Saving Lives, One Case Note at a Time

How to write complete and effective case notes

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OBJECTIVES:

The learner will be able to:

1. Explain the importance of writing good case notes
2. Explain how case notes are being used in today's healthcare system
3. Identify common mistakes in case notes and ways to protect yourself by following best practice documentation
4. Develop a process for writing clear, concise and accurate case notes

Nursing offers many rewards and responsibilities. Most people thinking about nursing as a career are drawn to it by a desire to help other people, their interest math and science, or the security of knowing that they will always be in high demand. What is less clear is how important writing skills are to being not just a good nurse, but an excellent one. Nursing case notes on a patient may be done in a variety of different ways. Often, the specifics of these notes depend on a nurses' clinical placement. Regardless of the environment, all nurses' notes usually follow the same important guidelines for ensuring proper care for the patient and the assurance that you are protected, not only by the quality of your care, but by its proper documentation.

What is so important about keeping good case notes, anyway?

In order to learn good case note writing skills, it is a good idea to first understand the importance placed on them. Case notes are nothing new to nursing, what is new is how they are being used in today's healthcare settings. In many settings with Medicare patients, a facilities' payment is based on their patients' medical diagnosis. Each patient's chart must show that the care received was in accordance with their diagnosis. This is commonly known as the Diagnosis-Related Group (DRG) system of reimbursement. Peer Review Organizations (PROs) use nurses' notes to decide whether a DRG code assigned to a patient is the correct one. PROs look to see whether the care hospital patients are receiving requires extended stays, and whether a long-term care facility might be a more appropriate placement. They check to see whether the procedures and treatments a patient receives match their DRG code, and if discharge planning was started at the time of admission. It is also important that PROs see that patients are instructed in appropriate self-care methods that will enable them to return to their activities of daily living as soon as possible. Equally important is the patient's response to the care received. Nurses' notes must also provide objective, clinical feedback from the patient about the care received. With the added pressure in many facilities of helping contain costs and increase revenues, the nursing staff bears a significant burden in making sure that their care is carefully documented.

Those interested in a nursing facilities' bottom line are not the only ones who may be reading nurses' notes. As malpractice law suits have risen, so has the need to know how to avoid being put in jeopardy of involvement with them. According to one article, "the decisive factor in about one out of four malpractice suits is the chart" (Rutkowski, 50). Nurses need to protect themselves from negligence in care, and equally from the negligence resulting from

careless documentation. This can be done by recognizing some of the common mistakes that are made in cases against nurses, and by writing notes that reflect the quality of care that was provided, thereby leaving little room for interpretation by others.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that the nursing process of: assessing, diagnosing, care planning, implementing and evaluating must be applied to all patients' care. Therefore, it is critical that your notes show that each patient's care plan is followed according to this process. The following set of questions will help ensure that your notes are following the five stages of the nursing process.

Do my notes reflect that I am:

- ☑ Following the patient's stated care plan?
- ☑ Acknowledging the patient's needs, complaints, and any questions about their care?
- ☑ Acknowledging when a treatment option is not successful, or that a patient will not comply with their care plan?
- ☑ Providing instructions on treatment and self-care that are understood by the patient?
- ☑ Describing the circumstances around non-compliance and treatment failure, that could result in a change to their care plan?

These self-check questions are a good way of assuring yourself and others that the five stages of the nursing process are recognized in the patient care you provide. These questions can also seem very broad and difficult to answer in a complete and direct manner.

How do I organize my case notes?

The best way to deal with the frustration is to organize your responses to each question using a systematic approach. One commonly used method is called SOAPE. This organizational method uses a problem-oriented nursing record approach for managing patient issues. Each of the first letters of SOAPE represents a type of information that should be included in your notes, and their order is intended to help 'chunk' types of information, the same as you would with paragraphs in an essay format. Here is what each letter of the SOAPE acronym stands for:

S – Subjective information
O – Objective information
A – Assessment
P – Planned care and interventions
E – Evaluation of interventions based on patient response

Using the SOAPE method, not only guarantees that the five stages of the nursing process are followed, but it also helps to arrange notes in a way that is easy to recognize and can be quickly read by other staff. 'S', for subjective information, is where the patient's feedback should be noted. Here is where you may include quotes from the patient to describe how they are feeling, or ask to rate themselves on a 1-10 pain scale. 'O', for objective information, refers to your analysis of their condition. This section should include only factual details, like the time, route of admission for new arrivals, vitals, presenting conditions (ie. vomiting, diarrhea, etc.). 'A', for assessment, is where your diagnostic skills, or those of the attending physician, are required. What is the suspected cause underlying the patient's condition? 'P', for planned care and interventions is where your clinical skills come into play. What is the immediate care plan for the patient? What will you do for the patient over the course of your shift? Longer-term care plan

information should be documented in the patient's care plan. 'E', for evaluation, should reflect your continued monitoring of the patient's condition while on duty. Is the prescribed care plan adequately meeting the needs of the patient? If not, what actions are being taken to meet these needs? Errors are going to happen in your note-keeping. Relax, the solution is an easy one. Simply, draw a line through the error and write the date and your initials next to it and continue with your notes as before.

