Improving Nursing Documentation and Reducing Risk

HCPro a division of BLR, Patricia A. Duclos-Miller MSN RN NE-BC

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In the age of electronic health records (EHR) and value-based purchasing, accurate and complete nursing documentation is crucial. Proper documentation affects not only quality of care, but also facilities' costs and revenues. Redundant documentation wastes time and money, while inadequate documentation negatively affects Joint Commission core measures and can result in license suspensions or legal action against a healthcare facility an expensive and often damaging outcome.

Improving Nursing Documentation and Reducing Risk **helps nurse managers create policies, processes, and ongoing auditing practices to ensure that complete and accurate documentation is implemented by their staff, without creating additional time burdens.**

Nurse managers, especially new nurse managers, do not clearly understand their legal accountability for poor or inadequate documentation created by nursing staff who report to them. While each state's nurse practice act (NPA) differs, every NPA addresses nursing liability for documentation; however, many nurse managers remain unaware of these and other regulations that hold them accountable for the documentation crafted by their nurses.

This book helps nurse managers protect themselves and their staff by clearly explaining to their employees the impact of documentation practices on reimbursement, educating them on the consequences of failure to document, and training them on how to document properly.

This book will help you:
- Work directly with your staff to ensure accurate documentation - Train nurses during orientation - Educate your staff on the consequences of inaccurate documentation - Create steps to share with your staff that will improve documentation - Ensure complete comprehension of documentation issues through sample forms, auditing tools, and case studies

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