

Documentation Reminders

By Nicole Harmon, RN, BSN

Nurses Service Organization (NSO) is a leading provider of professional liability insurance for nurses and offers information for protecting nurses from a lawsuit.

One area of focus is the ever-important documentation. According to NSO, there are five main purposes for good documentation:

- Protecting your patient.
- Demonstrating that you are a competent nurse.
- Keeping you from being named in a lawsuit.
- Keeping you out of court if you are named in a suit.
- Helping you win if you do go to court.

NSO also gives the Top 10 Rules of Good Documentation:

1. Never alter a record – mark through errors with one line, indicate the correction and initial.
2. Record only the facts. Chart only observed behavior.
3. Do not chart critical comments or opinions.
4. Begin each entry with the date/time and end with signature and

title (Meditech does this for you as long as you remember to set the correct time stamp!)

5. Use only approved abbreviations.
6. Record all hand written entries legibly and in ink (be sure your signature is legible too!)
7. Avoid using generalized phrases (“The pt had a good day” can be interpreted many ways.)
8. Document circumstances and handling of errors (Unusual Occurrence reports are NOT a part of the patients’ records)
9. Chart only for yourself – don’t let anyone else chart for you.
10. Do not allow any unauthorized person access to a pt’s medical record.

Remember, if it’s not documented, it’s not done. If it’s poorly documented, it’s poorly done. If it’s incorrectly documented, it’s fraudulent!

Reference: <http://www.brainshark.com/brainshark/vu/view.asp?pi=871020673>

We Need You! Annual Competency & Skills 2010

By Katherine Cholet, MSN, RN

In July, I had the opportunity to go to the National Nursing Staff Development Conference, attending several presentations on competency assessment, development, research, and future trends in clinical education in times of budget restraints. After returning to work, I began to ponder our annual competency process and what steps we might take to achieve real excellence in this area.

In 2009, everyone did a fantastic job with attendance, participation, and online testing. In addition, the organization was able to meet and document all the required accreditation standards for the education processes for the American Osteopathic Association, the College of American Pathologists, and the Joint Commission, but I have to ask myself, “Is it the best it can be? Does it meet the needs of the direct caregivers?”

Currently, the Magnet Education Council is discussing how to improve this endeavor for the 2010 year. As a learning organization, we want to move forward to improve our learning needs in a fluid, rather than stagnant, environment. To that end, I am requesting your input regarding the annual competency and skills day’s process. How would you move from accreditation-focused to learner-focused education while meeting the required standards?

I value your thoughts, ideas, and concerns and would love to hear from you. Please call me at 256-6197 or email me at kcholet@gjhosp.org.

Thank you in advance for your valued input.



Community Hospital Nurses:
**Driven to Excellence,
Compelled by Compassion**
Non Sibi Sed Omnibus (not alone, but together)

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American Association for Respiratory Care Webinar:

Corticosteroid Therapy
and Chronic Obstructive
Pulmonary Disease
Featuring Neil MacIntyre MD,
FAARC
August 26 • 5:45 - 6:45 p.m.
LLCRs 1 & 2

*This session has been approved
by the Magnet Education
Council for one hospital
education hour.*

ANA Bill of Rights for Nurses

August 25 • 11 a.m.
Boardroom
Please bring your lunch &
take part in an informative
presentation by Beth Bricker.

Magnet Council Meetings

Recruitment & Retention
2nd Wednesday • 3 p.m.
August 12 • Board Room

Evidence-based Practice
3rd Tuesday • 3:30 p.m.
August 18 • LLCR 1 & 2

Nurse Leadership
3rd Wednesday • 3 p.m.
August 19 • Board Room

Education
4th Wednesday • 2 p.m.
August 26 • Board Room

Nurse Practice
1st Wednesday • 3:30 p.m.
September 2 • LLCR 1 & 2

Red and Yellow, Black and White: Cultural and Ethnic Diversity

By Kathy Olsen, BSRN, MGH, MHA

Ethnic and cultural diversity is commonplace and has a daily impact on the provision of healthcare, even in Grand Junction.

