Documenting Your Practice

Foundations of Faith Community Nursing Course
Faith Community Nurse Network of the Greater Twin Cities

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Materials adapted from The Foundations of Faith Community Nursing Course based on the curriculum developed through the Westberg Institute for Faith Community Nursing, which is owned by the Spiritual Care Association, New York, NY

Documenting Practice

Reflection: *"I too decided, after investigating everything carefully from the very first, to write an orderly account for you, most excellent Theophilus, so that you may know the truth concerning the things about which you have been instructed."*

Luke 1:3-4

Reflection: *"…despite the level of a nurse's devotion, it is useless if the observations are not noted."*

Florence Nightingale

Reflection: *"Everything you write, represents the care you give."* Jackie Nightingdale, Lead Practice Nursing Educator

Documenting Practice

Learning Outcomes:

1. Document in accordance with legal guidelines and practice standards. (self-learning module)

2. Use documentation structures suitable to the FCN's practice setting.

3. Apply systematic approaches to collect appropriate and relevant documentation data.

4. Use accountable strategies to manage documentation and client records.

Outcome 1: Document in accordance with legal guidelines and practice standards.

Documenting as a faith community nurse is often very different than charting within a health care facility or other work setting where other health professionals document and have access to your notes. Nevertheless, documentation is legally required by all state Nurse Practice Acts and a professional responsibility of our Scope and Standards as FCNs.

What are some reasons FCNs need to document?

- Documentation demonstrates accountability to the ministry and funding entities.
- Documentation provides a framework for working with the client and guides the subsequent interactions.
- Documentation includes both qualitative and quantitative information.
- Legal compliance: Nurse Practice Acts; Scope and Standards; Health Insurance Portability and Accountability Act (HIPAA) ; Mandatory reporting laws
- Documentation provides a foundation for EBP and research.

There is concern among nursing leaders, that many FCNs are not documenting their practice adequately.

What are the barriers to FCNs documenting their practice?

Barriers or not!

Documentation is not optional!

"If it isn't documented, it wasn't _____!"

"Documentation is an integral part of the practice of faith community nursing and the quality of care provided by the FCN, whether in a paid or unpaid position.
The weight of nursing practice standards and legal guidelines make documentation an extremely critical responsibility of the FCN.
(Potter et al., 2017)

A documentation system and written policies and procedures for documentation should be in place from the start of a faith community practice.

We'll look at this later, but some of the issues FCNs need to consider are:

What method of documentation will I use?
What forms will I need?
When will I document?
How will I honor confidentiality (HIPAA?)

Outcome 2. Use documentation structures suitable to the FCN's practice setting.

Outcome 3: Apply systematic approaches to collect appropriate and relevant documentation data.

FCNs can use either paper or electronic documentation.

A paper documentation system is the use of an organized set of paper forms to enter handwritten information about the patient and the care delivered.

The set of forms for a single patient is the patient record.

The patient record should include:

1. Initial encounter information (demographics/history/ assessment, etc)
2. Documentation of the care delivered using the nursing process.

You will want to use an assessment tool/form that works for you.

- **Demographic data**
- **Health care directive?**
- **Physical, emotional, spiritual health history and current status?**
- **Vital signs?**
- **Include admission date and discharge date**

You can design your own assessment tools or use those others FCNs have developed. See your FCN digital tools for examples. FCNNtc.org also has forms that are downloadable.

This is in your digital tools.

Demographic and Assessment

Directions to home: _____ **Date:** _____

CLIENT INFORMATION

Client Name:
Last: _____ First: _____ Middle: _____ Maiden: _____

Address: **Telephone:**
Street: _____ (H): _____
_____ (W): _____
City, State, Zip Code: _____ (Other): _____
_____

Birthdate: _____ **Race:** _____ **Gender:** _____
Language Spoken: _____
Highest level of education: _____ **Literacy:** _____
Marital Status: _____
Spouse/Significant Other Name: _____
Employment Status: _____ **Occupation:** _____
Income Source: _____
Special Job Skills: _____ **Veteran:** ___Yes ___No
_____

CONTACT(S) IN CASE OF EMERGENCY:

Name: _____ Phone: _____
Address: _____ Relationship: _____
Name: _____ Phone: _____
Address: _____ Relationship: _____

Living Arrangements: ___Home ___Apartment ___Facility ___Homeless

PHYSICIAN INFORMATION:

Physician Name: _____ Phone: _____
Address: _____
Physician Name: _____ Phone: _____
Address: _____

DURABLE POWER OF ATTORNEY:

Financial ___Yes ___No Name: _____ Phone: _____
Health care ___Yes ___No Name: _____ Phone: _____

INSURANCE:

Primary Insurance: _____ **Group #:** _____
Secondary Insurance: _____ **Group #:** _____

Household Member Name	Relationship	Age/ Date of Birth

_____ _____
Faith Community Nurse Signature **Date**

Assessment leads to Nursing Diagnosis

NANDA has developed a comprehensive list of standardized nursing diagnoses.

www.nanda.org/nanda-international-glossary-of terms.html

NANDA Examples:

Caregiver role strain
Death anxiety
Health Promotion/Wellness
Knowledge deficit
At risk for infection related to inadequate primary defense: broken skin

Top 10 Nursing Diagnoses Used by FCNs in 2017:

1. Self-health Management, Readiness for enhanced.
2. Comfort, impaired, physical
3. Coping, Readiness for Enhanced
4. Comfort, Impaired:psychospiritual
5. Anxiety
6. Mobility: Physical, Impaired
7. Falls, Risk for
8. Spiritual Well-Being, Readiness for enhanced
9. Grieving
10. Loneliness, Risk for

Cumulative Data from Henry Ford Macomb Hospitals Faith Community Nursing Documentation and Reporting System, 2017

Case Study:

You visit Myrtle, a visually impaired 90-year-old and have assessed that she is not setting up her medications correctly. She has hypertension, Type 2 diabetes and osteoarthritis. Her 90-year-old husband, Art, seems confused because he repeatedly asks you if you are the doctor. Myrtle and Art have no children, live in their own tri-level home and drive their car on errands. Myrtle tells you that Art has fallen twice in the last week, but adamantly states, "Don't you try to get us to move…we love it here!"

What might be a nursing diagnosis?

(In older documentation models, you may have called this the "problem.")

Nursing Diagnosis leads to identifying outcomes.

The FCN should develop these outcomes with the client, taking into consideration the client's values, beliefs, motivation, etc.

Write the outcomes using a SMART goal structure:

- **Specific**
- **Measurable**
- **Attainable**
- **Reasonable**
- **Timed**

What might be some nursing outcomes for Myrtle and Art?

Example:

Nursing Diagnosis: Self-Health Management, Readiness for enhanced (medication administration)

Outcomes:

