2022 New School Nurse Orientation

Documentation in School Health Services

Learning Outcomes

By the end of this presentation, learners will be able to

- List 2 legal protections offered by appropriate documentation
- List 2 standards for electronic documentation systems
- Articulate one difference between HIPAA and FERPA laws in schools
- Discuss the concept: "need to know”

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Why Document?

- Communication
- Legal evidence
- Research
- Education
- Quality assurance
- Statistics
- Accrediting and licensing
- Reimbursement

HIPAA versus FERPA:
What school nurses need to know

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HIPAA
(Health Insurance Portability and Accountability of 1996)

Personal information and health data is always protected (both paper and electronic)

HIPAA restricts access, use and disclosure of "protected health information" maintained by ***"covered entities"***

Covered entities are typically health plans, health-care clearinghouses, and health-care providers

School are not ***covered entities***, unless they provide "health care," through a free clinic or other service beyond a day-to-day school nurse.

- *Top 5 FERPA & HIPAA Misconceptions for Schools (frontlineeducation.com)*

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FERPA

(Family Education Rights to Privacy 1974 Buckley Amendment)

Ensures access by parents and students and protects against the non-approved disclosure of “personally identifiable information”

Includes all information collected and maintained on a student, including special education and Section 504 files

Student health records are educational records and fall under FERPA, not HIPAA

Some medical information in Educational records require special protection (i.e.. HIV status of students)

FERPA rights are transferred to students at age 18

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Documentation

- Records what, when, how
- Creates a record of health information and supports provided to students
- Demonstrates individualized plan of care
- Facilitates communication with
  - Other school nurses
  - Districts' school staff
  - Community providers
  - Other districts (upon transfer in Connecticut)

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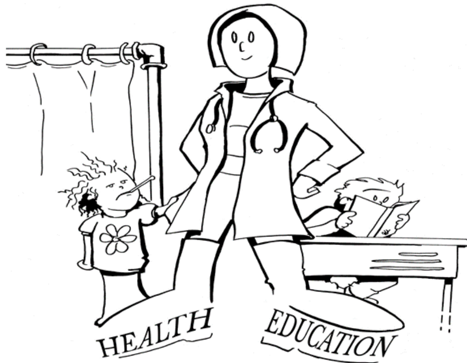
Documentation

