chapter 7

Documentation of Nursing Care

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Objectives

Upon completing this chapter, you should be able to:

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 six main methods of written documentation.
5. List the legal guidelines for recording on medical records.
6. Relate the approved way to correct errors in medical records.

Clinical Practice

1. Correctly make entries on a daily care flow sheet.
2. Use a systematic way of charting to ensure that all pertinent information has been included.
3. Document the characterization of signs or symptoms in a sample charting situation.
4. Apply the general charting guidelines in the clinical setting.
5. Navigate electronic medical records and document care correctly.

Key Terms

case management system charting (p. 83)
charting (p. 83)
charting by exception (p. 83)
computer-assisted charting (p. 83)
computerized provider order entry (CPOE) (p. 88)
electronic health record (EHR) (p. 87)
focus charting (p. 83)
medical record (chart) (p. 81)
PIE charting (p. 86)
problem-oriented medical record (POMR) charting (p. 83)
protocols (PRŌ-tō-kŏlz, p. 87)
source-oriented (narrative) charting (p. 83)

PURPOSES OF DOCUMENTATION

Documentation provides a written record of the history, treatment, care, and response of the patient while under medical and nursing care. It justifies claims for reimbursement, may be used as evidence of care in a court of law, shows the use of the nursing process, and provides data for quality assurance studies. Each person who provides care for the patient adds written documentation to the **medical record (chart).** The medical record contains all orders, tests, treatments, and care that occurred while the person was under the care of the health care provider. The chart is a communication tool for the professionals involved in patient care. Health team members use documentation to communicate what has been done, how the patient responded, and the current plan for care. Many different forms are used for documentation, and the most common forms are shown in the chapters specific to their content; for example, an intravenous (IV) flow sheet is shown in Chapter 36. The Joint Commission sets the standards for documentation. Common types of forms in patient charts are listed in Table 7-1.

Insurance companies and Medicare rely on documentation to determine actual length of stay, procedures performed, and diagnoses established and to calculate charges due for reimbursement. Each piece of equipment in service must be documented. Charts must display data that support the medical and nursing diagnoses. Evaluation data indicating that the treatment was successful or unsuccessful must be present to justify the duration of the hospital stay. Documentation of this type is also necessary for accreditation of the health care agency. Charts are also used for research data collection. For example, statistics may be compiled for the number of cases of pneumonia treated, the average age of the patients, and treatment results to see which treatments are most effective.

The medical record is a legal record and can be used as evidence of events that occurred or treatment that was given. When documentation is thorough, the

Table 7-1 Forms Used for Hospital Documentation

FORM	TYPE OF INFORMATION
General Forms	
Face sheet	Patient data, including the patient's name, address, phone number, next of kin, hospital identification number, religious preference, place of employment, insurance company, occupation, name of admitting physician, and admitting diagnosis
Physician's orders	The physician's directives for patient care
Graphic sheet	Record of serial measurements and observations, such as temperature, pulse, respiration, blood pressure, weight
Nursing care plan	Care plan for the patient, including nursing diagnoses, goals and expected outcomes, and nursing interventions
Nurse's notes	Written report of the nursing process (i.e., assessment, nursing diagnosis, planning, implementation, and evaluation); record of interventions implemented and the patient's response to them
Care flow sheet	Form on which check marks or short entries are made to indicate dietary intake, type of bath, wound dressing changes, oxygen in use, physician visits, equipment in use, level of activity, and so forth
Medication administration record (MAR)	Documentation of all medications ordered, doses given, and doses not taken by the patient
History and physical examination forms	Physician's record of the patient's medical history and findings of the current physical examination
Nurse's admission history and assessment	Nurse's current history, including usual habits, medications usually taken, and physical assessment findings at admission
Progress sheet	Physician's notes regarding the patient's progress
Laboratory reports	Results of laboratory tests
Radiology reports	Results of x-ray examinations
Admission forms	Information on patient identification, conditions for admission, and consent for general medical and nursing care
Intake and output (I&O) record	Serial record of 24-hr intake and output
Miscellaneous Forms	
Ancillary staff sheets	Records of treatments by physical therapists, occupational therapists, respiratory therapists, and so forth
Consultation sheet	Record of another physician called in to consult by the attending physician
Diabetic flow sheet	Record of blood glucose determinations and amounts of insulin administered
Discharge form	Information about instructions given regarding wound care, medications, rest, activity restrictions, needed exercises, diet, and signs and symptoms to report to the physician; also includes when to next see the physician
Discharge planning sheet	Records by social services, home health agencies, case managers, and clinical nurse specialists regarding the discharge plans and patient's needs
Fall risk assessment	Information regarding the patient's potential fall risk; particularly used for frail, elderly, or patients with neuromuscular impairments
Frequent observations sheet	Used when frequent measurements of vital signs or neurologic assessments are needed (e.g., after surgery or after head trauma)
Intravenous (IV) flow sheet	Record of IV fluids and additives infused, type of IV catheter in use, date tubing was changed, date dressing was applied
Pain assessment	Record of pain level, when assessed, measures to reduce it, effectiveness of treatment
Preoperative checklist	List used to verify that the patient is ready to go to surgery
Skin risk assessment	Data from thorough skin assessment on admission; evaluation of risk factors for skin breakdown; diagrams showing areas of redness, breaks in the skin, or pressure ulcers
Surgical or treatment consent form	Patient authorization for surgery or treatment
Time-out form	Patient verification, site mark verification, and time out performed before surgical procedure
Transfer form	Information pertinent for the transfer of the patient to another unit or facility

record provides a way to show that standards of care have been met.

Documentation, also called **charting,** is used to track the application of the nursing process. The nurse writes down observations made about the patient, notes the care and treatment that was delivered, and adds the patient's response. Documentation shows progress toward the expected outcomes listed on the nursing care plan.

Documentation is useful for supervisory purposes to evaluate staff performance. Charting is audited as part of the health care agency's quality improvement program. Evidence that care adheres to accepted standards should be present in the nurse's notes. The results of chart audits tell nurse managers where improvement may be needed.