The SOAPE method is only effective when it is adopted and used by all nursing staff in a facility. If the facility where you work does not have an existing method, or if their method is not successful, it might be helpful to recommend SOAPE to a supervisor. If you work in a large facility, start small at first. If you can get the nursing staff on your unit to use SOAPE successfully, other staff will see the advantages, and want to adopt ~~if~~ it for their units as well. Forming a small committee of staff nurses from each unit of your facility, along with an administrator, can help to ensure that your use of the SOAPE is consistent with the policies of your facility, and recognized by the nursing staff as a sound method for organizing nurse's notes. It is important to remember, that as a nurse, you can be an instrumental figure in the policymaking for your facility. After all, who else knows the patients you are there for better than nurses? Remember, however, that you have to approach your administration with respect, and in the interest of improving patient care, as the heart of every action.

So, how can I avoid common mistakes in my case notes?

Nurses, by nature, are 'multi-taskers'. You have to be in order to get everything done on time. With all of the responsibilities of the job, taking time to write up your notes can seem like a luxury. Hopefully by now, you have a better understanding of why case notes are important. Finding time can still be one of the biggest challenges to getting the job done. Whenever you are tempted by the idea of putting them off, just realize how making time to keep current can actually save you time in the long run. One time-saving strategy might be to put your notes on the medicine cart and write in each patient's chart as you dispense their medicine. You might also try setting up a schedule with other nurses to allow you each 15 minutes of uninterrupted time to write notes, while you take turns covering each others' patients. If neither of these are an option, consider investing in a small voice recorder to carry with you and dictate your notes ~~into~~. Then, when you have time, you will have the information on each patient right at your fingertips. The important point to remember is to take the time to write quality notes on each patient in your care. The alternative of not making the time can be costly to your patients, your co-workers and administration, and ultimately, you.

Signing case notes is another situation where nurses have the potential to get themselves into trouble. Smaller facilities often pride themselves on offering a sense of community to patients, as well as staff. In some instances, nurses will feel like everyone knows everyone else, so they do not need to sign their notes. Instead, they may use their initials. This is not a good policy to follow. Even if your facility does not require it, get into the habit of signing your notes with your first initial and full last name, at a minimum. Going a step further, you may want to consider developing a policy requiring nurses to write their name and credentials whenever signing any document.

Regarding the documentation of accidents and other adverse incidents that may occur, remember, it is critical to develop an organized response. It is important that you understand the difference between your notes and an incident report. Incident reports are used as a quality assurance tool by the administration of a facility. They are not a part of a patient's medical record. On the other hand, your notes are the medical record of a patient's involvement in the incident. Therefore, your notes should reflect a patient-centered view of the incident. Leave concerns about the facility to your administration and its incident report. The best approach is to keep your focus on the patient. Use the following checklist as a guide to help develop a system

that works for you and your facility.

- ☑ The date and time of the incident
- ☑ An *objective* account of the event
- ☑ A physical assessment of the patient(s) involved
- ☑ A record of the physician notification
- ☑ A record of the family notification

Always record the date and time of the incident. Next in your account of the event, remember to stay *objective*. This means sticking to facts that can be verified by the patient, yourself or another staff member. Including quotes from the patient is also a good way to remain objective in your account. The physical assessment should include any visible harm to the patient, as well as any areas of the body where they report pain or discomfort, even if there is no physical evidence. It is important to continue assessing the patient's condition for at least two complete shifts, or until further orders are given by a physician. If you are not attending to the patient for that length of time, your notes should recommend continued assessment to the next shift. Physician and family notification should include the names and times of contact for each party, and whether you spoke directly to them, or left a message. In speaking with the physician, whether or not they provide orders for treating the patient, you should include their response in your notes.

Documenting medications is another very important consideration when writing case notes. A patient's Medication Administration Record (MAR) should be checked to make sure that it lists all medications that the patient is currently taking. For medications on the MAR, you should include the dose, route and time of administration, and the patient's response. For any medications not listed in the patient's MAR, they must be added immediately, and you should write that it was added in the case notes. Checking a patient's MAR is not only a good habit in keeping your notes up-to-date, it is simply good nursing practice.

Informed consent is another area where nurses must carefully document patient's acceptance of the risks and benefits associated with different procedures. Some facilities have consent forms specific to each procedure, along with a list of the common complications. Other facilities use a generic form that includes a place for the patient to acknowledge that they have read the information related to the procedure, or have talked with their physician about risks and benefits. Regardless of how consent is handled in a facility, nurses receive questions about procedures by patients before, and sometimes even after, consent has already been given by a patient. Having good nursing skills means that you will respond to the patient's questions; however, it is equally important that you also document these questions in your notes. Legislation around informed consent allows the patient to revoke their consent at any time. Therefore, it is critical that you note any doubts expressed by the patient.

Nursing is an exciting profession to be a part of right now. Along with that excitement comes a great deal of responsibility to your patients, co-workers and self. People are what most likely drew you into the field and they are where you will find your greatest rewards. Keeping complete, accurate notes on patients will help you realize the valuable skills you offer each one, and ensure that you continue doing so for years to come.

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