School Nurses- Health and Education



Provides

- Historical perspective
- Current data
- Direction for planning

Supports

- Academic success

Lasts

- Entire school career

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Legal Protection

Documentation provides

- Written proof of care
- Quality of care

Documentation serves as protection for

- Students and families
- School nurses
- School districts

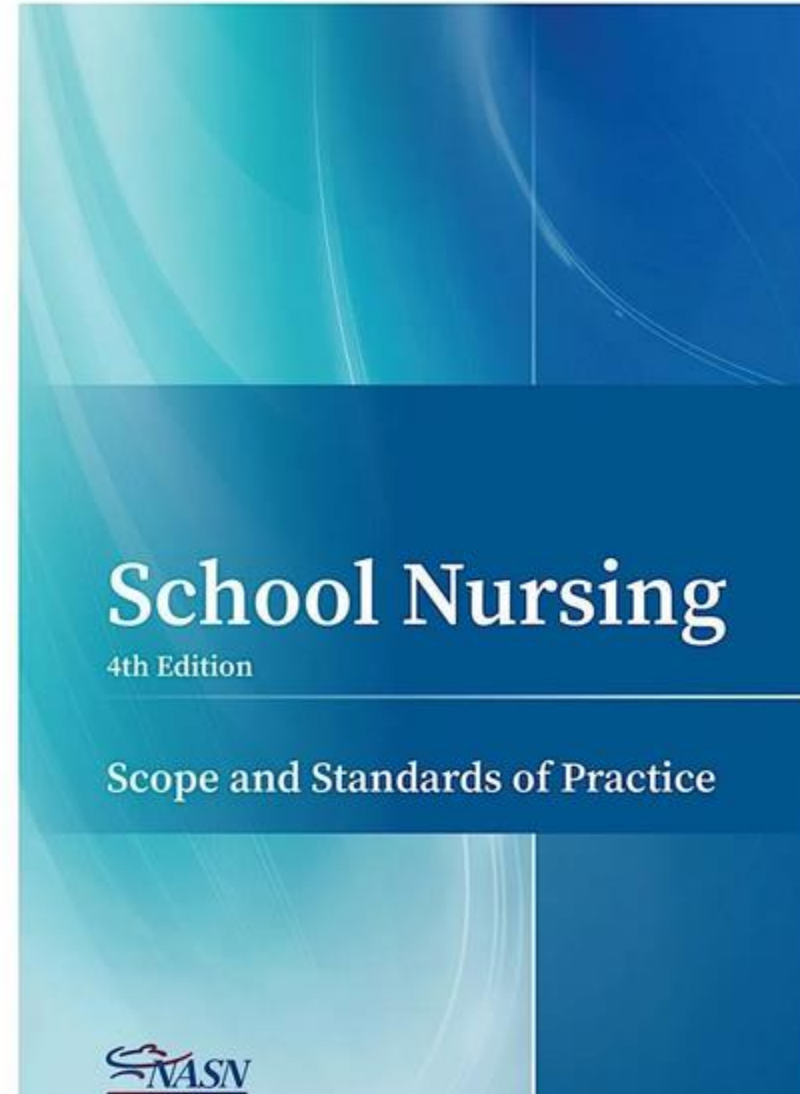
Legal Protection, cont'd

- Principles based on standards of practice
  - Current
  - Consistent
  - Nursing language
  - Student words (subjective)
  - Factual (objective)
  - Use standardized measures (e.g. pain scale)

Standards of Professional School Nurse Practice

School *Nursing: Scope and Standards of Practice* 4th Edition

(ANA & NASN, 2022)



Legal Protection

- Basic Principles
  - Legible
  - Accurate
  - Date & time

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Legal Protection

- Was an appropriate assessment done?
- Was reasonable treatment administered?
- Did the appropriate follow-up occur?

Quality Assurance

Documentation supports care that is:

- Consistent
- Accurate
- Safe

Accident/Incident (A/I) Reports

Purpose and use of A/I Reports

- Risk management, administrative tool
- Not part of the students' health records
- Documents what happened and school staff involved
- Documents nursing assessment/intervention (if any)
- Staff supervising student at time of incident documents on the A/I

Nursing Notes

- DO NOT reference accident/incident report

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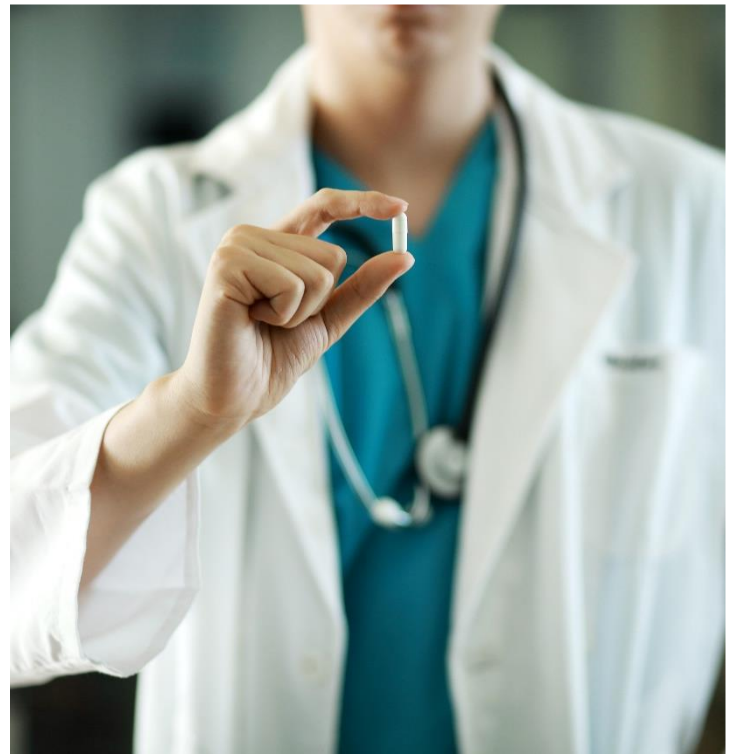
Risk Management

