Chapter 7

Documentation of Nursing Care

Chapter 7

Lesson 7.1

Learning Objectives

Theory

1) Identify three purposes of documentation.
2) Correlate the nursing process with the process of charting.
3) Discuss maintaining confidentiality and privacy of paper or electronic medical records.
4) Compare and contrast the five main methods of written documentation.

Clinical Practice

1) Correctly make entries on a daily care flow sheet

Purposes of Documentation

- Provides a written record of the history, treatment, care, and response of the patient while under the care of a health care provider
- Is a guide for reimbursement of costs of care
- May serve as evidence of care in a court of law
- Shows the use of the nursing process
- Provides data for quality assurance studies

Purposes of Documentation(cont'd)

- Is a legal record that can be used as evidence of events that occurred or treatments given
- Contains observations by the nurses about the patient's condition, care, and treatment delivered
- Shows progress toward expected outcomes

Documentation and the Nursing Process

- Written nursing care plan or interdisciplinary care plan is framework for documentation
- Charting organized by nursing diagnosis or problem
- Implementation of each intervention documented on flow sheet or in nursing notes
- Evaluation statements placed in nurse's notes and indicate progress toward the stated expected outcomes and goals

The Medical Record

- Contains data about patient's stay in a facility
- Only health care professionals directly caring for the patient, or those involved in research or teaching, should have access to the chart
- Patient information should not be discussed with anyone not directly involved in the patient's care

Methods of Documentation (Charting)

- Source-oriented (narrative) charting
- Problem-oriented medical record (POMR) charting
- Focus charting
- Charting by exception
- Computer-assisted charting
- Case management system charting

Source-Oriented or Narrative Charting

- Organized according to source of information
- Separate forms for nurses, physicians, dietitians, and other health care professionals to document assessment findings and plan the patient's care
- Narrative charting requires documentation of patient care in chronologic order

Source-Oriented or Narrative Charting (cont'd)

- Advantages
  - Information in chronologic order
  - Documents patient's baseline condition for each shift
  - Indicates aspects of all steps of the nursing process
- Disadvantages
  - Documents all findings: makes it difficult to separate pertinent from irrelevant information
  - Requires extensive charting time by the staff
  - Discourages physicians and other health team members from reading all parts of the chart

Example of Source-Oriented (Narrative Charting)

Date	Time	Problem	Nurse's Notes
6/25/13	2015	#1	States has "sharp throbbing" pain at a 7 on a 1-10 pain scale.
			Started at 2000 when amb down hall. T 99, P 88, R 24, BP
			146/82. Unrelieved by change in position or rest.----R. Hill, LVN
	2020		Meperidine 75 mg IM RUOQ.----------R. Hill, LVN
	2045		Resting quietly in bed. P 86, R 20, BP 146/78. States pain "has
			decreased considerably."----------R. Hill, LVN

Problem-Oriented Medical Record Charting (POMR)

- Focuses on patient status rather than on medical or nursing care
- Five basic parts: database, problem list, plan, progress notes, and discharge summary

Problem-Oriented Medical Record Charting (POMR) (cont'd)

- Advantages
  - Documents care by focusing on patients' problems
  - Promotes problem-solving approach to care
  - Improves continuity of care and communication by keeping relevant data all in one place
  - Allows easy auditing of patient records in evaluating staff performance or quality of patient care

Problem-Oriented Medical Record Charting (POMR) (cont'd)

- Disadvantages
  - Results in loss of chronologic charting
  - More difficult to track trends in patient status
  - Fragments data because more flow sheets required

PIE Charting

- P—problem identification
- I—interventions
- E—evaluation
- Follows the nursing process and uses nursing diagnoses while placing the plan of care within the nurses' progress notes

Example of PIE (Problem, Intervention, Evaluation) Charting

Date	Time	Problem	Nurse's Notes
7/18/13	1420	Pain r/t ROM	**P.** Reinstruct in use of PCA and measures for distraction.
		exercises of rt	**I.** Instructions for use of PCA given; encouraged to watch
		knee by CPM	TV movie for distraction. Knee position on CPM machine
		machine	OK; machine functioning at ordered settings. Repositioned
			upper body for comfort.
			E. Using PCA as needed; pain decreased. States is tolerable at
			3 on a scale of 1-10. Watching movie.--------C. Harris, LPN

Question 1

Monica, a nurse in the operating room, knows that charting must be all of the following except:

1) subjective.
2) accurate.
3) brief.
4) complete.

Chapter 7

Lesson 7.2

Lesson Objectives

Theory

4) Compare and contrast the five main methods of written documentation. (continued)

5) List the legal guidelines for recording on medical records.

6) Relate the approved way to correct entries in medical records that were made in error.

Lesson Objectives

Clinical Practice

2) Document the characterization of signs or symptoms in a sample charting situation.

3) Use a systematic way of charting to ensure that all pertinent information has been included.

4) Apply the general charting guidelines in the clinical setting.

5) Navigate electronic medical records and document care correctly.