DOCUMENTATION AND THE NURSING PROCESS

The written nursing care plan or interdisciplinary care plan provides the framework for nursing documentation. Charting is organized by nursing diagnosis or problem. An initial assessment is charted for each shift. Standard areas of assessment are usually noted on flow sheets, and a written note is added if an abnormality exists. Nursing diagnoses or problems are entered on the care plan, which is created soon after the admission assessment is complete. The plan is reviewed and updated every 24 hours. Implementation of each intervention is documented on a flow sheet or within the nursing notes. The specifics of what was done and how, plus the patient response, are charted. Evaluation statements are placed in the nurse's notes and indicate progress toward the stated expected outcomes and goals. Evaluation data must be documented showing that expected outcomes have been achieved before a nursing diagnosis is marked "resolved" or deleted from the care plan. When expected outcomes are not being met, the care plan is altered.

? Think Critically

If evaluation data are not showing progress toward expected outcomes, what part of the nursing care plan needs to be altered? Where in the chart would this be done?

THE MEDICAL RECORD

The **medical record,** or **chart,** contains data on a patient's stay in the health facility or while under the care of a health care provider. Each type of facility has a particular set of forms used to record information about the patient.

As a legal record, the chart's contents are **confidential;** this means you can only give out information with the patient's written consent, since the chart contains personal information regarding the patient. **Only health professionals caring directly for the patient, or those involved in research or teaching, should have access to the chart.** Protecting the patient's privacy is of prime importance. Do not discuss patient information with others not directly involved in the patient's care.

The chart is the property of the health facility or agency, not of the patient or physician. Patients do have a right to information contained in the chart under certain circumstances (see Chapter 3). Keeping the patient and the family informed in a clear and timely manner usually satisfies their need for information. After the patient has been discharged, the chart is sent to the medical records or health information department for safekeeping. It can be retrieved if the patient is admitted to service again within a 10-year span. Electronic records may be kept for longer periods, ranging from 10 years to indefinitely, depending on the state where the patient resides (Dixon and Shepard, 2008).

? Think Critically

What would you say to your neighbor, who sees you working on the unit on which her sister's husband is a patient, if she asks you to check and see what her brother-in-law's physician has charted about his condition?

METHODS OF DOCUMENTATION (CHARTING)

Different methods of charting are used in various health care agencies. The six main methods of charting are (1) **source-oriented (narrative) charting,** which is organized by "source" or author of the charting entry; (2) **problem-oriented medical record (POMR) charting,** which focuses on the problems the patient experiences as a result of being ill; (3) **focus charting,** which centers on the patient from a positive perspective; (4) **charting by exception,** which focuses on deviations from predefined norms, using preset protocols and standards of care; (5) **computer-assisted charting,** where data are input to the computer; and (6) **case management system charting,** which tracks variances from the clinical pathway.

Whatever method of documentation is used, you are required to chart the patient's progress periodically during the shift or at the time of a home health visit. The chart entries are either in your notes or on flow sheets (Figure 7-1). Flow sheets track routine assessments, treatments, and frequently given care. The specific time frame required for charting is found in the agency's policy and procedure manual. Some agencies require one note per patient contact; others require charting every 1 to 3 hours during the shift.

SOURCE-ORIENTED OR NARRATIVE CHARTING

These records are organized according to the source of information. There are separate forms for physicians (focusing on medical problems), nurses (focusing on nursing diagnoses), dietitians, and other health care professionals to document their assessment

FLOWSHEET	10/10	10/11	
ADLs—cont'd	11-7	7-3	3-11
Ambulate		done RN FR 10:00 done self FR 14:00	
Activity response		tolerated well FR 08:00 tolerated well FR 10:00 tolerated well FR 14:00	tolerated well FR 16:00 tolerated well RJK 20:00 tolerated well RJK 22:00
Feeding		self assist FR 08:00 self assist FRI 12:00	
Diet		regular FR 08:00 regular FR 12:00	
Ate %		80% FR 08:00 80% FR 12:00	
Hygiene		assist bath perineal care skin care back rub linen change FR 10:00	
Standard prec		yes FR 08:00 yes FR 10:00	yes RJK 20:00 yes RJK 22:00
SKIN	11-7	7-3	3-11
Skin assmnt	WNL RJK 00:00	WNL FR 08:00	WNL RJK 20:00
Braden sc	21 RJK 00:00	21 FR 08:00	21 RJK 22:00
INC/WDS UPPER	11-7	7-3	3-11
L shoulder			
Wound type	incision RJK 00:00	incision FR 08:00	incision RJK 20:00
Wound appearance	dry clean RJK 00:00	dry clean FR 08:00	dry clean RJK 20:00
L shoulder			
Wound dressing	dry intact checked RJK 00:00	dry intact checked FR 08:00	dry intact checked RJK 20:00
IV LINES	11-7	7-3	3-11
R subclavian			
Line type	triple RJK 00:00	triple FR 08:00	triple RJK 20:00
Rutken, Frances (FR) RN		Kahn, Roland J. (RJK) LPN	

Doe, John B.
Neverland Hospital
From 10/10/13 to 10/11/13
Room 645-1 ADM 10/09/13
Age 63Y Sex M
MD Sawbucks, Jackson
ID 4620958 MR 102756

FIGURE 7-1 Computer activity flow sheet.

findings and plan the patient's care. Narrative notes are phrases and sentences written without any standardized structure, content, or form. Narrative charting used in source-oriented records requires documentation of patient care in chronologic order. Assessments usually follow a body systems format. The content is similar to a set of dated and timed journal entries (Figure 7-2).

Advantages of the source-oriented (narrative) method are as follows:

- It gives information on the patient's condition and care in chronologic order.

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

FIGURE 7-2 Example of source-oriented (narrative) charting.

- It indicates the patient's baseline condition for each shift.
- It includes aspects of all steps of the nursing process.

Disadvantages of the source-oriented method are as follows:

- It encourages documentation of both normal and abnormal findings, making it difficult to separate pertinent from irrelevant information.
- It requires extensive charting time by the staff.
- It discourages physicians and other health team members from reading all parts of the chart because of the lengthy descriptive entries in it.

PROBLEM-ORIENTED MEDICAL RECORD (POMR) CHARTING

POMR charting focuses on patient status, emphasizing the problem-solving approach to patient care and providing a method for communicating what, when, and how things are to be done to meet the patient's needs. The POMR contains five basic parts: the database, the problem list, the plan, the progress notes (in which *all* members of the health care team document), and the discharge summary (Table 7-2). The precise form these records take varies greatly between agencies, but the essentials of charting are the same.

