Principles and Perils of Documentation

Karen Fogelman, RN, CRNO, CLNC
Patricia Lamb, RN, CRNO, CLNC
We have no financial interest in the material presented in this course
Documentation

- Process of providing evidence
- Official information that serves as a permanent record
- The act of furnishing or authenticating an event with documents
Documentation is
Like the Telephone game

- miscommunication
- story gets changed
- confusion is created
“The single biggest problem in communication is the illusion that it has taken place.”

George Bernard Shaw
Medical Documentation

Any written or electronically generated information about a patient that describes the care or service provided to that patient.
Principles of Documentation

- Clear and Legible
- Correct Spelling
- Accuracy
- Factual
- Appropriate
- Organized
- Signature
I've got to tell you something. Are you sitting down?

I am actually. What's up mom?

Your brother was adopted!

What??? What are you talking about?

Why are you telling me this over a text? Call me

Oh this damn phone. I wrote accepted and the phone changed it. He got accepted to Yale!
Great example of importance of accuracy!

<table>
<thead>
<tr>
<th>Procedure:</th>
<th>OD: PRK</th>
<th>OS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Rx:</td>
<td>OD: plano</td>
<td>OS:</td>
</tr>
</tbody>
</table>

**SURGICAL PLAN:**

- Conventional: OD: -1.35+1.25x170  OS:

Notice: Review Pending/Day of Surgery Testing Scheduled

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<table>
<thead>
<tr>
<th>Procedure:</th>
<th>OD</th>
<th>OS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Rx:</td>
<td>OD: plano</td>
<td>OS:</td>
<td></td>
</tr>
</tbody>
</table>

**SURGICAL PLAN:**

- Conventional: OD: -1.35+1.25x170  OS:

Document Generated by: Misty Butcher  03/15/2012 3:44 PM

Additional Information received and reviewed: ________

Minus cylinder

Plus cylinder
Importance of Documentation
(Cannot be Overstated)

- Chronologically Documents the care of the Patient
- Reports the Patient’s progress
- Contributes to High-Quality care
- Provides Communication and Continuity of care
Importance of Documentation

✦ Reflects Patient Compliance
✦ Monitors the Care of the Patient over Time
✦ Essential for Standards of Care to be Met
✦ Legal Protection for the Patient and Medical Personnel
The patient’s medical record is the **ONLY** place where **ALL** of the important information about that person can be found.
Poor Documentation Makes Good Care Look Bad
If it wasn’t documented…….

IT WASN’T DONE!!!
What to Include in Good Documentation

✦ Thorough Entries
✦ Timely Notes
✦ Objective and Measurable Statements
✦ Proper Correction of Errors
Correcting Errors

- Do not erase
- Never use correction fluid
- Never cross through a note and write over it
- Never cross through a mistake more than one time.....one strike through, write “error” beside the note, enter date, time and your initials
Good example of improperly making corrections by writing over numbers.
Documentation Don’ts

- Don’t be subjective
- Don’t attempt to change an entry after it is submitted
- Don’t document for someone else
- Don’t back-date entries
- Don’t tamper with records
- Don’t remove pages from a chart
what's wrong with this picture?
where are the documentation do’s?
where are the documentation don’ts?
Integrity of the Medical Record

The medical record is a major source of defense if there is a malpractice claim.

Lack of reliability and credibility is fatal to the defense of a claim.
Documentation In the Medical Record--Who Will Be Looking at Your Records?

✦ Yourself
✦ Other Doctors
✦ Nurses, Technicians, and Other Personnel
Who will REALLY be Looking?

- Lawyers
- Judges
- Patients
- Jury
- Members of the public
- Most of the witnesses
Medical Records: Medical and Legal Document
How do Lawyers Use Medical Records

- To Establish Facts
- To either destroy or bolster your credibility
- To educate the jury
- Through testimony
- With large graphic diagrams and charts
Why are Medical Records So Important In a Medical Malpractice Lawsuit?

- Legal business record—to assist the jury when deciding standard of care
- Credibility—bolster or tear down credibility of witness
- Presumed reliability—created at time of care: plaintiff’s expert must initially rely upon it
- Expectation—You will document what you do. If not, you did not do it
- Critical to defense of physician—Many cases are indefensible due to incomplete or inaccurate documentation
Credible Records

- Legible
- Organized
- Accurate
- Unambiguous
- Timely
- Signed
What Makes a Medical Record Credible From a Defense Standpoint?

