



“If You Didn’t Chart It, You Didn’t Do It” ONN Tracking and Documentation

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Oncology Nurse Navigators (ONNs) should understand the professional and legal significance of tracking and documentation, as well as specific methods and implementation strategies.

AVOIDING LEGAL LIABILITY

Nurses often hear, “If you didn’t chart it, you didn’t do it.” This warning is critical in today’s litigious society. We know that a lack of proper documentation at the bedside can negatively impact patient care. This fact was demonstrated in the nursing research conducted by Paice and colleagues.¹ They discovered the management of pain in surgical oncology patients was inadequate, noting the lack of documentation found in their study correlated with a “...lack of consistent care and the inability to evaluate the effectiveness of pain therapies.” Nurses must remember that insufficient documentation not only affects patients, it also exposes medical facilities to tremendous legal liability.

WHAT DO THE LAWS SAY?

The objective of state nursing practice legislation pertaining to documentation is the same nationwide: to provide a clear and accurate picture of the patient while under the care of the healthcare team. Documentation laws remain purposefully broad, leaving the details to healthcare institutions, specialty organizations, and practice groups. However, when conflicts arise, state law always trumps institutional policy. So the question remains: state laws and institutional requirements are there to protect both the patient and the nurse, but it is unclear whether these laws apply to ONNs when they are caring for patients not actively in their respective healthcare settings. These legal uncertainties must be addressed.

JUSTIFYING THE ONN

Tracking and documentation are also essential for supporting new ONN programs. Documentation is crucial to demonstrating to administrators that ONNs are essential to oncology care teams. The records will clearly demonstrate the ONN’s value for the patient. Additionally, tracking allows ONNs to show their value through measures such as patient outmigration reduction and the related revenue retention.

GETTING STARTED

Now that you are aware of the importance of tracking and documentation, the next step is implementation. When facing the challenge of starting a new tracking and documentation program, I recommend applying the nursing process:

- Assess:** What options are currently available (eg, EMR, Outlook, Excel, funds for new computer software, or the possibility of creating a new program with your IT department)?
- Plan:** Decide what will work best in your institution.
- Implement:** Create your database, tracking tools, and charting method.
- Evaluate:** Does this work and is it efficient?

ADDITIONAL HELP

The following questions should help ONNs diagnose and develop solutions for tracking and documentation issues.

1. What do you think should be documented?
2. What do you think should be tracked?
3. What do you use now?
4. Do you want a computer program such as NurseNav (www.nursenav.com), Priority Consult (www.priorityconsult.com), or Open Software Solutions (www.healthcareoss.com)?
5. Where do you document?
6. Do you keep your own charts?
7. If you make your own chart, does it become part of the permanent medical record?
8. Is there an interpretation of the Nurse Practice Act requirements for nursing documentation that applies specifically to bedside charting?
9. Do you track outmigration?
10. How is your data used and who looks at it? *Onc*

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REFERENCE:

1. Paice, JA, Mahon SM, and Faut-Callahan M. Factors associated with adequate pain control in hospitalized postsurgical patients diagnosed with cancer. *Cancer Nursing*. 1991;14(6):298-305.