As this documentation method evolved, the original *SOAP* format for progress notes (for *S*ubjective information, *O*bjective data, *A*ssessment data, and *P*lan) was modified to *SOAPIE* and *SOAPIER*. The additional letters stand for *I*mplementation, *E*valuation, and *R*evision. It is not necessary to use each component of the SOAPIER format each time you make an entry. If there are no subjective data, the *S* can be omitted or labeled "none." If there is no revision, the *R* can be left out (Figure 7-3).

Advantages of the POMR method of documentation are as follows:

- It provides documentation of comprehensive care by focusing on patients and their problems.
- It promotes the problem-solving approach to care.
- It improves continuity of care and communication by keeping data relevant to a problem all in one place so that it is more available to all who are providing care.
- It allows easy auditing of patient records in evaluating staff performance or quality of patient care.

Table 7-2 Major Components of the Problem-Oriented Medical Record

AREA	CONTENTS
Database	Initial assessment, general health history, findings of the physical examination, results of diagnostic and laboratory tests, psychosocial information, nursing assessment, patient's response to the illness or problem.
Problem list	A list of problems derived from the information in the database. The list is continually updated with resolved problems deleted and new problems added. Problems are listed in the chronologic order in which they were identified, not by priority. Both actual and potential problems are listed.
Plan	A three-part plan of care is devised based on the identified problems. For each problem there is a plan for diagnostic studies, a therapeutic plan, and a teaching plan. The physician orders therapies for medical problems, and the nurse orders care for nursing problems.
Progress notes	Contain the assessments, plans, and orders of the physicians, nurses, and other therapists involved in the patient's care. Notes are organized by problem number from the problem list, and each problem is addressed in the SOAP format: S: Subjective data that include symptoms and patient's description of the problem O: Objective data based on health care team's observations, physical examination, and diagnostic tests A: Assessment or analysis of the meaning of the data obtained P: Plan to resolve the problem It is not essential to write a progress note on each problem every day.
Discharge summary	A summary of the problems the patient had, how they were resolved, and the plan for care after discharge.

Date	Time	Problem	Nurse's Notes
7/18/13	0800	#2 Pain, Abd	S. States having RUQ pain radiating to right shoulder. Is "like a knife is poking me." States is a 6 on a scale of 1-10. "It started after I ate the bacon." States feels nauseous, but no vomiting.----------
			O. Pale, diaphoretic and shaky. Splinting abd c̄ hands. T 100° F, P 112, R 22, BP 134/88.
			A. Abd pain.
			P. Institute NPO status; medicate when IM order received. Notify physician.----------J. Sims, RN

A

Date	Time	Problem	Nurse's Notes
6/25/13	1620	#1 Hypertension	S. States feeling "warm and restless."----------
			O. Face flushed; skin hot to touch. T 103° F, P 120, R 26, BP 160/90.----------
			A. Hyperthermia r/t wound infection.
			P. Medicate for ↑ temp.----------
	1625		I. Acetaminophen 500 mg PO c̄ full glass of H_2O. Gown changed. Heat turned down, blanket removed.----------
	1700		E. T 101.6°F, P 95, R 24; temp falling. States is feeling better. Skin cooler to touch.----------M. Bailey, LPN

B

FIGURE 7-3 A, Example of problem-oriented medical record (POMR) charting. B, *Example of SOAPIE (Subjective, Objective, Assessment, Plan, Implementation, Evaluation) charting.*

Date	Time	Problem	Nurse's Notes
7/18/13	1420	Pain r/t ROM exercises of rt knee by CPM machine	P. Reinstruct in use of PCA and measures for distraction.
			I. Instructions for use of PCA given; encouraged to watch TV movie for distraction. Knee position on CPM 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

FIGURE 7-4 Example of PIE (*P*roblem, *I*ntervention, *E*valuation) charting.

- It requires continual evaluation and revision of the care plan.
- It reinforces application of the nursing process.

Disadvantages of the POMR method of documentation are as follows:

- It results in loss of chronologic charting.
- It is more difficult to track trends in patient status.
- It fragments data because of the increased number of flow sheets required.

PIE Charting

Another offshoot of this method is **PIE charting,** which stands for *P*roblem identification, *I*nterventions, and *E*valuation. This type of charting follows the nursing process and uses nursing diagnoses while placing the plan of care within the nurses' progress notes. It differs from SOAP notes because it does not use a traditional nursing care plan or require narrative charting of the assessment data as long as they are normal. The problems, teaching, and discharge needs are listed under the *P* of the PIE format. Nursing diagnoses are kept on a problem list *(P),* and each charting entry is marked with the problem number and title. With this method, the daily assessment information is placed on special flow sheets, and duplication of the information is avoided. Interventions performed are documented under *I*. The outcomes of the interventions are evaluated and documented under *E* (Figure 7-4). When assessment data are abnormal, an *A* is added (APIE).

FOCUS CHARTING

Focus charting is similar to the POMR system but it substitutes **focus** for the **problem,** eliminating the negative connotation attached to "problem." Focus charting is directed at a nursing diagnosis (e.g., pain), a patient problem (pressure ulcer), a concern (decreased food intake), a sign (fever), a symptom (anxiety), or an event (return from surgery). The note has three components: *D*ata, *A*ction, and *R*esponse (DAR) or *D*ata, *A*ction, and *E*valuation (DAE) (Figure 7-5). The data

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

FIGURE 7-5 Example of focus charting.

component contains subjective and objective information that describes or supports the focus of the note. The action component includes interventions performed or to be implemented. The response component describes the outcomes of the interventions and whether the goal has been met.

The advantages of focus charting are as follows:

- It is compatible with the use of the nursing process.
- It shortens charting time by using many flow sheets and checklists.
- The focus is not limited to patient problems or nursing diagnoses.

The disadvantages of focus charting are as follows:

- If the database is not complete, patient problems may be missed.
- It does not adhere to charting with the focus on nursing diagnoses and expected outcomes.

CHARTING BY EXCEPTION

Charting by exception was developed in the early 1980s by a group of nurses in Wisconsin. The goal was to decrease the lengthy narrative entries of traditional charting systems and reduce repetition of data. **Charting by exception is based on the assumption that all standards of practice are carried out and met with a normal or expected response *unless otherwise documented.*** Agency-wide and unit-specific **protocols** (standard procedures) and standards of nursing care are the heart of the system. The standards and protocols are integrated into flow sheets and forms, and the nurse needs only to document abnormal findings or responses correlated with the nursing diagnoses listed on the nursing care plan (Figure 7-6). **A longhand note is written only when the standardized statement on the form is not met** (Figure 7-7). Otherwise only a signature is necessary.

