

Documentation 101: Back to the Basics

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2012 School Nurse Documentation Survey

Purpose: To collect data for the
development of a PA
Department of Health's School
Nursing Manual

Who were the responders?

15 question survey sent to 2200 Certified School Nurses. Requested they share with colleagues

- Received 476 survey responses, with 454 usable responses (22 had errors in saving data, etc)
- 60% of responders have 11-20+ years of experience, with 40% having 10 years or less experience
- 90% were CSNs
- 51% work in a suburban school district
- 94.3 % work in a public school with 16.7% also covering a private or parochial school or exclusively working in one

What did you have to say?

- Electronic documentation outweighs pen/paper documentation with 388 responses
- 35% also use, or exclusively use pen/paper
- 72% use the nursing process
- 52% feel they document a nursing outcome
- Average caseload was 979 students, with a range of 70-1909 students with another CSN

What did you have to say?

- 65% said the most common way to document an error is to cross out inaccurate information, write the word error and initial it.
- 42% stated that their electronic documentation system has a time stamp or late entry signal to signify a late entry or data change.
- 44% say they document a hand written late entry by the following: "add or change data, write late entry with a date and signature.

What did you want to know?

- 17% asked for updates on the legal aspects of documentation
- 4% expressed frustration with a lack of consistency in state-wide nursing documentation between schools and would like forms and documentation to be more consistent throughout the state
- 6% asked for a state-wide electronic documentation system

Documentation takes 15 – 25% of a nurse's time.

“Documentation made at the time care was rendered is a defendant's most convincing evidence that care standards were met.” (Schwab & Gelfman)

Documentation

- Supports legal requirements
- Provides historical record of care
- Facilitates care team communication
- Develops aggregated reports of student needs
- Supports care planning
- Describes emergency care planning

Applicable State Laws/Regulations

PA Public School Code § 14-1402. Health services

(b) For each child of school age, a comprehensive health record shall be maintained by the school district or joint school board, which shall include the results of the tests, measurements and regularly scheduled examinations and special examinations herein specified.

Applicable State Laws/Regulations

§ 14-1409. Confidentiality, transference and removal of health records

All health records established and maintained pursuant to this act shall be confidential, and their contents shall be divulged only when necessary for the health of the child or at the request of the parent or guardian to a physician legally qualified to practice medicine and surgery or osteopathy or osteopathic surgery in the Commonwealth.

Applicable State Laws/Regulations

§ 14-1409. Confidentiality, transference and removal of health records

In the case of any child of school age who enrolls in any school, public or private, in any district and who previously attended school in another district in Pennsylvania, the district or school wherein the child is newly enrolled shall request and the district or school where the child previously attended shall surrender the health record of the child.

Applicable State Laws/Regulations

§ 14-1409. Confidentiality, transference and removal of health records

School districts, joint school boards or private schools, shall not destroy a child's health record for a period of at least two years after the child ceases to be enrolled, but may surrender such child's health record or portion thereof to his parent or guardian if the child does not re-enroll in an elementary or secondary school in Pennsylvania.

Applicable State Laws/Regulations

28 PA Code

§ 23.8. Maintenance of medical and dental records

(a) School districts and joint school boards shall maintain comprehensive medical and dental records of each individual child.

(b) The records shall contain all the information the school obtains concerning the health of the child.

Applicable State Laws/Regulations

§ 23.55. Maintenance of health records

Health records shall be maintained for each child. These records shall be kept in the school building where the child attends school and shall be available to the school nurse at all times. Records shall be transferred with the child when he moves from one school to another or from one district to another.

Applicable State Laws/Regulations

§ 23.72. Maintenance of records

School nurses shall maintain comprehensive health records of each child and records of school nursing services.

§ 23.74. Assist in interpreting health needs

School nurses shall assist in interpreting the health needs of individual children to parents and teachers and assist families to utilize community resources for improving the health of their children.

Applicable State Laws/Regulations

§ 23.75. Provide information

School nurses shall provide current information for use of school personnel on such subjects as the growth and development pattern of children, first aid practice, accident prevention, communicable disease regulations, home nursing and civil defense, and shall assist in evaluating the content material used for health teaching, and offer assistance in providing sources of information.

Applicable State Laws/Regulations

PA Nurse Practice Act

Section 3. Registered Nurse, Clinical Nurse Specialist, Use of Title and Abbreviation
"R.N." or "C.N.S." ; Credentials; Fraud.