✦ Legible--Can you read your own writing?
✦ Organized--Can you find important dates?
✦ Accurate--Any clear errors?
✦ Complete--Any blank spaces of lack of data?
✦ Timely--Any late entries well after the event?
✦ Signed--Did you read or make an entry?
✦ Changes to a record--Are there any changes from the first documentation and did you identify what changed and when?
Incredible Records

- Illegible--cannot even read their own writing
- Disorganized--cannot find or defend important data
- Incomplete--blank spaces, lack of data, no history of patient’s statements about condition, no summary of visit or plan of treatment, no time or date, no documentation of discussion between provider and patient
- Unsigned--did you ever read it or even see it
- Changes in the record--without identifying who made the change, identifying what was changed and when
Altered or changed medical records are fatal to the Defense.
General Examples of Questionable Documentation
The initials beside the adjustment were placed there ONLY after the technician asked the MD to do so!!
Which Wavefront correction is the physician’s choice?
How do we know a physician reviewed and approved this?
Who actually gave this order??!!
And which one do you use?

Physician initials should be present to show the chosen correction has been reviewed and approved.
Which is the chosen wavescan, #1, 2, or 3?

Answer: #3!
Consequences can be VERY Expensive!!
Reasons for Nursing Litigation

✦ Medication errors
✦ Communication errors
✦ Failure to monitor and assess
✦ Failure to properly advocate for the patient
✦ Standards of Care not met
✦ Lack of thorough documentation
Enemies of Documentation

- Time consuming
- Written evidence
- Subjective
Documentation as Your Friend

✦ Defense Shield
✦ Reduces Risk
✦ Saves Time
✦ Written Evidence

Medical records can be a major source of rationale for lawsuits OR a major source of defense in a malpractice claim.
Electronic Medical Records
Electronic Medical Records

- Provides ease of access
- Can be updated easily
- Standardizes forms, terminology, abbreviations, and data input
- Facilitates coordination of healthcare delivery
- Physical storage space is eliminated
Pros of Electronic Medical Records

- Doctors have greater access to other medical professionals
- It is easier for records to be updated
- Easier to locate records
- Workflow procedures run faster and more efficiently
- Relevant data is stored in one primary location
- Reduction in human errors
- Increased safety and security
- Cost efficiencies due to data consolidation
Cons of Electronic Medical Records

- More complicated to use than paper based medical records
- Threat to privacy
- Personnel require extra training
- Loss of human touch points in the healthcare setting
- Security procedures must be incorporated to ensure confidentiality
- Lack of standardization due to relatively new system
- Do not always offer enough flexibility in recording observations on a patient
EMR Drop Downs

- Very time consuming--boxes are tiny and menus are detailed
- Hard sometimes to find what you want
- Easy to miss something or check something wrong
- Because notes look so similar, it is hard to tell what actually happened at the visit
Admission notes have no mention of ophthalmic problems.
Documentation

MUST be legible
**Activity Date:** 04/29/07  
**Time:** 1658

<table>
<thead>
<tr>
<th>Document</th>
<th>04/29/07 1628 CMT</th>
<th>04/29/07 1629 CMT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake, Oral</td>
<td>1290</td>
<td></td>
</tr>
<tr>
<td>Output, Void</td>
<td>950</td>
<td></td>
</tr>
</tbody>
</table>

**Patient Notes:**
- **Activity Date:** 04/29/07  
  **Time:** 1820

**Ordered: 04/29/07 1820 DMT  
04/29/07 1930 DMT**

**Abnormal?** N  
**Confidential?** N

**Readings:**
- No ICU Lab Results as of yet. 1700 PS 488. Stat Glucose ordered. No results as of yet.
- No XCI Lab Results as of yet. 1700 PS 488. Stat Glucose ordered. No results as of yet.