Charting by exception is the direct opposite of the adage, "If it wasn't charted, it wasn't done." Charting by exception assumes that, unless documented to the contrary, all standards and protocols were followed and all assessment values were within accepted limits. This type of charting may present some problems with legalities when a chart is called into court because only abnormalities are documented in written words.

The advantages of charting by exception are as follows:

- It highlights abnormal data and patient trends.
- It decreases narrative charting time.
- It eliminates duplication of charting.
- It lends itself to computerized charting systems.

Disadvantages of charting by exception are as follows:

- It requires development of detailed protocols and standards.
- It requires retraining staff to use unfamiliar methods of record keeping and recording.
- Nurses become so used to *not* charting that important data are sometimes omitted.

COMPUTER-ASSISTED CHARTING

An **electronic health record (EHR)** is a computerized comprehensive record of a patient's history and care across all facilities and admissions. This type of record is a goal for the entire medical industry by 2014, mandated by the Stimulus Law that President Obama signed in 2009. The QSEN project (see Chapter 3) identifies informatics as one of the major areas where prelicensure knowledge, skills, and attitudes (KSAs) are important for nursing students to acquire.

Security and confidentiality of records are major concerns. Within a hospital system, computer records are protected by passwords and a firewall. With the addition of wireless technology, the security issues have increased. Each user who has access to a patient record must have a secure password, which must be changed regularly to maintain security. Encryption and authentication software is used when reports are transmitted outside of the health care facility campus. See Box 7-1 on p. 90 for tips on computer charting.

Legal & Ethical Considerations

Confidentiality and Security with Computer Charting

You have a legal obligation to guard your password and to not give it to anyone at any time for any reason. If you use printed automated Kardex sheets while caring for patients, be sure to shred them at the end of the shift before leaving the unit. HIPAA requirements mandate that all patient information be kept confidential.

Although your password gives you access to the records of patients on your unit, you will not be able to access patient records on other units. Only administrative personnel can view the record of any patient in the hospital.

GUIDELINES FOR USE OF THE NURSING/PHYSICIAN ORDER FLOW SHEET

1. Indicate the Nursing Diagnosis that relates to the nursing order in the far left-hand column of the category boxes. If the order is a physician order, indicate "D.O." ("Doctor Order") instead of the nursing diagnosis number.
2. Indicate the nursing or physician order. If the nursing order includes an assessment to be completed, use the following protocol:
   a. *NEUROLOGIC ASSESSMENT* - will include orientation, pupil movement, sensation, quality of speech/swallowing, and memory.
   b. *CARDIOVASCULAR ASSESSMENT* - will include apical pulse, neck veins, CRT, peripheral pulses, edema, and calf tenderness.
   c. *RESPIRATORY ASSESSMENT* - will include respiratory characteristics, breath sounds, cough, sputum, color of nailbeds/mucous membranes, and CRT.
   d. *GASTROINTESTINAL ASSESSMENT* - will include abdominal appearance, bowel sounds, palpation, diet tolerance, and stools.
   e. *URINARY ASSESSMENT* - will include voiding patterns, bladder distention, and urine characteristics.
   f. *INTEGUMENTARY ASSESSMENT* - will include skin color, skin temperature, skin integrity, and condition of mucous membranes.
   g. *MUSCULOSKELETAL ASSESSMENT* - will include joint swelling, tenderness, limitations in ROM, muscle strength, and condition of surrounding tissue.
   h. *NEUROVASCULAR ASSESSMENT* - will include color, temperature, movement, CRT, peripheral pulses, edema, and patient description of sensation to affected extremity.
   i. *SURGICAL DRESSING/INCISIONAL ASSESSMENT* - will include condition of surgical dressing and/or color, temperature, tenderness of surrounding tissue, condition of sutures/staples/steri-strips, appearance of wound including color, any exudate present, granulation tissue; approximation of wound edges, and presence of any drainage.
   j. *PAIN ASSESSMENT* - will include patient description, location, duration, intensity on a scale of 1 to 10, radiation, precipitating factors.
   k. *POST-MYELOGRAM COMPLICATION ASSESSMENT* - will include headache, nausea, and vomiting.
   l. *MYELOGRAM SITE ASSESSMENT* - will include presence of ecchymosis and drainage.

OR

Specify exactly which parts of assessment should be completed.

3. Top of sheet should be dated. Time should be indicated in the small box in upper right-hand corner of each category box.
4. Upon carrying out an order that has no significant findings, a "✓" in the appropriate category box is sufficient to indicate it was done. If the order includes an assessment, the following parameters will be considered a negative assessment and constitute the use of a "✓".
   a. *NEUROLOGIC ASSESSMENT* - Alert and oriented to person, place, and time. Behavior appropriate to situation. Pupils equal, round and reactive to light. Active ROM of all extremities with symmetry of strength. No paresthesia. Verbalization clear and understandable. Swallowing without coughing or choking on liquids and solids. Memory intact.
   b. *CARDIOVASCULAR ASSESSMENT* - Regular apical pulse, S_1 and S_2 audible. Neck veins flat at 45 degrees. CRT <3 sec. Peripheral pulses palpable. No edema. No calf tenderness.
   c. *RESPIRATORY ASSESSMENT* - Respirations 10-20/min at rest. Respirations quiet and regular. Breath sounds vesicular throughout both lung fields, bronchial over major airways, with no adventitious sounds. Sputum clear. Nailbeds and mucous membranes pink. CRT <3 sec.
   d. *GASTROINTESTINAL ASSESSMENT* - Abdomen soft. Bowel sounds active (5-34/min.) No pain with palpation. Tolerates prescribed diet without nausea and vomiting. Having BMs within own normal pattern and consistency.
   e. *URINARY ASSESSMENT* - Able to empty bladder without dysuria. Bladder not distended after voiding. Urine clear and yellow to amber.
   f. *INTEGUMENTARY ASSESSMENT* - Skin color within patient's norm. Skin warm and intact. Mucous membranes moist.
   g. *MUSCULOSKELETAL ASSESSMENT* - Absence of joint swelling and tenderness. Normal ROM of all joints. NO muscle weakness. Surrounding tissues show no evidence of inflammation, nodules, nail changes, ulcerations, or rashes.
   h. *NEUROVASCULAR ASSESSMENT* - Affected extremity is pink, warm and movable within patient's average ROM. CRT <3 sec. Peripheral pulses palpable. No edema. Sensation intact without numbness or paresthesia.
   i. *SURGICAL DRESSING/INCISIONAL ASSESSMENT* - Dressing dry and intact. No evidence of redness, increased temperature, or tenderness in surrounding tissue. Sutures/staples/steri-strips intact. Wound edges well-approximated. No drainage present.
   j. *PAIN ASSESSMENT* - If medication alone relieves pain and expected outcome is met, documentation on the Medication Profile is sufficient. No specific problem needs to be identified in the Nurses' Notes or Flow Sheet.
   k. *POST-MYELOGRAM COMPLICATION ASSESSMENT* - Absence of headache, nausea, and vomiting.
   l. *MYELOGRAM SITE ASSESSMENT* - Steri-strip dry and intact. No drainage present.
5. Upon carrying out an order that has significant findings, an asterisk is entered in the appropriate box. An asterisk (*) in the category box indicates to "See Significant Findings Section."
6. If status remains unchanged from previous asterisk entry, current entry may be indicated with an "→."
7. If an order no longer needs to be carried out, the next unused category box in that row indicates "order D/Ced," and a line should be drawn through the remaining boxes. Any unused rows can be left blank.
8. Each flow sheet is used for 24 hours.