Focus Charting

- Directed at nursing diagnosis, patient problem, concern, sign, symptom, or event
- Three components:
  - D: data, A: action, R: response (DAR)
- OR
  - D: data, A: action, E: evaluation (DAE)

Focus Charting (cont'd)

- Advantages
  - Compatible with the use of the nursing process
  - Shortens charting time: many flow sheets, checklists
- Disadvantages
  - If database insufficient, patient problems missed
  - Doesn't adhere to charting with the focus on nursing diagnoses and expected outcomes

Example of Focus Charting

Date	Time	Problem	Patient Progress
7/01/13	1300	Impaired skin	**D.** Slight serous drainage on dressing; wound 1x2 cm c̄ left red
		integrity right	border; no odor; states hurts slightly.----------
		ankle	**A.** Cleansed c̄ sterile saline. DuoDerm thin applied.
			R. Wound clean; minimal drainage present.-----T. Harper, RN

Charting by Exception

- Based on the assumption that all standards of practice are carried out and met with a normal or expected response unless otherwise documented
- A longhand note is written only when the standardized statement on the form is not met

Charting by Exception (cont'd)

- Advantages
  - Highlights abnormal data and patient trends
  - Decreases narrative charting time
  - Eliminates duplication of charting
- Disadvantages
  - Requires detailed protocols and standards
  - Requires staff to use unfamiliar methods of recordkeeping and recording
  - Nurses so used to not charting that important data is sometimes omitted

Computer-Assisted Charting

- Electronic health record (EHR)
  - Computerized record of patient's history and care across all facilities and admissions
- Computerized provider order entry (CPOE)
  - Provides efficient work flow
  - Automatically routes orders to appropriate clinical areas

Computer-Assisted Charting (cont'd)

- Documentation done as interventions are performed using bedside computers
- Variations depending on the system
- Some produce flow sheets with nursing interventions and expected outcomes
- Others use a POMR format to produce a prioritized problem list

Computer-Assisted Charting (cont'd)

- Advantages
  - Date and time of the notation automatically recorded
  - Notes always legible and easy to read
  - Quick communication among departments about patient needs
  - Many providers have access to patient's information at one time
  - Can reduce documentation time
  - Reimbursement for services rendered is faster and complete
  - Can reduce errors

Computer-Assisted Charting (cont'd)

- Disadvantages
  - Sophisticated security system needed to prevent unauthorized personnel from accessing records
  - Initial costs are considerable
  - Implementation can take a long time
  - Significant cost and time to train staff to use the system

Case Management System Charting

- A method of organizing patient care through an episode of illness so clinical outcomes are achieved within an expected time frame and at a predictable cost
- A clinical pathway or interdisciplinary care plan takes the place of the nursing care plan

Accuracy in Charting

- Be specific and definite in using words or phrases that convey the meaning you wish expressed
- Words that have ambiguous meanings and slang should not be used in charting

Brevity in Charting

- Sentences not necessary
  - Articles (a, an, the) may be omitted
  - The word “patient” omitted when subject of sentence
- Abbreviations, acronyms, symbols acceptable to the agency used to save time and space
- Choose which behaviors and observations are noteworthy

Legibility and Completeness in Charting

- If writing not legible, misperceptions can occur
- Be sure to include as much information as needed
- Completeness is more important than brevity (see Boxes 7-1 through 7-3 for charting guidelines)

The Kardex

- Not a part of the permanent medical record
- A quick reference for current information about the patient and ordered treatments
- Usually consists of a folded card for each patient in a holder that can be quickly flipped from one patient to another

Information on the Kardex

- Room number, patient name, age, sex, admitting diagnosis, physician's name
- Date of surgery
- Type of diet ordered
- Scheduled tests or procedures
- Level of activity permitted
- Notations on tubes, machines, other equipment in use
- Nursing orders for assistive or comfort measures
- List of medications prescribed by name
- IV fluids ordered

Question 2

John is reviewing the Kardex on his patient. Which statement is *not* true regarding the Kardex?

1) A Kardex is a work tool rather than a required part of the medical record.
2) A Kardex does need to be kept up to date.
3) A Kardex will have information such as room number, date of surgery, diet, medications, etc.
4) A computerized patient care system will definitely have a Kardex for each patient.

Question 3

Madison, a pediatric nurse, prefers charting by exception. She realizes all of the following are true *except*:

1) charting by exception was developed in 2005 by a group of nurses at St. Luke's Medical Center in Sarasota, Florida.
2) the goal is to decrease the lengthy narrative entries of traditional systems.
3) charting by exception is based on the assumption that all standards of practices are carried out.
4) a longhand note is written only when the standardized statement on the form is not met.

Question 4

Mrs. Smith, LPN, has just charted the following assessment on her patient.

2/14/2008 3:00 PM VS stable. Voided 450 mL clear straw-colored urine. Pt denies pain but appears tired. Amy Smith, LPN

Which of the following entries is *incorrect*?

1) Time of entry
2) Nurse stating an opinion
3) No line before name
4) All of the above

Question 5

Sally went into her patient's room to administer an antibiotic. Her patient states, "I am not going to take another pill because they aren't working." What should Sally do?

1) Leave the pill on the bedside table and come back in a few minutes.
2) Throw the pill in the trashcan.
3) Circle the medication on the medication record, give a reason for the refusal in the progress notes, and notify the physician.
4) Crush up the medication in the patient's food and inform the charge nurse.