status. Assess pupils – Pupils Equal Round Reactive to Light and Accommodation (PERRLA)?
7. Musculoskeletal: All extremities present? Assess strength, sensation, motor function of extremities. Can patient move all extremities equally and freely? Is range of motion within normal limits? Assess gait and weight bearing status. Note any casts, splints, braces, mobility aids.  
**Complete Falls Risk assessment.**

## The Importance of SBAR

- LITERATURE SUPPORTS THAT ORGANIZED COMMUNICATION IN HEALTHCARE IS ESSENTIAL AND THE JOINT COMMISSION HAS DETERMINED THAT 70% OF SENTINEL EVENTS ARE RELATED TO INEFFECTIVE COMMUNICATION BETWEEN HEALTHCARE PROVIDERS.

(ONCOLOGY NURSING FORUM, 2007).

# SBAR –VERBAL COMMUNICATION

## *Situation, Background, Assessment, Response*

We want to teach students how to communicate effectively between caregivers about a patient's condition - safety innovation. Each scenario will include a call to MD and shift hand-off or transfer report.

## USE OF DAR NOTES

- 1) DATA- objective/subjective
- 2) ACTION- intervention
- 3) RESPONSE- evaluation (new time)

This process stimulates critical thinking and use of the nursing process.

## DEBRIEFING

1. Students will analyze their narrative assessment, DAR notes, and use of SBAR.
2. Facilitators will answer questions and reinforce documentation techniques.
3. Facilitators will reinforce the positive and be supportive.
4. Make debriefing a safe environment thus engaging the students.

## Questions Asked in Debriefing

- 1) HOW DID YOU FEEL USING THE NARRATIVE FORMAT?
- 2) DID IT HELP TO COLLABORATE WITH OTHER MEMBERS OF THE TEAM BEFORE CALLING PHYSICIAN ?
- 3) WAS THERE A POINT YOU SHOULD HAVE WRITTEN A DAR NOTE? LET'S DO IT NOW AS A GROUP.
- 4) COULD WE HAVE DOCUMENTED DIFFERENTLY TO GET OUR POINT ACROSS MORE SUCCINCTLY?
- 5) DESCRIBE YOUR KEY ASSESSMENTS.

## WHAT WE LEARNED:

- 1) Students need a foundation in documentation with consistent reinforcement.
- 2) Integrate EMR system in PSL (purchase or partner with Hospital System).
- 3) Continue the use of SBAR, DAR, and narratives in both the PSL and clinical setting.



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