**Description:**
- **Note Type:** None
- **Description:** None

---

**Activity Date:** 04/29/07  
**Time:** 1830

**Assessment:**
- **Assessment: Adult Head/Toe (SHIFT)**  
- **Document:** 04/29/07 1330 DMT | 04/29/07 2320 DMT

**Weight:** 235  
**Method of Determining Weight:** 1 ACTUAL

**Level of Consciousness:** Alert

**Responds To:** Alert
**Alert & Oriented X 3 Y**

**Neurological Comments:** NONE

**Airway:** CLEAR

**Respiratory Depth:** Normal  
**Respiratory Effort:** Shallow

---

**Gastrointestinal Comments:** CLAIMED HAD BM TODAY WITHOUT PROBLEM

**Does Patient Have Any Genital or Urinary Problems?** N

**Urine Color:** Yellow
**Urine Character:** Clear

**Dysuria?**? N  
**Foley Catheter?** N  
**Bladder Incontinence?** N

**Voiding Sufficient Amounts? Y**

**Genitourinary Comments:** VOIDING WELL PER URINAL

**Range of Motion Arms:** BOTH  
**Range of Motion Legs:** BOTH

**Muscle Strength Extremities:** ALL EXT  
**WEAK**

**Joint Swelling or Pain?** N  
**Edema?**  Y

**Musculoskeletal Comments:** WITH EDEMA ON BOTH UPPER AND LOWER EXTREMITIES

**IV or Arterial Lines Present?** N

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**Activity Date:** 04/29/07  
**Time:** 1811
<table>
<thead>
<tr>
<th>Activity Date: 04/30/07</th>
<th>Time: 1400 (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse Type: Normal</td>
<td>Temperature: 98.8</td>
</tr>
<tr>
<td>Source: ORL</td>
<td>Respiration: 20</td>
</tr>
<tr>
<td>02 SAT: 91</td>
<td>Oxygen Flow Per Minute: RA</td>
</tr>
<tr>
<td>02 Therapy: Room Air</td>
<td>Pain Scale: 0</td>
</tr>
<tr>
<td><strong>Activity Date: 04/30/07</strong></td>
<td><strong>Time: 1430</strong></td>
</tr>
<tr>
<td><strong>Patient Notes:</strong> Nursing Notes</td>
<td></td>
</tr>
<tr>
<td>Create: 04/30/07 1420</td>
<td>NOTE: GONE FOR OPHTHM APPT VIA AMBULANCE.</td>
</tr>
<tr>
<td>No Type</td>
<td>Description</td>
</tr>
<tr>
<td>None</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity Date: 04/30/07</th>
<th>Time: 1620</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake and Output</td>
<td>A QS CP</td>
</tr>
<tr>
<td>Intake: Oral: 825</td>
<td>Output: Void: 950</td>
</tr>
<tr>
<td>60116 DIET-Amount Taken</td>
<td>A TID CP</td>
</tr>
<tr>
<td>Diet: American Diabetic Assoc.</td>
<td></td>
</tr>
<tr>
<td>% of meal taken: 75%</td>
<td></td>
</tr>
<tr>
<td><strong>Activity Date: 04/30/07</strong></td>
<td><strong>Time: 1700</strong></td>
</tr>
<tr>
<td>Bedside Glucose</td>
<td>A AC and HS PS</td>
</tr>
<tr>
<td>Result(s): 447</td>
<td>T Y</td>
</tr>
<tr>
<td>Patient Notes: Nursing Notes</td>
<td></td>
</tr>
<tr>
<td>Create: 04/30/07 1700</td>
<td>No Abnormal? N Confidential? N</td>
</tr>
<tr>
<td>Back FROM OPHTHM APPT, SCRIPTS AND ORDERS SCANNED TO PHARM.</td>
<td></td>
</tr>
<tr>
<td>No Type</td>
<td>Description</td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity Date: 04/30/07</th>
<th>Time: 1830</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003S-8 Assessment, Adult Head/Toe (SHIFT) A QS CP</td>
<td></td>
</tr>
<tr>
<td>Document: 04/30/07 1830</td>
<td>05/03/07 0249</td>
</tr>
<tr>
<td>Method of Determining Weight: 1 ACTUAL</td>
<td></td>
</tr>
<tr>
<td>Level of Consciousness: Alert</td>
<td></td>
</tr>
<tr>
<td>Responds To: Alert</td>
<td></td>
</tr>
<tr>
<td>Alert &amp; Oriented X 3 Y Neurological Comments: NONE</td>
<td></td>
</tr>
<tr>
<td>Airway: CLEAR Respiratory Depth: Normal</td>
<td></td>
</tr>
<tr>
<td>Respiratory Effort: Shallow</td>
<td></td>
</tr>
<tr>
<td>L.Upper Lobe Clear</td>
<td></td>
</tr>
<tr>
<td>L.Lower Posterior Lobe Clear R.Upper Lobe Diminished</td>
<td></td>
</tr>
<tr>