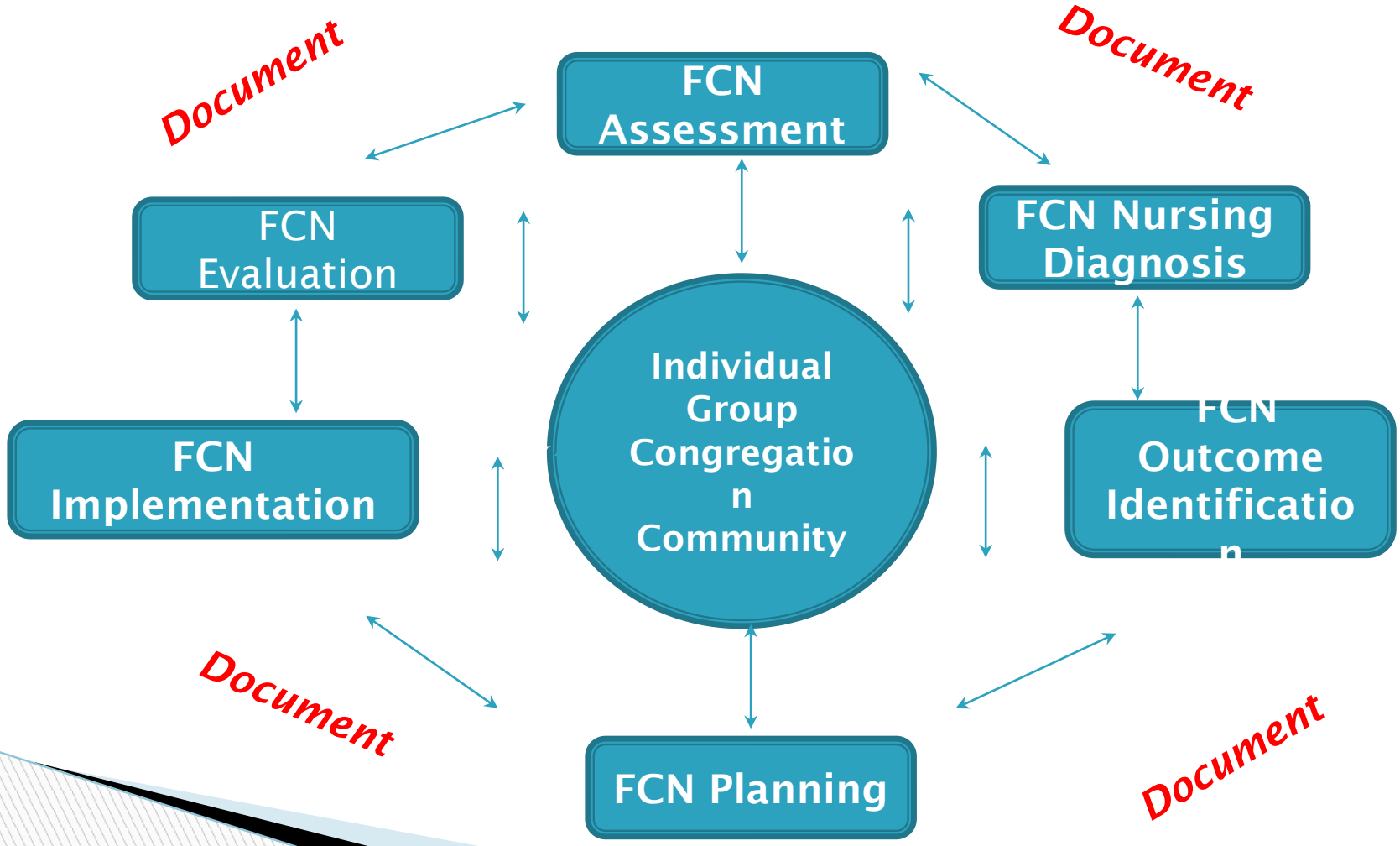
1. **Physician aware of medication concerns within 1 day.**
2. **Assist pt in set-up of meds for the next few days.**
3. **Help with finding resource to help with medication set-up within 5 days.**

Nursing Outcomes lead to Nursing Interventions and Planning

Develop the plan of care with the client and client caregivers.

What might be your nursing interventions and plan for Myrtle and Art?

You've assessed, identified a nursing diagnosis, identified outcomes and a plan. Your next step is implementation.



Implementation and nurse-initiated actions in faith community nursing must be within the domain of nursing and <u>not require orders from another healthcare professional.</u>

Let's identify "nurse-initiated actions" appropriate in faith community nursing and in Myrtle and Art's case.

Evaluation is an ongoing step in the nursing process that provides important information for future interventions and care plans.

- ✓ Document the response to the plan of care, goals, outcomes.
- ✓ Document the client's self-management skills and self-efficacy over several visits.
- ✓ Evaluate emotional and spiritual care outcomes.

Critical thinking skills are imperative in our practice because:

- Our practice includes pastoral care and whole-person care.
- We rarely have other health professionals available to discuss complex cases.
- Our practice is a ministry *and* a recognized nursing specialty.
- FCN is not a reimbursable health care service
- Government mandates enforcing documentation have not been applied to our practice but nursing standards and state practice acts require documentation.
- Our practice includes application of the nursing process to groups or population level health problems

How many of you are familiar with NANDA, NOC, NIC language?

This standardized nursing language can have great value in faith community nursing because it facilitates efforts at EBP and research.

The challenge is finding affordable, practical methods for FCNs to be able to use this language consistently.

Your "Digital Tools" file will include documentation forms and more information on documentation. As you develop your ministry, you'll want to consider which methods are most workable for you.

