Documentation

All nurses must document care provision to be compliant with laws and regulations governing the profession regardless of specialty or compensation (paid or unpaid). Documentation is the written record of patient care in electronic or hard copy format. In all cases, the written record of professional nursing care delivered by a faith community nurse (FCN) provides evidence of care provision at a point in time. Evidence of care provision includes: **a)** what services or care the patient received; **b)** when services were rendered; **c)** the response or reaction the individual had to the services/treatment; **d)** who provided the services; and **e)** whether communication to other providers were carried out.

Laws governing nursing documentation may vary among states. Nursing practice is under the legal authority of each state's Nurse Practice Act and Board of Nursing policies. Nurse Practice Acts are statutory laws enacted by state legislators, and the State Boards of Nursing and exist to safeguard the public. In addition, all FCNs are guided by *Nursing: Scope and Standards of Practice* and by *Faith Community Nursing: Scope and Standards of Practice*.

What does the FCN need to document?

Per *Nursing: Scope and Standards of Practice*, *Faith Community Nursing: Scope and Standards of Practice* and the Board of Nursing, the nurse needs to document: assessment, planning (implementation/interventions), outcome, and evaluation.

Why is documenting so important?

Beyond ensuring good quality care, documenting protects the nurse against the risk of a malpractice suit. Malpractice is negligence, misconduct, or breach of duty by a professional person that results in injury or damage to a patient. In most cases, it includes failure to meet a standard of care or failure to deliver care that a reasonably prudent nurse would deliver in a similar situation. Many lawsuits do not come to fruition until years after the incident, so the court will try to establish the standards of care and practice at the time of the incident in question.

The most common reasons that nurses have been sued for malpractice are: 1) failure to follow standards of care, 2) failure to communicate, and 3) failure to document.

Who keeps the records?

Regardless of the model, there needs to be a written policy to clarify who—health care organization or the FCN—is the custodian of the FCN's documentation and a procedure to address the maintenance and storage of it. The FCN's documentation, whether electronic or hard copy, should be safely stored for seven years and available to the patient upon request. After seven years, the documentation should be destroyed.

1. When an FCN is employed by a health care organization, the organization is the custodian of the documentation.
2. When an FCN is in a formal, contractual partnership with a health care organization, but not employed by it, there needs to be a determination of who is the custodian of the documentation. If the health care organization is not the custodian of the documentation, then custodianship falls to the FCN.
3. When an FCN is working without a formal partnership with a health care organization and is working in or with a faith community, whether in a paid or unpaid position, he or she is responsible to maintain and store the documentation. When there is a change in a faith community nursing position, the documentation can be transferred to a new FCN with the permission of the patient (Burton Wagner, Legal Counsel for the Wisconsin Nursing Association).

What does the research say about FCN documentation?

The research summary in the *Documenting Practice* module of *Foundations of Faith Community* Nursing includes this explanation:

The ability of the FCN to document appropriately and comprehensively is an indicator of the quality of the content regarding the nursing process, as well as demonstration of the practice (Wang & Hailey, 2011). The content of the FCN's documentation contains the evidence of patient care and information critical for continuity and patient safety. In addition, the content of documentation is critical for tracking patient outcomes. Dyess, Chase and Newlin's (2009) review of FCN research in the areas of evaluation and documentation, found a lack of outcomes. The study further found that only 7 out of the 25 FCN articles reviewed had content related to documentation and evaluation. This insufficiency in documentation is a barrier to demonstrating the legitimacy and effectiveness of the practice as a specialty. To improve the quality of documentation content, several research studies emphasized the use of a standardized nursing language, documentation education, use of electronic documentation systems, application of nursing theory, and emphasis on standards of practice or guidelines (Solari-Twadell & Hackbarth, 2010; Wang & Hailey, 2011; Dyess, Chase & Newlin, 2009).

In a recent research study (Dyess, Callaghan & Andra, 2017), types of documentation approaches most often used by FCNs (N= 153) were identified through survey as:

- Daily Activity Log 32%
- Monthly Activities Report 33.3%
- Individual Interaction Form 40.5%
- Computer Program 9.2%
- Web-Based System 17.6%
- Use of NANDA classifications 19.6%
- Use of NIC classifications 20.3%
- Use of NOC classifications 17.6%
- Use of no standardized classifications 46.4%

The article states that FCNs document mostly numbers of interactions and not the outcomes that were accomplished as a result of their interactions. Outcomes of care are one of the components of the nursing process that is missing from most documentation methods

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Resources

- *Nursing: Scope and Standards of Practice* (American Nurses Association, 2015) is available at https://www.nursingworld.org/nurses-books/nursing-scope-and-standards-of-practice-3rd-ed/.
- *Faith Community Nursing: Scope and Standards of Practice* (American Nurses Association & Health Ministry Association, 2005, 2012, 2017) is available at https://www.nursingworld.org/nurses-books/faith-community-nursing-scope-and-standards-of-practice-3rd-edition/
- Ziebarth, D. J., & Solari-Twadell, P. A. (2020). *A Wholistic and Holistic Nursing Practice In Faith Community Nursing* (pp. 33-49). Springer, Cham.

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