<td>R.Lower Posterior Lobe Diminished On Oxygen Y Oxygen Delivery Device: IV</td>
<td>Oxygen Flow Rate: 2 LPM</td>
</tr>
<tr>
<td>Cough: Y Productive Cough: N Hemoptysis: N</td>
<td></td>
</tr>
<tr>
<td>Pulmonary Comments: NONE Rate: Normal</td>
<td></td>
</tr>
<tr>
<td>Rhythm: Regular</td>
<td></td>
</tr>
<tr>
<td>ICU or Telemetry Unit Patient? N Heart Sounds: Regular</td>
<td></td>
</tr>
<tr>
<td>Right Radial Pulse: 83 Left Radial Pulse: 83</td>
<td></td>
</tr>
<tr>
<td>Right Pedal Pulse: 83 Left Pedal Pulse: 83</td>
<td></td>
</tr>
<tr>
<td>Jugular Venous Distention Present? N Peripheral Edema: Y</td>
<td></td>
</tr>
<tr>
<td>Capillary Refill: 2 SECs Periphereral Vascular Device: None</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Comments: NONE</td>
<td></td>
</tr>
<tr>
<td>Any GI Problems? N Bowel Sounds: NORMAL</td>
<td></td>
</tr>
<tr>
<td>BS 4 Quadrants? N Abdomen Assessment: Soft</td>
<td></td>
</tr>
<tr>
<td>Tenderness? Y Passing Flatus? Y Nausea or Vomiting? N</td>
<td></td>
</tr>
<tr>
<td>Bowel Incontinence? N GI Bleeding? N</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal Comments: DENIES PROBLEM</td>
<td></td>
</tr>
<tr>
<td>Does Patient Have Any Genital or Urinary Problems? N Urine Color: Yellow</td>
<td></td>
</tr>
<tr>
<td>Urine Character: Clear</td>
<td></td>
</tr>
<tr>
<td>Dysuria? Y Foley Catheter? N</td>
<td></td>
</tr>
<tr>
<td>Activity Date: 04/30/07</td>
<td>Time: 1830 (continued)</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Activity Date: 04/30/07</td>
<td>Time: 1830 (continued)</td>
</tr>
<tr>
<td><strong>Activity Type</strong></td>
<td><strong>Date</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Bleeding Incidences?</strong></td>
<td>N</td>
</tr>
<tr>
<td><strong>Voiding Sufficient Amounts?</strong></td>
<td>Y</td>
</tr>
<tr>
<td><strong>Gastrointestinal Comments:</strong></td>
<td>VOMITING WELL PER URINAL</td>
</tr>
<tr>
<td><strong>Range of Motion Arms:</strong></td>
<td>BOTH</td>
</tr>
<tr>
<td><strong>Range of Motion Legs:</strong></td>
<td>BOTH</td>
</tr>
<tr>
<td><strong>Muscle Strength Extremities:</strong></td>
<td>ALL EXT WEAK</td>
</tr>
<tr>
<td><strong>Joint Swelling or Pain?</strong></td>
<td>N</td>
</tr>
<tr>
<td><strong>Edema?</strong></td>
<td>Y</td>
</tr>
<tr>
<td><strong>Musculoskeletal Comments:</strong></td>
<td>INJURY ON BOTH UPPER AND LOWER EXTREMITIES</td>
</tr>
<tr>
<td><strong>IV or Arterial Lines Present?</strong></td>
<td>N</td>
</tr>
<tr>
<td><strong>Skin Integrity:</strong></td>
<td>INTACT</td>
</tr>
<tr>
<td><strong>Color of Skin:</strong></td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Skin Temperature:</strong></td>
<td>Warm</td>
</tr>
<tr>
<td><strong>Turgor:</strong></td>
<td>Good</td>
</tr>
<tr>
<td><strong>Fever:</strong></td>
<td>N</td>
</tr>
<tr>
<td><strong>Sensory Perception:</strong></td>
<td>4 No Impairment</td>
</tr>
<tr>
<td><strong>Moisture:</strong></td>
<td>3 Occasionally Moist</td>
</tr>
<tr>
<td><strong>Activity:</strong></td>
<td>2 Chairfast</td>
</tr>
<tr>
<td><strong>Mobility:</strong></td>
<td>3 Slightly Impaired</td>
</tr>
<tr>
<td><strong>Nutrition:</strong></td>
<td>3 Adequate</td>
</tr>
<tr>
<td><strong>Total Braden Score:</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>In your opinion is skin condition worsening?</strong></td>
<td>N</td>
</tr>
<tr>
<td><strong>Patient Incubated More Than 24 Hours?</strong></td>
<td>N</td>
</tr>
<tr>
<td><strong>Side Rails Up?</strong></td>
<td>2/4</td>
</tr>
<tr>
<td><strong>Bed Position:</strong></td>
<td>SEMI FOWLER</td>
</tr>
<tr>
<td><strong>Isolation:</strong></td>
<td>LOW POSITION</td>
</tr>
</tbody>
</table>