(a) Any person who holds a license to practice professional nursing in this Commonwealth, ... shall have the right to use the title "registered nurse" and the abbreviation "R.N." No other person shall engage in the practice of professional nursing...

Applicable State Laws/Regulations

49 PA Code

§ 21.11. General functions

(a) The registered nurse assesses human responses and plans, implements and evaluates nursing care for individuals or families for whom the nurse is responsible. In carrying out this responsibility, the nurse performs all of the following functions:

Applicable State Laws/Regulations

§ 21.11. General functions

(d) The Board recognizes standards of practice and professional codes of behavior, as developed by appropriate nursing associations, as the criteria for assuring safe and effective practice.

Applicable State Laws/Regulations

§ 21.18. Standards of nursing conduct.

(a) A registered nurse shall:

(4) Safeguard the patient's dignity, the right to privacy and the confidentiality of patient information.

(5) Document and maintain accurate records.

Applicable State Laws/Regulations

ANA/NASN Scope and Standards of Practice: School Nursing, 2nd ed.

1. Assessment

Documents relevant data in a retrievable format.

2. Diagnosis

Documents diagnoses or issues in a retrievable format that facilitates the determination of the expected outcomes and plan.

3. Outcomes Identification

Documents expected outcomes as measurable goals.

Applicable State Laws/Regulations

ANA/NASN Scope and Standards of Practice: School Nursing, 2nd ed.

4. Planning

Develops an individualized plan...

Documents the plan in a manner that uses standardized language or recognized terminology.

5. Implementation

Documents implementation and any modifications, including changes or omissions, of the identified plan in the appropriate health and educational records.

Applicable State Laws/Regulations

ANA/NASN Scope and Standards of Practice: School Nursing, 2nd ed.

6. Evaluation

Documents the results of the evaluation.

7. Ethics

Upholds healthcare consumer confidentiality...

Takes appropriate action regarding instances of illegal, unethical or inappropriate behavior...

Speaks up when appropriate to question healthcare practice when necessary for safety...

Applicable Federal Laws/Regulations

Family Educational Rights and Privacy Act (FERPA)

- Protect privacy of student education records (inc. health records) maintained by a school
- All schools receiving federal funds
- Right of parents to inspect & review record
 - Right transfers to student at age 18
 - Request needs to be in writing
- Written log of all who access records
 - Include name, title, reason for access, date and time

▶ Applicable Federal Laws/Regulations

Family Educational Rights and Privacy Act (FERPA)

- “Legitimate educational interest”
 - ▣ Need to know to benefit the student
 - ▣ Does not require personnel to be trained in confidentiality requirements
- Personal or sole possession notes made by school staff are not considered education records
- Records may be disclosed to comply with a “judicial order or lawfully issued subpoena”

Applicable Federal Laws/Regulations

Individuals with Disabilities Education Act (IDEA)

- Create health records for eligible students
- Parent request to review records in writing
 - School has up to 45 days to respond
- Requires school maintain record of all who accessed educational records

▶ Applicable Federal Laws/Regulations

Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973

- Create health records about students with special health care needs
- Requires school maintain record of all who accessed educational records
- Parent request to review records should be in writing

▶ Applicable Federal Laws/Regulations

Health Insurance Portability and Accountability Act (HIPAA)

- Requires health care providers to keep confidential personally identifiable health records
- School educational records not generally bound by HIPAA
 - ▀ Exception: Medicaid reimbursement; School-based health centers

Basic Principles of Documentation

- “Documentation of care is synonymous with care itself and failure to document implies failure to provide care.” (Schwab and Gelfman)
- Accurate, objective, concise, thorough, timely & well organized
- Legible and written in ink
- Include date and exact time with each entry
- End each entry with signature and title
- Do not leave blank spaces

Basic Principles of Documentation

- Able to be authenticated
 - ▣ Author identified
 - ▣ Nothing added or inserted
- Avoid terms suggestive of an error
 - ▣ Don't chart that an incident report was completed
- Avoid late entries
 - ▣ If necessary, be sure to mark as "late entry"
- Chart only for yourself
- Use only standard abbreviations and measurements

Basic Principles of Documentation

- Names of other students should not be recorded in any health record but their own
- Try not to change pens while writing an entry
 - ▀ If must change pens, document reason why
- Never document on a task before it's completed
- Should be based on nursing classification languages
- Maintain confidentiality, security and privacy of records

Basic Principles of Documentation

- What to document:
 - ▣ Assessments
 - ▣ Clinical problems
 - ▣ Communications (including telephone, fax or e-mail)
 - ▣ Other health care professionals
 - ▣ School staff
 - ▣ Parents/guardians and other family
 - ▣ Students
 - ▣ Medication administration
 - ▣ Order acknowledgement/clarification
 - ▣ Plans of care
 - ▣ Student responses and outcomes

Documentation Concerns

- Conflicting laws (education vs health, state vs federal)
- Duplication of records
- Lack of standardization
- Time documenting takes time away from direct care
- Administration interpretation of laws/regulations differ from nursing interpretation
 - ▀ Nursing standards of documentation do not change across practice settings.