Proper documentation for

- Medical interventions, (orders, notes...)
- Training
- Supervision
- Medication administration
- Controlled drug destruction



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Risk Management Strategies

- Do not document in advance
- Always include date & time
- Document on correct record

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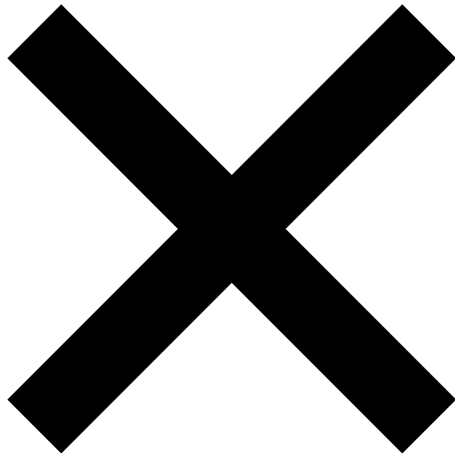
Allegations of Negligence



Failure to

- Properly assess the student
- Properly administer treatment
- Monitor the student
- Properly document

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Risk Management Strategies

- There are cases where a nurse failed to do (or document) a proper assessment

Strategy:

- Document assessment, including what is not seen, when appropriate

(Example, no bruising or swelling)

Risk Management

Charting By Exception: The Legal Risks

- Minimizing documentation is risky
- Could compromise student safety
- Could compromise nurse
- Could compromise district

Essential question:

- *Does this document tell the full story of the student's condition and of your professional assessment and care?*

Chart as if your records will be in court!

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Common Charting Errors

Failing to

- Record health information
- Record nursing actions
- Record medications given
- Record reason medication not given
- Document a discontinued medication
- Record response to intervention
- Record changes in condition
- Record in the right record keeping system

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Errors

- Exclude references to problems
- Avoid terms suggestive of error
- No erasures, scratch outs or white outs
- Do not write "error," use a line with initials only
- Avoid late entries

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Who?

The RN:

- Within scope of practice

The LPN:

- Within scope of practice

The Health Assistant:

- Documents care they give, not what the nurse does

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How?

- Stick to the facts
- Avoid labeling
- Be specific
- Use neutral language

“If it wasn’t charted, it wasn’t done!”

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How?

- Health Office Visits
  - **NO** multiple student daily logs
  - Document in real time
  - Use appropriate language
  - Use accepted abbreviations

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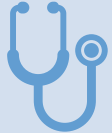
Health Problems



Medical Diagnosis

Psychological Diagnosis

Functional Diagnosis

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What about…

- DCF?
- Pregnancy?
- STD’S?
- Depression?
- Suicide?

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Phone and Other Contacts

Record:

- Date and time
- With whom
- Title of person
- Summary of conversation
- Instructions, if any, and check for understanding

Personal Notes

- Temporary
- Memory jogger
- Not to be shared
- Eventually destroyed

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Electronic Records

- Health Records
- Faxes
- Emails

Electronic Recording System

Does it:

- Meet confidentiality standards
- Provide essential record keeping
- Allows documentation by all school health staff
- Provide health alerts
- Generate data
- Support communication

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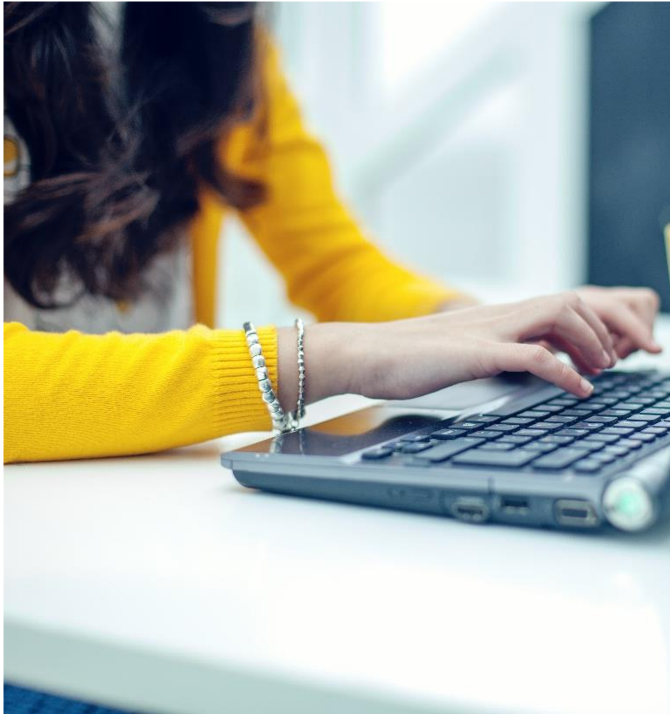
Questions to ask