According to the April 2003 Grand Junction Report, the 2000 census statistics reveal that the Hispanic population accounts for 10 percent of Mesa County's overall population. This represents only a 2 percent increase from the 1990 census statistics, however according to the Colorado Advisory Committee to the U.S. Commission on Civil Rights report, this is likely a significant undercount due to the influx of seasonal and migrant farm workers needed for agriculture. It is also revealing that approximately 14.6 percent of all students enrolled in the public schools are Hispanic, additionally suggesting that the Latino population is young and growing. These facts put into



perspective the importance of caregiver's cultural awareness and cultural competence.

According to the Provider's Guide to Quality and Culture web site:

- Providers may order fewer diagnostic tests for patients of different cultural backgrounds because they may not understand or believe the patient's description of symptoms, or conversely may order more diagnostic tests to compensate for not understanding what the patient is saying.
- Patients may not adhere to medical advice because they do not understand or trust the provider.
- African-Americans may be less likely to be referred for cardiac catheterization versus Whites, even when presenting with the same symptoms.
- Although Hispanics have a lower incidence of breast, oral cavity, colorectal, and urinary bladder cancers their mortality from these is similar to that of the majority population.

Our patients are shaped by many influences including culture, environment, economics, genetics, health status (previous and current), as well as psycho-social factors. They depend on us as nurses to advocate for their needs in a culturally sensitive and knowledgeable manner when in our care.

References:

The Grand Junction Report: Issues of Equality in the Mesa Valley.

Colorado Advisory Committee to the U.S. Commission on Civil Rights.
www.usccr.gov/pubs/sac/co0403/gj.pdf.

Common Beliefs and Cultural Practices. The Provider's Guide to Quality and Culture www.erc.msh.org/mainpage.cfm?file=5.3.0.htm&module=provider&language=English.

The Insulin Project: Addressing Issues

By the Medication Administration Team

Each month all completed med events reports are analyzed and reported to identify possible trends and concerns. Through this data analysis process, it was identified that there are some issues with the process of administering insulin.

The medication administration team analyzed the processes and identified:

- issues with the MARs,
- that the insulin protocol and the nursing intervention must match, and
- that the process of independent nurse verification might be misunderstood by direct-care nurses.

Double-checking insulin administration includes subcutaneous insulin administration, as well as IV and IV insulin infusion programming.

However, double-checking does not simply mean you need five units and you have five units. Rather the MAR is checked, and the time, the amount, and the type of insulin are independently verified by a second nurse. (Hint... carbohydrate coverage must be evaluated to obtain the right dose.)

Please contact your representatives on the Medication Administration Team Insulin Project for any suggestions and/or feedback. Team members include: Cindy Wells, RN and Paula

Wiman, RN for the medical surgical units; Susie Schultz, RN for ICU; Leanne Pankey, RN for surgical services; Tami Roberts, RN for ED; Jim Gardner, pharmacist; Sandie Davis, IT; Kathy Olsen, RN-nursing; Terri Thompson, RN, CDE; and Katherine Cholet, RN educator.



Hard to Swallow

By Barbara Gardner, RN, CIC

Patients at risk for developing complications of aspiration and malnutrition must be identified on admission or throughout a patient's hospital stay according to Centers for Medicaid and Medicare Service requirements. The American Osteopathic Association surveyors identified that we could be more inclusive by adding to our current assessment. As a result, on July 7, 2009 the inpatient admission assessment was enhanced to include the following aspiration assessment:

Recent onset of impaired swallowing/speech? (Y/N)	
Do you cough/choke when eating/drinking? (Y/N)	
Where does the food FEEL like it's caught?	

If yes is answered on either of the questions an automatic referral is made to Speech Therapy for evaluation.