FIGURE 7-6 Guidelines for the use of the nursing or physician order flow sheet. These guidelines appear on the reverse side of the first page of the flow sheet.

Computerized provider order entry (CPOE) provides for efficient work flow because, when orders are entered into the computer, they are automatically routed to the appropriate clinical areas for action. For example, a physician order for a new medication is entered on the computer and then automatically posted to the electronic medication administration record (eMAR) for that patient and to the pharmacy for the order to be filled. The order is always legible, and transcribing errors are eliminated.

St. Luke's Medical Center
Milwaukee, WI

NURSING/PHYSICIAN ORDER FLOWSHEET
X-3856 (2/89)

John Smith

MYELOGRAM PROCEDURE PROTOCOL
Date 5-16-13 to 5-17-13

NRSG DX	NURSING/PHYSICIAN ORDER	16		20												
P	Myelogram site assessment	✓		✓												
P	Encourage fluids	✓		✓												
P	Pain assessment	*	→ 18	*												
P	Neurovascular assessment	*		→												
P	Post myelogram complication assessment	*	→ 18	*	* 21											
I	GI assessment	✓														
DO	Pelvic traction	*														
DO	Aqua K pad	*														
	* SIGNIFICANT FINDINGS ▼ NURSE INITIAL ►	BK	BK	BK	BK											

NRSG	TIME		INITIAL
P	1600	Pain to low back radiating down posterior (R) leg to foot ± numbness/tingling. ↑ headache which increases ± activity; relieved by lying flat. Traction & Aqua K off re: post myelograms.	BK
P	2000	Headaches decreased ± lying still & p.o. meds. Pt. has suprapubic distension - unable to void per urinal re: positioning. MD contacted.	BK
P	2100	Straight cath done ± return of 700 mL clear yellow urine.	BK

See Reverse Side

MYELOGRAM PROCEDURE PROTOCOL
NURSING/PHYSICIAN ORDER FLOW SHEET

WHITE - Chart YELLOW - Bedside

FIGURE 7-7 Physical assessment documentation on a nursing or physician order flow sheet, with significant findings noted.

In computerized charting systems, it is important to have standard terminology appropriate for the entire interdisciplinary team. The Systematized Nomenclature of Medicine–Clinical Terms is a reference vocabulary developed for this purpose. This is important in evidence-based practice for researchers to understand the relationships in the data to predict trends and consequences of care (Lunney et al., 2005).

Health care agencies are moving toward electronic documentation of patient care. Documentation can be done as interventions are performed with the use of a workstation on wheels (Figure 7-8) or a hand-held terminal carried from room to room. Computer-assisted charting can save nursing time. Entries can be made at the point of care, at the time a change in condition is observed or a treatment is given. The information is fresh, and no time has to be spent recalling details or organizing events in sequence. If the system uses a drop-down table or menu to select from, you can quickly choose the appropriate description or intervention and do not have to key in free text. Test and diagnostic results can be electronically added to the medical record as they are received, allowing for more rapid information flow between health care providers.

Computerized systems for charting vary. Any documentation system can be supported using electronic documentation. Some organizations use a combination

Box 7-1 Tips for Computer Charting

- Attend a computer documentation orientation held by the facility. Obtain a "quick reference guide."
- Determine the "superuser" on your unit to be used as a resource.
- Refresh the computer screen often to keep track of the most current medical orders and other health care providers' entries.
- Chart in a timely manner.
- Do not share passwords or computer codes. Your code is your legal electronic signature.
- **Review your notes for accuracy before you select "confirm" or "save."**
- Never walk away from your terminal without logging off.

FIGURE 7-8 Nurse using a workstation on wheels at the bedside to do point-of-service charting.

of manual and electronic documentation. For example, some documentation systems produce a flow sheet with the expected patient outcomes and nursing interventions listed. The nurse initials those interventions that were implemented, writes a narrative note for other necessary information, and adds the printout page to the chart. This adds some limited electronic functions to a basically manual system.

Other systems use the POMR format and produce a prioritized problem list. A care plan is constructed by selecting the diagnoses, expected outcomes, and nursing interventions from specific screens on the computer and keying in required information. A touch screen may be part of the system for choosing items.

A third type of system consists of selecting data from display screens to build the flow sheets and progress notes. The display screens are structured to allow documentation of current data and provide space for the addition of new findings. Much of the everyday care can be charted rapidly and completely in just seconds using such screens. Often the progress notes from all disciplines involved in the patient's care are integrated. A chart of vital sign trends or laboratory value trends can be printed quickly. Figure 7-9 shows a printout of part of a patient's electronic chart.

If an organization and medical community have fully implemented EHRs, clinical information from all sources will flow into the record. This results in a longitudinal medical record that contains documentation of all of a patient's health care through time. The record is divided into episodes of care. An episode of care can occur in the outpatient or inpatient setting, any time the patient received medical assessment and/or medical intervention. As mentioned earlier, laboratory results, diagnostic imaging results, pathology reports, medication administration, and other information from all care delivery settings will be available via the EHR. This provides virtually instant access to a complete medical history.

At this time, fully integrated EHRs are not common. There are multiple vendors for EHR systems. Integration of these systems with an agency's current needs requires computer programming and interfaces, which can be expensive and time-consuming. Organizations must invest significant time and money to develop a true longitudinal EHR.

