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## LETTERS TO THE EDITOR

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### **DOCUMENTATION: THE COST OF EXCEPTION**

**To the Editor:** Technologists, like nurses and physicians, are now at risk of being named in lawsuits. In 1990, our radiology department began to analyze what documentation should and must be made in the patient record on a regular basis to help decrease the likelihood of such occurrences. We had to answer several basic questions before we could begin this documentation process.

- Why would it be necessary for the technologist to keep a chart when the radiologist dictates the amount and type of radiopharmaceutical/contrast in the patient report?
- What would be necessary information for the technologist to chart?
- What form was appropriate for us to use to enter information on the patient's chart?
- How were our chart entries to be structured?

The first question was our greatest hurdle because radiologists have traditionally performed these charting duties. Several issues were addressed since chart entries are legal documents, which are admissible in a court of law as evidence. Any technologist performing a procedure, even under the direction of the radiologist, is responsible for his or her actions. Since the radiologist did not observe the procedure or the appearance of the patient, before, during, or after the procedure, the chart entry gives a description of what action was performed and what occurred, with the technologist being the only witness. Documenting any change in the patient's condition and contacting the proper people, at the proper time, provides the technologist with a record that shows the patient's safety was not neglected.

In concurrence with risk management, we felt documentation in the

patient's permanent medical record by the technologist would protect the technologists, the radiologists, the hospital, and the patient by recording information firsthand. If a lawsuit or a grievance should be filed at a later date, the facts would be documented in the patient's record. Also, we would be able to communicate in a common language (narrative notation) with others on the patient care team, physicians, nurses, aides, and other technologists, describing what happened with that patient in our department. Thus, the continuity of the patient's record would be maintained 24 hr per day.

We began this process by defining and refining what needed to be documented. Deciding what should be documented gave everyone the most trouble. The necessity of recording injections of radiopharmaceuticals or contrast materials was easily understood, but other items were not as clear. The following list was compiled in order to clarify when documentation was appropriate.

1. IV starts/attempts and discontinuations with site observation.
2. Injections of radioactive or contrast materials or blood products, including amounts and dosages of each, the date and time of administration, and the technologist who injected the dose.
3. Reactions to injections or procedures. Administration of radiopharmaceutical or contrast doses by a physician's verbal order. Administration of blood products, especially for indium leukocyte imaging, because a blood product is being given.
4. Any problem the patient experiences while in the technologist's care. This includes any accidents or occurrences that adversely affect the patient or the outcome of his test. This may be a physical problem, such as pain, contractions, or noncompliant behavior

that compromises the results of the exam.

Every department that delivers direct patient care has a form that represents the designated place for documentation. In our hospital, the form is titled: Paramedical Progress Notes. It resembles a Physician's Progress Note, in that it is a lined sheet of paper for narrative entries. By using the existing form, we could avoid designing a new form, which could take months to be approved by the various medical committees.

Our next step was to give each technologist this list of documentation guidelines with an example on how to structure a narrative notation. Examples of narrative chart entries were placed in the procedure manual. Chart audits for every department are done on regular basis, with the emphasis on continual improvement in charting skills. Initially, our greatest resistance from the technologists was related to the amount of time it would take to complete their chart entries. Within six months, most of the technologists could easily document injections of radiopharmaceuticals or contrast materials with three lines of narration, taking about 1.5 minutes. Even the most complicated incident related documentation should take 10 min or less.

### **Documentation Examples**

The following two examples are of documentation of indium leukocyte administration.

5/14/92. 0800. 50 ml blood withdrawn from right antecubital fossa on 1st attempt with 19 G[auge] needle. Specimen sent to Syncor Pharmacy. No hematoma or bleeding at site. Tech T, CNMT.

5/14/92. 1200. Syringe label and patient bracelet identical. Witnessed by Nurse N, RN and Tech T, CNMT. 3.16 ml, 0.53 mCi of indium-111 leukocyte injected through 21-G butterfly, which was placed into left forearm vein on 1st attempt with good

blood return, and flushed easily with 6 ml of normal saline. No redness, edema, or pallor at site. Tech T, CNMT.

The following five examples are of documentation of the premature termination of scans.

5/19/92. 1240. 0.5 ml, 10 mCi  $^{99m}\text{Tc}$   $\text{MAG}_3$  injected into right forearm IV port and flushed easily with 6 ml normal saline. No redness, edema, or pallor at IV site. Tech T, CNMT.

5/19/92. 1300. Patient experiencing chest pressure, SOB with diaphoresis during renal exam. Scan terminated. Nurse N, RN called STAT. Tech T, CNMT.

5/19/92. 1305. Monitor showing sinus rhythm with depressed ST segments. Dr. D in ER called STAT. Nurse N, RN.

5/19/92. 1307. Attending physician, Dr. J, informed. Nurse N, RN.

5/19/92. 1310. Administered 1 nitrostat tablet, 0.4 mg sublingual. Patient transferred to floor on stretcher. Report given to UN-5, Nurse A. Nurse N, RN.

pinned under a microscope surrounded by hot accusatory lights?

Our department has always documented the date, the time of injection, the radiopharmaceutical name, the dose volume, the dose activity, and the name of the patient. This is the same procedure that I have followed in every department in which I have worked. Now we document not only the above information, but the patient's response while in our care. The case did not go to court because of our documentation policy.

Busy days, staff shortages, and tighter schedules never seem to leave any extra time for more paperwork. But the cost of that one exception could mean your license, your job, your professional reputation, or even your peace of mind. Should you document? Can you afford not to?

**Charise Miltenberger**  
**Yvonne Fugee**  
*Memorial Hospital Northwest*  
*Houston, Texas*