Documentation Errors

- Never recopy pages of a health record
- Don't erase or use white-out
- Draw line through the error, initial line & write correct entry
- If enter information on wrong chart, line through incorrect entry, initial and date and note: "Entry made in error."

Sharing Health Information

- FERPA- may share for “legitimate educational interest”
 - Will further a student’s academic achievement
 - Maintain a safe and orderly teaching environment
- Share specific information and interpretation, not health record itself
- CSN (per state regulation) is responsible for maintaining and interpreting student health information
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Types of Charting

- Narrative
 - ▣ Most familiar
 - ▣ Nursing interventions and outcomes recorded in chronological order
 - ▣ Supplemented by flow sheets and checklists
 - ▣ Lacks structure and focus
 - ▣ Time consuming
 - ▣ Information difficult to retrieve

Types of Charting

- Problem-Oriented (SOAPIER)
 - ▼ Organized by identified problems or nursing diagnosis
 - ▼ S- subjective data
 - ▼ O- objective data
 - ▼ A- assessment
 - ▼ P- plan
 - ▼ I- intervention
 - ▼ E- evaluation
 - ▼ R- revision

Types of Charting

- Chart by Exception
 - Only unusual or out-of-the-ordinary events are documented
 - Based on premise that planned nursing care is documented in plans of care
 - Supplemented with flow sheets
 - Must establish individual's baseline

Plans of Care

- Individualized Health Care Plan (IHP)
- Emergency Care Plan or Action Plan (ECP or EAP)
- Individualized Transportation Plan (ITP)
- Individualized Education Program (IEP) with medical component
- 504 Accommodation Plan

Plans of Care

- IHP
 - ▣ Nursing Process
 - ▣ Assessment
 - ▣ Nursing diagnosis
 - ▣ Goals or outcomes
 - ▣ Nursing intervention
 - ▣ Evaluation

Plans of Care

- IHP (Cont)
 - ▣ Nursing diagnosis (NANDA)
 - ▣ Diagnostic classification system that results in clinical judgment about clients' responses to actual or potential health problems based on assessment data
 - ▣ Parts
 - ▣ Label- nursing diagnosis statement
 - ▣ Etiology- contributing factors
 - ▣ Signs/symptoms

Plans of Care

- IHP
 - ▣ Types of Nursing diagnoses
 - ▣ Actual
 - ▣ Risk or potential for
 - ▣ Possible
 - ▣ Wellness
 - ▣ Syndrome- cluster of actual & “at risk for” diagnoses

Plans of Care

- IHP (Cont)
 - ▣ Goals or Outcomes (NOC)
 - ▣ Realistic & obtainable
 - ▣ Reflect optimal level of functioning so fewer days are missed
 - ▣ Clear & concise terminology
 - ▣ Measureable

Plans of Care

- IHP (Cont)
 - ▣ Nursing intervention (NIC)
 - ▣ Validate each nursing diagnosis.
 - ▣ Actual- decrease or eliminate contributing factors or promote higher level of wellness
 - ▣ Potential for- reduce or eliminate risk factors

Plans of Care

- IHP (Cont)
 - ▣ Prioritize health needs that occur on daily basis
 - ▣ Students who are medically fragile
 - ▣ Require complex health services on daily basis
 - ▣ Illness that could result in health crisis
 - ▣ Have IEP or 504 plan

Plans of Care

- ECP or EAP
 - ▣ Developed from IHP or Medical Management Plan
 - ▣ Required by professional standards of practice (ANA, NASN)
 - ▣ Doesn't require parental involvement
 - ▣ Simple format for school staff
 - ▣ See this, do this

Plans of Care

- ITP
 - Consistent and uniform approach to assessing transportation needs of students
 - Identify training needs of school staff, including bus driver
 - Special Kids Network Systems of Care statewide initiative