**Nursing Notes:**
- **Patient in a Negative Pressure Room?** N
- **Seizure Precautions?** N
- **Special Bed/Mattress?** N
- **Special Bed/Mattress Type:** NONE
- **Special Bed Mattress?** N
- **Stop Specialty Bed Now?** N
- **Stop Wound Vac Now?** N
- **Restraints?** N
- **Age (Choose 1 Only):** 60-69 Years Old 1

**Assessment:**
- **Done by R.N.? Y**

**Patient Notes:**
- **Nursing Notes:**
  - 04/30/07, 1830 DMT
  - 04/30/07, 2248 DMT
- **Abnormal?:** N
- **Confidentiality:** N
- **Received Report from MD and Patient Care, High Potency Alert and/or Oral Medication, and Denies Alcohol Intake at 2PM Via NC, NG IV access with INJURY ON BOTH UPPER AND LOWER EXTREMITIES. Had dinner with a fair appetite. With redness noted on right eye. Assessment done and will continue to monitor.**

---

**Activity Date: 04/30/07 | Time: 1830 (continued) |**

**Mental Status:**
- **Choose 1 Only:** Oriented Always or Coma 0

**Length of Stay:**
- **Choose 1 Only:** 4-7 Days 1

**Elimination:**
- **Choose 1 Only:** Continent/Independent 0

**Impairments:**
- **Choose 1 Only:** Mild Visual/Hearing Prob 1

**Blood Pressure/Vomiting:**
- **Choose All That Apply:** Hypertensive 0

**ADD-Totals Points in BP/Vomiting Block: 0**

**Predisposing Conditions/Diseases:**
- **Choose All That Apply:** Lung/Diabetes 1

**ADD-Totals Points in Pr-existing Condition Block: 6**

**Gait and Mobility:**
- **Choose All That Apply:** Significant Weakness 1

**ADD-Totals Points in Gait and Mobility Block: 1**

**Medications/Alcohol in PAST 24 Hours (Choose All That Apply): None**

**ADD-Totals Points of All Meds Picked In Block Meds/Alcohol: 0**

**TOTAL FALL RISK: 10**

**In your professional opinion should patient be fall prone? N**

**Special Diet: 1800 ADA LOM FA**

**Clear Liquids or No固体 for greater than 3 days? N**

**Currently on tube feeding or TPN or PN? N**

**Nutrition Comments:**
- **NONE**

**Does the Screen or Diagnosis Indicate Nutrition Risk? N**

**Does Patient Need to be Evaluated by a R.N. to assess? Y**

**Reason for Rehab Evaluation: GENERALIZED WIKENESS**

**Does Pt have difficulty managing ADL's? N**

**Any New Problems with speech, feeding, or swallowing? N**

**Does Patient LACK Adequate Support to Meet Discharge Needs? N**

**Does patient require transportation assistance? N**

**Discharge Planning Comments:**
- **NONE**

**Does the Screen or Diagnosis Indicate Case Management Risks? N**

**Any CHANGE in 1st Assessment Indicating New Risk? N**

**Social Services Comment:**
- **LIVE ALONE. NO FAMILY HERE.**

**Pt/Family Oriented: Room/Equipment/Staff on Admit/Transfer? Y**

**Patient/Family Involved in Plan of Care: Y**

**Pt/Family Concerns:**
- **PLAN OF CARE**

**Patient safety issues:**
- **BED IN LOW POSITION, SIDE RAILS UP 2/4, CALL BELL IN REACH, PATIENT ORIENTED TO STAFF, FREQUENT SAFETY ROUNDS.**

**Patient or Family Teaching Done During Shift? Y**

**CODE STATUS:**
- **FULL CODE**

**Assessment Done by R.N.? Y**

**Patient Notes:**
- **Nursing Notes:**
  - 04/30/07, 1830 DMT
  - 04/30/07, 2248 DMT
- **Abnormal?:** N
- **Confidentiality:** N
- **Received Report from MD and Patient Care, HIGH POTENCY ALERT and/or ORIENTED NOT IN BED, DENTED PAIN. ON 02 INHALATION AT 2PM VIA NC, NG IV access with INJURY ON BOTH UPPER AND LOWER EXTREMITIES. HAD DINNER WITH FAIR APPETITE. WITH REDNESS NOTED ON RIGHT EYE. ASSESSMENT DONE AND WILL CONTINUE TO MONITOR.**