- ✓ What do you want your documentation system to do?
- ✓ Does it allow customized menu options?
- ✓ Can it be networked in district?
- ✓ Is technical support available?
- ✓ Who is the system administrator?
- ✓ What are the training needs?
- ✓ Who has access?

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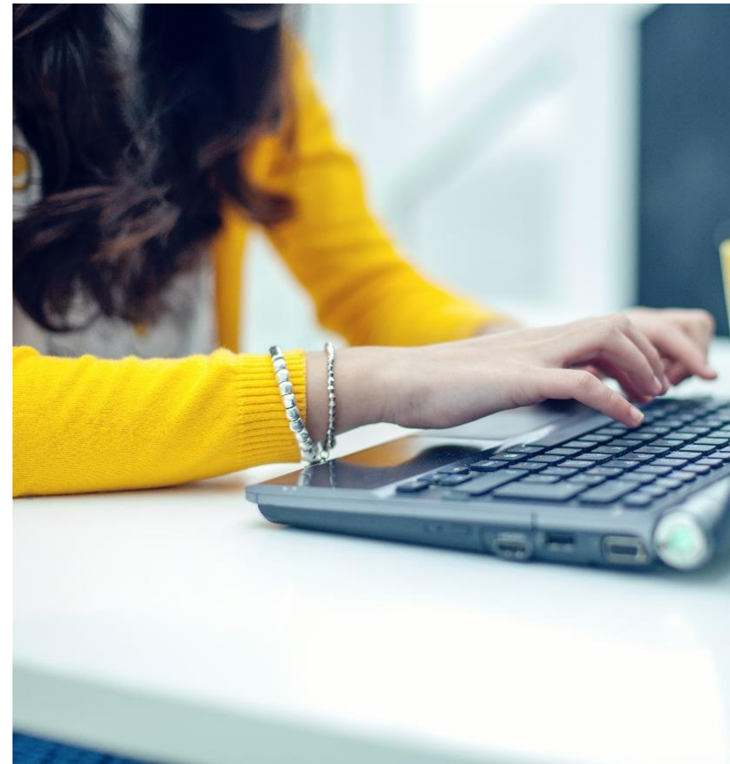
When documenting electronically:

Do

- Note on outside of CHR stating- “electronic record summary inside”
- Check district policy on transferring electronic version of record to a district with the same documentation system



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Receiving Faxes

01
Secure area with limited access

02
Monitor incoming documents

03
Verify all information received & legible

04
Verify orders from authorized prescriber

Sending Faxes

- Authorization to release
- Call first to alert recipient
- Verify number- to eliminate errors, program numbers
- Include confidentiality statement

Documentation via Email

- **Never** send sensitive information via email
- Do not forward messages unless permission is obtained
- Work email is public record

Confidentiality:
“Need to Know” vs “Right to Know”

When to share confidential information?

Must have

- A legitimate educational interest
- A “need to know”
- Be released by the school health professional to interpret health information

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References

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- Resha, C. and Taliaferro, V. (2017) *Legal Resources for School Health*
- Selekman, Shannon Yonkaitis. *(2019) School Nursing: A Comprehensive Text*

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Resources

- Connecticut State Department of Education (2011) *Cumulative Health Record Guidelines*
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Presenter:

Dr. Stephanie Knutson, RN
Stephanie@Schoolnurseguru.com