Many FCNs who tend to use narrative forms of documentation. If you do so, be sure to use <u>standardized nursing language.</u>

Subjective	**D**ata	**A**ssessment
Objective	**A**ssessment	**P**roblem
Assessment	**R**esponse	**P**lan
Plan		**I**ntervention
Intervention		**E**valuation
Evaluation		
Revision		

Who has used these forms of documentation?

Do they include all the steps of the nursing process?

Let's practice documenting the case study of Myrtle and Art using the SOAPIER acronym:

S: Subjective Observation

O: Objective Observation (Nursing Diagnosis)

A: Assessment

P: Plan

I: Intervention

E: Evaluation

R: Revision

S: 90 y.o. female with Type 2 DM, osteoarthritis, hypertension.
No children, Niece, Sarah lives 50 miles and phones weekly.
Spouse, Art, is 90. Myrtle states he's fallen twice in last 7 days.
Art says: "Don't you try to get us to move…we love it here."

O: BP: 174/90; P:88; live in trilevel home. Meds are set-up incorrectly.

A: Not taking meds correctly; spouse is fall risk; want to stay in own home; support from family limited. Uncontrolled hypertension. Needs help with self-management of health.

P: Contact MD with permission. Seek help with med set-up. Home care?
Do fall risk assessment and prevention.
Check BP weekly
Assess for more help at home (financial/willingness) Contact niece with permission from Myrtle and Art.

I: Called Dr. Ainslet on 1/16/22. Wanted Myrtle to make appt. Appt 1/17/22 at 10 a.m. Asked Myrtle to notify her niece. FCN to arrange ride and accompany Myrtle to appt.

E. MD ordered home care referral to set up meds. Myrtle refused.

R: Explore other options for improving medication administration.

You are a new FCN and make your first visit to Ed, an 80 year-old member of your faith community. Ed's daughter had called the faith community office and requested a visit. Ed seems pleased to see you, and after visiting casually, you conduct your initial assessment. You find that Ed has several physical, emotional and spiritual needs. For example, Ed tells you that he misses his wife who died 6 months ago and because of his grief can't motivate himself to go to church anymore. He has lost contact with many of his friends at church and is somewhat angry that no one from the church (other than you) has called or visited him in the past 6 months. He says, "I thought the pastors or someone would touch base with me after the funeral, but they seemed to forget about me. My kids live out of town and are busy. Everyone else just 'goes on with their lives.'"

Document this visit using one of acronyms (SOAPIER/DAR/APPIE)

Case Study

You are a FCN working at a church, but this morning you are worshipping at another church as a visitor. During the service a woman falls coming down the choir steps. As a nurse, you go to her aid and suspect that she has hurt her leg because she has some trouble standing and limps to the pew. You recommend calling 911. The woman refuses, saying "I want to stay and enjoy the service." Even though you keep trying to convince her, (as do other parishioners) she says, "I'm fine," and is adamant that you not call 911. She is helped to a pew, and stays for the service. You observe her walk to her car without assistance after the service.

Do you need to document in this situation?

If so, what would you document about this episode?

Outcome 4: Use accountable strategies to manage documentation data and client records.

A. Client records must be confidential:

- **Use a locked file or password-protected systems.**
- **Back-up electronic files.**

