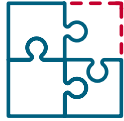


RISK MANAGEMENT RECOMMENDATIONS: Documentation for Nurses



The risk management recommendations included in this resource may not apply equally to all readers. Scope of practice set forth in state nurse practice acts and other regulatory guidelines vary by educational level, licensure, and facility policies and procedures. Yet every nurse must act within a defined scope of practice.

Maintaining a consistent, professional patient health information record is essential to providing quality patient care, ensuring consistent communication among all professionals caring for the patient, and establishing the basis for an effective defense should litigation arise. The following guidelines can help reduce risk:

➤ **Clinical Content**

Documentation in the patient's health information record should include, but not be limited to, the following:

- Allergies, which should be conspicuously marked
- Current and past medications, including both prescribed and over-the-counter medications, including supplements and holistic/alternative remedies, and whether the patient has varied from their current prescribed medication regimen
- Nursing risk assessments including, but not limited to, the following areas:
 - Ambulation status
 - Need for assistance with activities of daily living
 - Bowel and bladder function
 - Mental status (i.e., emotional and cognitive functioning)
 - Elopement risk (for higher-risk individuals, including, among others, children, the aged, behavioral health and developmentally disabled patients)
 - Fall risk
 - Nutritional status
 - Pain management
 - Skin and wound condition
- Discussions with the patient about medical issues that require additional explanation by the physician/licensed independent practitioner or other healthcare provider
- Medications administered, including injections, ointments, infusions, as well as a description of the patient's response
- Nursing observations during patient contacts

- Patient's questions and responses regarding the nursing care/service plan, as well as the goals and methods of treatment
- Patient's response to nursing care
- Patient's chief complaint or current healthcare concerns
- Review of current problems or symptoms
- Review of clinical history, including relevant social and family history
- Skin and wound condition, including nursing assessment, clinical findings and observations, the nursing care/service plan and the patient's response to treatment
- Vaccine tracking information for all vaccines administered
- Encounters with healthcare providers, including those via telephone, facsimile, and email, with a summary of the discussion and any subsequent nursing actions taken
- Use of an interpreter, including the interpreter's contact information

➤ **Diagnostic Tests, Referrals, Consultations**

- Contact the patient's healthcare provider to report abnormal test results and any provider orders for additional testing or follow-up and document the interaction
- Contact consulting physicians/licensed independent practitioners to confirm that the consulting provider was notified of the consultation request and to facilitate the timely provision of the consultation and receipt of the results. Document these actions in the patient's health information record.
- Utilize the chain of command to report abnormal laboratory results and the results of consultations if the ordering/primary care physician is not available or does not respond to messages.
- Initiate additional steps, if necessary, to ensure timely patient care. These may include reporting to the supervisor/nurse manager, administrators, last attending or covering physician, licensed independent practitioner and/or medical staff leadership until the abnormal result is addressed.

➤ Medications and Prescriptions

- Review and update the current medication list and patient's reported compliance with prescribing orders.
- Perform the appropriate medication reconciliation process following patient admission, changes in care or treatment, transfer from one service to another (e.g., after surgery or delivery), or post-discharge return to care.
- Notify the physician/licensed independent practitioner of the need for medication order changes or prescription renewals.
- Clearly describe patient responses to medications, positive or negative.
- Document signs or symptoms of adverse drug reactions, contact with physicians/licensed independent practitioners and subsequent follow-up.

➤ Patient Education

- Conduct and document an informed consent discussion with the patient prior to implementing any aspect of the treatment plan that involves potential risk, ask the patient to repeat the main points of the discussion, and obtain the patient's stated and written consent.
- Describe patient and family healthcare education encounters, listing the presence of specific family members and their relationship to the patient.
- Provide a written assessment of the patient's ability to comprehend and repeat information provided both initially and after three or more minutes have elapsed.
- Maintain a copy of written material provided and document references to standard educational tools.
- Retain patient-signed receipts for any educational materials provided.
- Document the use of interpreters, if needed, and include the interpreter's contact information.



Maintaining a complete and accurate medical record is essential in defending against any potential allegations of malpractice.