**Note Type:**
- **Description:** None
### Activity: 04/30/07 Time: 0700 (continued)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Type</th>
<th>Occurred</th>
<th>Recorded</th>
<th>Documented</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>90281</td>
<td>Stress management, promote improved (continued)</td>
<td>04/30/07</td>
<td>0700</td>
<td>04/30/07</td>
<td>AS NEEDED</td>
</tr>
</tbody>
</table>

- Assist patient to identify early warning signs of increasing stress and promote this as the opportune time to try to intervene to reduce stress.
- Encourage the use of activities that promote safe expression of stress (journaling, talking, exercise, art).
- Teach (11 and through groups) relaxation techniques (deep breathing, visualization, pregresssive muscle relaxation) and promote practice of these techniques.

<table>
<thead>
<tr>
<th>Activity</th>
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<th>Recorded</th>
<th>Documented</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>90924</td>
<td>Counseling, refer if needed</td>
<td>04/30/07</td>
<td>0700</td>
<td>04/30/07</td>
<td>AS NEEDED</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Recorded</th>
<th>Documented</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>90001</td>
<td>Goals, set realistic</td>
<td>04/30/07</td>
<td>0700</td>
<td>04/30/07</td>
<td>AS NEEDED</td>
</tr>
</tbody>
</table>

### Patient Notes: Physical Therapy Progress Note (continued)

- LE pain has decreased a lot and now only feels "sore".

**OBJECTIVE:**
- Treatment: supine -> sit independently; sit -> stand independently; then ambulated 300 feet without assistive device independently w/ only slight L LE limp. Patient back to bed p/ Rx.
- Number of Minutes/Rx: gait x 10
- Patient return demonstration of: safety w/ gait

**Start time:** 925  
**Stop time:** 935  
**Total # minutes:** 10

**Pain rating at beginning of treatment (0-10):** 1/10
**Pain rating after treatment (0-10):** 1/10

**ASSESSMENT/PROGRESS TOWARD GOALS:** Tolerated well w/ no report of increased L LE pain w/ ambulation. Due to patient's high, independent functional level believe no further skilled PT is required at this time.

**New goals:**
- PLAN: Continue current plan of care.
  - Other: DVC pt from PT to nursing ambulation care.

### Activity: 04/30/07 Time: 0800

<table>
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<th>Type</th>
<th>Occurred</th>
<th>Recorded</th>
<th>Documented</th>
<th>Change</th>
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<tbody>
<tr>
<td>60116</td>
<td>DIET: Amount Taken</td>
<td>04/30/07</td>
<td>0800</td>
<td>04/30/07</td>
<td>TID</td>
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</tbody>
</table>

**Patient Notes: Case Management Notes**

- Create: 04/30/07 1241 MCT
- Abnormal? N  Confidential? Y
- ARRANGEMENTS HAVE BEEN COMPLETED FOR PT TO BE TRANSFERRED TO DR OFFICE AT 1430 VIA SW AMBULANCE SERVICE, ARRANGED WITH BRANDON/CONFIRMED WITH JODY. FINANCIAL RESPONSIBILITY WITH ENROLL WITH ATTIN TO BE MADE TO LEAVE HACKER, CFQ (PER ON DIRECTOR). SW AMB AWRE, CASE NEXT TO CONT TO ASSIST UPON REQUEST- TN RM

### Activity: 04/30/07 Time: 1100

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<tbody>
<tr>
<td>60172</td>
<td>Bsedt Glucose</td>
<td>04/30/07</td>
<td>1100</td>
<td>04/30/07</td>
<td>AC and HS</td>
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**Result (mg/dl):** 374

**Insulin Given:** Y

### Activity: 04/30/07 Time: 1107

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<tbody>
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<td>Vital Signs, Monitor</td>
<td>04/30/07</td>
<td>1100</td>
<td>04/30/07</td>
<td>A QAH</td>
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</table>

**Blood Pressure:** 149/67
**Blood Pressure Source:** L arm
Good argument for electronic medical records and legibility!!
In Summary

Poor documentation leads to a very CLEAR record of very UNCLEAR thinking!
Simple Measures of Protection

- Thorough documentation of all events
- Share information with the patient regarding medication and procedures to be done
- Be realistic about your limitations
- Professional liability insurance
Thank You