Plans of Care

- IEP
 - ▣ Describes special instruction & related services
 - ▣ Annual goals
 - ▣ May include short-term goals
 - ▣ Behavior plan (if appropriate)
 - ▣ How progress will be measures

Plans of Care

- IEP (Cont)
 - If school health services identified as required related service
 - CSN under whose caseload the student falls should be part of IEP team
 - Develop IHP which becomes medical component

Plans of Care

- 504 Service Agreement
 - ▣ States services that will be provided
 - ▣ Team not required
 - ▣ Recommended
 - ▣ Including CSN under whose caseload the student falls
 - ▣ IHP can serve as the medical portion of 504

Electronic Health Record

- Areas of consideration:
 - ▣ Confidentiality
 - ▣ Security
 - ▣ Legal implications
 - ▣ Stand-alone nursing program vs module in education program
 - ▣ Loss of data

Electronic Health Record

- Confidentiality
 - ▣ Same confidentiality requirements as paper records
 - ▣ Audit of access- records user's trail of access
 - ▣ Multiple layers of access (partitioning)
 - ▣ Set up office so computer screen can't be seen
 - ▣ Limit time open before screensaver appears
 - ▣ CSN is trustee of health information
 - ▣ Should be person responsible for approving access to student health records

Electronic Health Record

- Security

- ▣ Access

- ▣ Refuses access if multiple incorrect attempts to enter password
 - ▣ Multiple layers of access
 - ▣ Access for substitutes
 - ▣ Consequences for inappropriate access

- ▣ Data

- ▣ Secure server
 - ▣ Protections against loss or damage

Electronic Health Record

- Legal implications
 - Must provide assurance that record has not been altered from original state (overwrite protection)
 - Same legal requirements as paper records
 - Authentication- legally recognized electronic signature

Electronic Health Record

- Legal implications
 - ▣ Audit log- log of changes to prove record is original entry & not changed in any way
 - ▣ Verification- date/time stamp for original entry and any changes

Electronic Health Record

- Stand-alone nursing program vs component of educational program
 - ▣ Stand-alone nursing program
 - ▣ Often uses nursing language
 - ▣ Limited access to sensitive data
 - ▣ May not allow direct communication with education staff
 - ▣ Component of educational program
 - ▣ Access to education data (grades, absences)
 - ▣ Direct communication with education staff
 - ▣ Increased risk of unauthorized access

Electronic Health Record

- Miscellaneous considerations
 - ▣ Availability of training and support
 - ▣ Availability of computer
 - ▣ Comfort of CSN with use of technology
 - ▣ Procedure for transferring record to another school
 - ▣ Within district
 - ▣ To another school entity
 - ▣ Laptop vs desk top computer

Electronic Communications

- E-mail
 - ▣ No guarantee of privacy
 - ▣ Similar to a postcard- not sealed, can be read by anyone
 - ▣ Can be read, forwarded and printed
 - ▣ Verify e-mail address of recipient
 - ▣ Include confidentiality warning
 - ▣ Not recommended as a method for transmission of health information

Special Situations

- Abuse
 - ▣ AAP- Suspected Child Abuse and Neglect Program (SCAN)
 - ▣ Document injuries, statement made by child and action taken
 - ▣ Document ChildLine notified or who was contacted to “cause a report to be made”
 - ▣ Copy of CY47 should be place in student health record
 - ▣ Add note (if available) whether outcome was unfounded, founded or substantiated

Special Situations

- Abuse (Cont)
 - ▣ Family Policy Compliance Office (FPCO), US Dept. of Education
 - ▣ Parents have a right to access student records
 - ▣ School may copy records and redact name of reporter

Special Situations

- Accident/Incident Reports
 - ▣ Student Health Record, document:
 - ▣ Objective recording of the incident
 - ▣ Quotes from student
 - ▣ Assessment and intervention
 - ▣ Communication with parent/guardian
 - ▣ Accident/Incident Report Form
 - ▣ Filed according to school policy
 - ▣ Do not mention in student health record
 - ▣ Intended for purposes of risk management

Special Situations

- Suspected Drug/Alcohol Use
 - ▣ Document in student health record:
 - ▣ Objective findings
 - ▣ Quotes from student
 - ▣ Assessment and intervention
 - ▣ Communication with parent/guardian

Special Situations

- Minor Consent Act
 - ▣ PA law allows minors (under age of 18) to consent to variety of medical testing and treatment
 - ▣ Parental consent not needed
 - ▣ Ex. Pregnancy, birth control, mental health, sexually transmitted infections
- FERPA doesn't recognize minor consent to treatment statutes