B. Client records must include date, time, and location for the visit and your signature and qualifications.

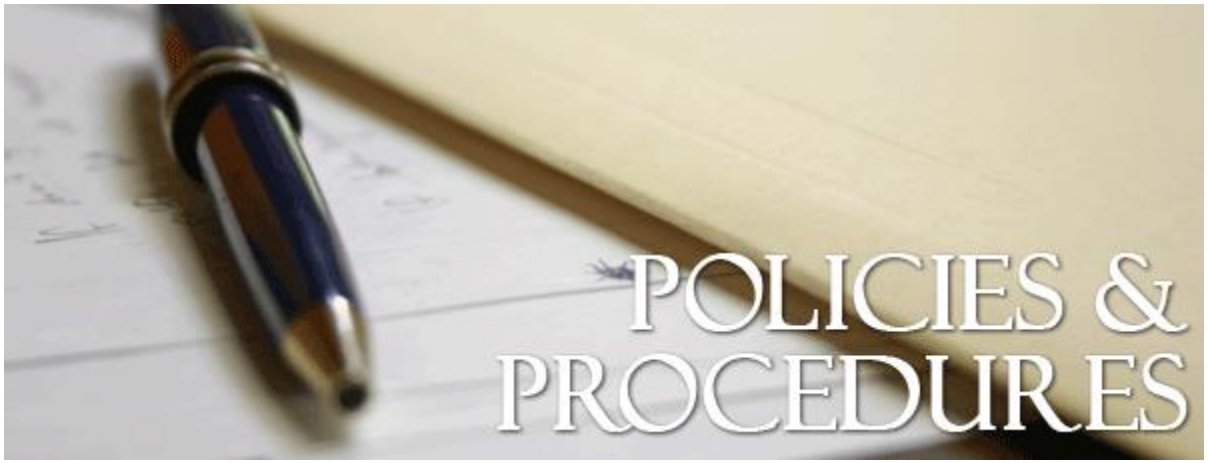
C. Ownership of records?

D. Brief encounter forms can be used for one-time, short visits with clients. (See digital tools for FCNs)

E. Documentation of group activities organized by the FCN should include statistics and also follow the nursing process.

F. Documenting activities of the FCN is helpful in demonstrating to stakeholders the value of your ministry. (See flow sheets)

As a new FCN, you realize that there are no policies or procedures in place for documentation in regards to the FCN role at your faith community.
If you were to write these policies and procedures what would you need (and want) to include?



A few more things to keep in mind:

- **Release of patient information or records must follow legal policies.**
- **Using a "Release of patient information form" is a good idea.**
- **Use the "read-back" process when gathering client information over the phone. Write down the information, read-back and confirm with caller. Document date, time, name of person providing information, the information itself and that the read-back was performed.**
- **Never assume it is acceptable to share patient information with family or others except in an emergency situation.**

Case Study:

For 5 years a FCN worked about 10 hours a week. Most of her time was focused on hypertension control among parishioners. She provided BP screening and individual counseling sessions every Sunday evenings and made home visits to follow up with parishioners with hypertension during the week. The only documentation the FCN did was to keep a flow sheet of each parishioner's BP readings over the five year period. The FCN stated in her annual report to the congregation that "parishioners who took part in her hypertension screening and counseling experienced no strokes over the five year period.

a. Do you see any issues with this FCN's documentation?
b. Could "no strokes" be credited to her? Why or why not?
c. What opportunities for evaluating the work of FCNs were missed by her documentation methods?

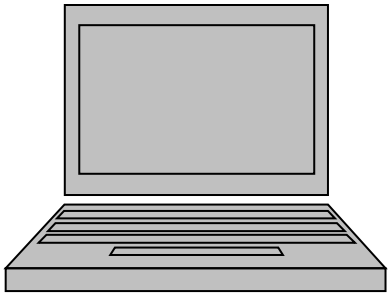
The FCNN website has documentation forms you can use under “resources.”
www.fcnntc.org

There are many excellent forms you can use in your Digital Tools file. You can adapt them for your own use.

What about electronic/computerized systems?

Henry Ford Macomb Hospital FCN Documentation System
www.fcndocumentation.com

When you visit these sites, you'll have an opportunity to try the documentation forms for free. If you decide to use them in your practice there is an annual fee.



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Faith Community Nursing/Health Ministries
Documentation and Reporting System

HENRY FORD MACOMB HOSPITALS

Logged in as: Sondra Weinzierl

- What's New
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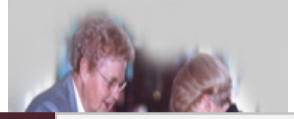

Add Patient

To add a new patient to your list, simply fill out the form below. All fields with a red asterisk by them(*) are required.

*First Name:		*Last Name:	
*Address 1:		Address 2:	
City:		*State:	
Zip:		Denomination:	
Home Phone:		Work Phone:	
Mobile/Cell Phone:		Gender Identification	
		*Sex Assigned at Birth	
Sexual Orientation		Language	
Nationality		English Fluency	

Questions/Discussion?

What is one thing you want to take with you from this discussion on documentation you will be able to use in your practice as a faith community nurse?