Full-Day Program

Agenda
7:30 Registration
08:00 am – 4:00 pm

Setting the Stage
- Medical records are just as important as testimony

Legal and Ethical Implications of Documentation
- “Get it right the first time”
- Standards of Care/Documentation
- Incident reports

Admissible Forms of Documentation
- Common documentation mistakes
- Assessment
- Medications/Interventions
- Patient education and responses

Charting Systems
- Electronic entries

Avoiding Legally Risky Documentation
- Credible evidence
- Maintaining factuality & thoroughness
- Ambiguity and bias
- Late entries and personnel notes
- Error corrections

Bioethical Dilemmas
- End-of-life
- HIPAA
- Falsifying and covering up
- Tampering

Analyze a Real Case Scenario

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Your Speaker

Rachel Cartwright, PhD(c), MS, RN, LHRM, CCRN-K, LNCC

Rachel has a unique teaching style which helps audiences to easily understand the complex concepts in the medical field. She is a member of the National Speakers Association. She is a published author in peer reviewed journals and textbooks. She is a PhD candidate in Public Policy and Administration: Law and Policy. She is a licensed healthcare risk manager. Connecting with the audience is the magic that creates memorable seminars. Her humor and entertaining presentation style turns seemingly boring topics into fun conversations. Rachel has the right chemistry of expertise, experience and passion, and she will inspire, motivate and refresh novice and seasoned nurses.

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Learn from the Mistakes of Others: Nursing Documentation

March 14, 2017
Sheraton at Palo Alto
625 El Camino Real, Palo Alto, CA 94301

MEDICAL LEGAL CONCEPTS, LLC
6231 PGA Blvd, Suite 104-243
Palm Beach Gardens, FL 33418

Presented by
Rachel Cartwright, PhD(c)
A year from today you may have wished that you started today – Karen Lamb

Program Objectives
1. Describe the application of the Nurse Practice Act/Laws to documenting care of patients.
2. List ten ways to keep your documentation notes and charts out of the courtroom.
3. Integrate the correct practices into your documentation notes to keep your license unblemished.
4. List at least three ways to safeguard electronic documentation.
5. Utilize actual medical malpractice cases to learn how to improve your documentation.
6. Compare and contrast the different forms of nursing documentation and how they are used in the courtroom.

Program materials include:
- Course manual
- Personal interaction with speaker during breaks
- Pre-order at a discount:

"Nursing Nuggets"; a documentation reference book (publication Fall 2017)

“You’ve got to do your own growing no matter how tall your grandfather was.”

Tuition for Two-day program: $179.00
This program provides the participant 6.3 CEs Provider #50-19431

Publications:


If you were required to testify in court in defense of the care you provided to a patient, would your documentation be adequate to protect you from legal liability?

If the care you provided came under scrutiny months or years after it occurred, would your documentation enable you to accurately describe the standard of care delivered to the patient?

If you are not absolutely certain...YOU do not want to miss this program!

During this in-depth, interactive seminar, you will have the opportunity to review real court cases and learn from the actual testimonies provided through depositions of nurses. Rachel, an independent legal nurse consultant has over 33 years of clinical, management, and consulting experience. She will provide information you need to ensure that your documentation, handwritten or electronic, depicts a level of care that meets or exceed applicable standards.

Learn how to identify and avoid risky documentation and integrate practice that will keep your license unblemished. What you learn will be immediately applicable to your practice and may keep you out of the courtroom.