Most organizations using EHRs have a computer system that collects health care information while the patient is receiving either inpatient or outpatient services. The inpatient and outpatient systems may be integrated, allowing physicians to access all patient information in the computer system from their offices. However, the clinic medical record and the hospital system's medical record may still remain separate and require access to both computer systems to review.

A major consideration when using an electronic documentation system is confidentiality. Every individual who accesses the medical record has a password that is necessary for access to the assigned patient's chart. Based on her position or job code, the person will be given a level of security that will allow access to only the specific information required for the job. When working on documentation at the computer, **never leave the terminal while part of a patient's chart is on the screen.** Situate terminals so that passersby cannot view the information displayed. Organizations have specific policies outlining access, security, and use of the EHR. Organizations often require health care providers to sign nondisclosure agreements (see Chapter 3) regarding confidential patient information.

Electronic records provide vital information to health care personnel instantly so they can immediately review previous problems, treatments, and responses.

Doe, John Page 4
Charity Hospital
Assessments/Interventions
FROM; 10/8/13 07:00 TO: 10/8/13 23:30
ROOM 123-01 ADM: 10/8/13 05:21
AGE: 56Y SEX: M MD: J. Jones
ID: 000004444

FLOWSHEET	10/07	10/08		
INC/WDS UPPER-cont'd	11-7	7-3	3-11	11-7
Wound dressing		dry intact checked CP 14:14	dry intact checked CP 16:11	stained stain marked checked CP 23:06 stained stain marked checked NI 23:30
L shoulder				
Closure type		tegaderm CP 14:14	tegaderm CP 16:11	
Closure condition		intact CP 14:14	intact CP 16:11	
Davol #1				
Location		L shoulder CP 14:14	L shoulder CP 16:11	L shoulder NI 23:30
Drains		patent draining suction emptied CP 14:14	patent draining suction emptied CP 16:11	patent draining NI 23:30
Drain drainage		moderate sero-sanguin CP 14:14	moderate sero-sanguin CP 16:11	sero-sanguin NI 23:30
Medicated incis		done CP 14:14	done CP 16:11	
Teaching inc/wnd		done SeeMultidisForm CP 14:14	done SeeMultidisForm CP 16:11	
Incis intv resp		tolerated CP 14:14	tolerated CP 16:11	

FIGURE 7-9 Example of part of a patient's electronic chart.

Cultural Considerations

Helpful Specific Cultural Information

Including the following patient information can enable the health care team to provide enhanced care:

- Primary language spoken and communication needs (The Joint Commission requirement)
- Head of family or spokesperson
- Dietary differences and foods not permitted in the diet
- Ability to read and write in English
- Beliefs about cause of illness
- Special concerns related to religious/spiritual beliefs
- Individual needs for uninterrupted time for meditation or prayer

Advantages of computer-assisted documentation include the following:

- The date and time of the notation are automatically recorded.
- Notes are always legible and easy to read.
- There is quick communication between departments about patient needs.
- Multiple health care providers can access the same patient's information at one time.
- It can reduce documentation time.
- Electronic records can be retrieved quickly.
- Reimbursement for services rendered can be faster and more complete because of complete and accurate documentation.
- A true electronic medical record can provide a complete longitudinal record of the patient's medical history at one point of access.
- Well-designed systems can reduce errors, having a positive impact on patient safety.

Disadvantages include the following:

- A sophisticated security system is necessary to prevent unauthorized personnel from accessing patient records.

- Initial costs are considerable because many more terminals and an appropriate networking system must be purchased and interfaced for the system to work efficiently.
- Implementation of a full EHR system can take considerable time. This results in the need to use two systems, paper and electronic, during that transition.
- Significant cost and time are involved in training staff to use the system.
- Computer downtime can create problems of input, access, and transfer of information. Well-established backup plans (downtime procedures) must be developed.

CASE MANAGEMENT SYSTEM CHARTING

Case management is a method of organizing patient care through an episode of illness so that clinical outcomes are achieved within an expected time frame and at a predictable cost (see Chapters 1 and 2). A clinical pathway or interdisciplinary care plan takes the place of the nursing care plan. Documentation of variances is placed on the back of the pathway sheets. For example, a patient is admitted for abdominal surgery. The wound is healing well, but the patient develops pneumonia. The variance would be documented as in Figure 7-10.

? Think Critically

Which method of charting seems easiest to you? Can you explain why?

THE DOCUMENTATION PROCESS

When documenting patient care, present the patient's needs, problems, and activities in terms of **behaviors.** The notes focus on the immediate past and the present, never the future. In other words, only chart what you have done for the patient, not what you plan to do. For example, after assisting a patient to ambulate, you might chart, "Ambulated 20 feet down the hall and back."

Charting should be accurate, brief, and complete. When charting follows these guidelines, it presents a photographic view of the patient to anyone who reads the nursing notes.

ACCURACY IN CHARTING

Be specific and definite in using words or phrases that convey the meaning you wish expressed. Avoid using the words "appears to" or "seems" in phrases such as "appears to be resting." Chart the behavior; the patient either is or is not resting. Words that have ambiguous meanings and slang should not be used in charting. For example, how much is "a little," "a small amount," or a "large amount"? What do phrases such as "ate well," "taking fluids poorly," and "tolerated well" mean? Although such words give a general idea of what is meant, they are not specific. Someone else reading the notes will not know if the patient who "ate well" had a half a piece of toast, juice, and a cup of coffee or ate a bowl of cereal, scrambled eggs, two slices of bacon, 4 oz of orange juice, and two cups of coffee. Instead of charting a conclusion such as "taking fluids poorly," chart the behavior and the specific amounts of liquid taken in a particular amount of time, such as "given fluids at frequent intervals, but takes only a few swallows; intake from 0700–1000: 30 mL of coffee, 60 mL of orange juice, and 50 mL of water." Specific data about size, amounts, and other measurements provide a means for determining whether the condition is getting better, getting worse, or staying the same. Rather than use the term "tolerated well," describe what happened, even if it is a statement such as "walked in hall without problems."

BREVITY IN CHARTING

When charting, sentences are not necessary. Articles *(a, an, the)* may be omitted. Because the chart is about a particular patient, the word "patient" is left out whenever it is the subject of the sentence. Each statement should begin with a capital letter and end with a period. Rather than stating, "Patient left for surgery via stretcher at 10:15," simply state, "To surgery via stretcher at 10:15."

Abbreviations, acronyms, and symbols acceptable to the agency are used in charting to save time and space. Each agency has its own list of acceptable abbreviations and symbols. This list is usually found in the policy and procedures manual. A list of commonly used abbreviations and symbols is provided in Appendix H.

You must choose which behaviors and observations are noteworthy, or your nurse's notes will be lengthy and irrelevant. In most agencies, if data (such as patient voiding) are recorded on a flow sheet, they need not be documented again in the nurse's notes. No other notation is made in the nurse's notes unless there is a

Variation	Cause	Action Taken
Airway	Pneumonia	7/23 ↑ fluids to 2000 mL/day
Clearance	7/23	7/24 Proventil inhaler for wheezing
		7/24 Incentive spirometer use encouraged every 1° while awake
		7/26 Instructed in home O_2 use
		7/26 Unit Air contacted for oxygen delivery

FIGURE 7-10 Example of variance charting.

problem or some significant related data. A good way to learn what should and should not be charted is to read over the notes of experienced nurses who are known to chart accurately and well. **A rule of thumb is that if the behavior or finding is abnormal or a change from previous behavior or data, chart it.**

LEGIBILITY AND COMPLETENESS IN CHARTING

Legibility is extremely important when charting. The medical record may be called into court, and what you wrote may be scrutinized and evaluated. If the writing is not easily legible, misperceptions of what was written can occur.

Completeness is more important than brevity. You should record information about the patient's needs and problems and also specify the nursing care given for those needs or problems. If you chart, "Skin at IV site reddened and slightly swollen," you must include a note about what you did about the problem. The full note should read, "Skin at right forearm IV site reddened and slightly swollen in 4-cm area. IV dc'd and warm moist pack applied for 20 minutes. Redness and swelling receding. IV restarted in left hand with 20-ga catheter."

What constitutes complete charting may vary among hospitals, extended-care facilities, and other health care agencies. Home care charting must particularly note safety factors in place and the need for continued care (Figure 7-11). Long-term care facilities may require only a monthly summary for patients in stable condition or a note when their condition changes (Figure 7-12), whereas hospitals caring for acutely ill patients require continual documentation of the patient's condition, with entries made every few hours. For completeness in charting about the patient's signs or symptoms, note something about each of the seven factors listed in Box 7-2.

WHAT TO DOCUMENT

In addition to assessment data related to signs and symptoms, information on the topics in Box 7-3 is to be documented either on flow sheets or in the nurse's notes. The charting examples included with the procedures throughout this book show how to describe different types of information.

General Charting Guidelines

In addition to those mentioned above, there are several other general rules to consider when charting (Box 7-4). Figure 7-13 shows the use of regular versus military time for chart entries.

THE KARDEX

The Kardex is a quick reference for current information about the patient and ordered treatments, updated daily. The Kardex is being phased out in many facilities and being replaced by EHRs. When used, however, the Kardex contains a separate card for each patient on a rotary spool that can be flipped through quickly. Each card contains the following information:

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

Currently, instead of the Kardex, worksheets or working care plans are typically printed out for each patient each shift from the electronic medical record. During shift report, the nurse assigned to the patient receives the printed sheet for that patient or reviews her electronic care plan. The unit secretary has a census sheet or an electronic census board listing the room numbers, patient names, and diagnoses. For the computerized system, these sheets are automatically updated as new orders are entered into the computer.

The patient care plans can be used to organize your work and to record key nursing observations of the patient (e.g., noting the time at which PRN medications are given, the amounts of intake and output, vital signs, and wound appearance). You should exercise caution when using printed care plans because, although they were valid at the time they were printed, they will not reflect any subsequent changes to the real-time electronic medical record.

HOME HEALTH SKILLED NURSING NOTE

PATIENT NAME	MEDICAL RECORDS #	SERVICE DATE	DAY	TIME IN	TIME OUT
Thompson, James	56043	12-4-13	SA SU M TU W TH (F)	3:10 P	4:00 P

VISIT CODE: ○ADMISSION X SCHEDULED VISIT ○SUPERVISORY VISIT ○DISCHARGE ○UNSCHEDULED (EXPLAIN IN NOTES)

DISCIPLINE: ○RN X LVN/LPN

MILEAGE: FROM: Jones TO: Thompson TOTAL MILES DRIVEN: 21

PAYOR: X MEDICARE ○MEDICAID ○INSURANCE ○CONTRACT ○PRIVATE ○OTHER:

EMPLOYEE NAME: Anders, Julia

EMPLOYEE NUMBER: 473

EMPLOYEE SIGNATURE/TITLE: J Anders LVN

PATIENT SIGNATURE: James Thompson

I WAS SEEN BY THE NURSE TODAY, CARE WAS PERFORMED IN A SATISFACTORY MANNER, AND I AGREE TO THE TERMS AND CONDITIONS SET FORTH ON THIS FORM.

LAB SPECIMEN COLLECTED — TYPE: Urine C+S — DELIVERED TO: General Hosp

CLINICAL FINDINGS: T 101 AP ____ RP 92 R 20 B/P 146/96 (○STAND X SIT ○LIE) WEIGHT ____

WOUND EVALUATION: L: ____ W ____ D ____ LOCATION: ____ COLOR: ____ DRAINAGE: ____ ODOR: ____

SUPPLIES USED: gloves, sterile urine cup

NURSING OBSERVATION AND ASSESSMENT Indicate areas of concern with an X and address in narrative.

CARDIOVASCULAR:		GASTROINTESTINAL		NUTRITION		NEUROLOGICAL	
Rate and Rhythm	X	Bowel Sounds		Appetite		Syncope/Vertigo	
Chest Pain		Nausea/Vomiting		Fluid Intake		Headache/LOC	
Neck Vein Distention		Constipation/Diarrhea		SKIN		Grasp	
Edema		Incontinence (Bowel)		Injury/Wound/Incision/Ulceration		Pupillary Reaction	
Ascites		Colostomy/Ileostomy		Jaundice/Pallor/Cyanosis		(Movement) Tremors s/p CVA	X
Dysrhythmia		Difficulty Swallowing		Turgor/Hydration		Vision	
Peripheral Pulses		GENITO-URINARY		Rash/Itching		Hearing	
RESPIRATORY		Burning/Pain	X	MUSCULOSKELETAL		Verbalization	
Lung Sounds		Distention/Retention		Balance/Endurance/Weakness	X	Tactile Sensation	
Cough/Sputum		Frequency/Urgency/Hesitation	X	Pain		PSYCHOSOCIAL/EMOTIONAL	
Dyspnea/SOB/Orthopnea COPD	X	Incontinence (Bladder)		SAFETY		(Anxious) Depressed	X
Trach/Vent		Color/Odor	X	Falls	X	(Confused) Forgetful/Disoriented	X
Oxygen		Catheter/Ileoconduit		Other:		Affect/Thought Process/Coping	

ACTIVITY LEVEL ○INDEPENDENT ○MINIMAL ASSIST X MODERATE ASSIST ○DEPENDENT IN ALL ADLs Reason Homebound: (R) hemiparesis severe dyspnea on exertion

INTERVENTIONS

○CATHETER	○IMPACTION	○INJECTION	○TUBE FEEDING	○ACTIVITY RESTRICTIONS	○IV THERAPY	○OTHER (list)
○DRESSING CHANGE	○ENEMA	○DIABETIC CARE	○TRACH CARE	○NUTRITION	○TPN	
○PRESSURE WOUND	X BOWEL/BLADDER	○INSULIN	○RESPIRATORY CARE	X MEDICATIONS	○CHEMO	
○VENIPUNCTURE	○C/P INSTRUCTION	X DISEASE PHYSIOLOGY	○TERMINAL CARE	X SAFETY	○CENTRAL LINE	
○CHEST PT	○C/V INSTRUCTION	○OSTOMY CARE	○BEDRIDDEN CARE	○PAIN MANAGEMENT	X UNIV PREC UTILIZED	

ASSESSMENT NOTES, INTERVENTION SPECIFICS AND OUTCOME

Mr. Thompson's urine has developed foul odor + he c/o pain on urination. Also confused + febrile, agitated. More unsteady when ambulation. Wife states he fell 2 days ago but she did not call anyone. No injuries apparent, she states he did not hit his head. Fever + urine odor began yesterday.

SPECIFICS TAUGHT: Encourage clean fluids; begin antibiotics when they arrive from pharmacy – be sure to finish.

CONTACT WITH OTHERS: WHO: Dr Smith REASON: Fever, urine odor, recent fall disorientation

ORDERS RECEIVED? ○NO X YES: Urine for C+S; antibiotics will be ordered.

CARE PLAN REVISED? X NO ○YES: Pt has hx of UTI, so already monitoring

Wife does well managing antibiotics. Given written inst.

ASSESSMENT OF AIDE SERVICES: AIDE PRESENT? ○YES X NO CARE PLAN FOLLOWED? X YES ○NO PATIENT NEEDS MET? X YES ○NO
ASSIGNMENT SHEET UPDATED? X YES ○NO AIDE USES GOOD CLINICAL SKILLS? X YES ○NO PATIENT/CAREGIVER EXPRESSES SATISFACTION? X YES ○NO

Comments: Wife states PJones CHHA very thorough and gentle.

FIGURE 7-11 Example of home care agency charting.

Date/Time	Licensed Nurses Progress Notes
4/15/13	Pt asked both nurses at med carts for IM injection Cortisone and "could I have meds right
7-3 shift	now?" Instructed to take seat at breakfast table. Pt's roommate called nurse. Pt supine on
	floor no LOC. Walker at side A/O. Answered all questions appropriately, no Δ in speech and
	mentation.----------
	VS taken by this RN: T 98.6, P 76, R 16, BP 120/80.----------
	Denies HA, no s/s CVA/TIA- clear conversation, no paralysis. C/O right knee discomfort
	when asked what heppened- why she fell. Assisted to chair. Denies pain. Neuro VS
	unremarkable: PERL hand grips strong- no s/s hypoglycemia, no sweating or lethargy, alert,
	gave complete date, answered questions appropriately. Reported to supervisor: Vivian Violet, RN DON.
	----------M. Markham, RN

FIGURE 7-12 Example of long-term care facility charting.

Box 7-2 Guidelines for Charting About a Sign or a Symptom

Location in the body: Describe the exact location.

Quality: Describe in patient's terms; for example, a person having a myocardial infarction (heart attack) might describe the chest pain as feeling like the chest is being "squeezed in a vise."

Quantity: Chart the intensity of the symptoms (i.e., mild, moderate, or severe). Use a scale of 1 to 10 for pain, with 10 being the highest. Indicate the degree of impairment and the frequency, volume, and size or extent of the sign or symptom. Note the number of times the patient has vomited, amount each time, and whether nausea is constant or intermittent.

Chronology: Note the sequence of development:

a. Time of onset of the sign or symptom
b. Duration (minutes, hours, days)
c. Pattern of variation and frequency and the course of the signs or symptoms (e.g., Do they stay the same, get better, or get worse over time?)

Setting: Where is the patient (e.g., at home, in bed, in the car), what is the patient doing (e.g., running, sleeping, eating), and who is the patient with (e.g., mother, spouse, boss) when the symptoms occur?

Aggravating or alleviating factors: What makes the signs or symptoms worse and what makes them better? Does a hot shower make a skin rash worse? Does eating cause more or less pain?

Associated manifestations: Signs and symptoms rarely occur singly. For instance, does the patient have nausea before vomiting? Has there been a weight change since the onset of vomiting?

Box 7-3 Types of Information to Be Documented

- Admission note
- Assessment data for all body systems
- Body care
- Death
- Degree of activity
- Diagnostic tests
- Diet and fluids
- Discharge from the facility
- Dressings and wound care
- Intake and output
- Intravenous infusions
- Medications
- Mental state and mood
- Mood, concerns, or discomfort
- Oxygen in use
- Physician's visits and calls to physician
- Postoperative care
- Procedures performed
- Sleep
- Specimens obtained and their disposition
- Teaching
- Travel from the unit
- Tubes and equipment in use
- Visitors

Box 7-4 General Guidelines for Charting

- Verify the name on the chart and the page *before* beginning to chart. Each page should have an imprint of the patient's name and hospital number on it. For EHR documentation, verify you are on the correct patient's computer screen.
- Chart the initial assessment at the beginning of the shift.
- Preferably use black ink; blue may be acceptable in your agency.
- Place date at beginning of day's entries and time each entry; use either a regular clock or a 24-hour clock (military time; see Figure 7-13).
- Charting is done only by the person who made the observation or performed the intervention and who is legally responsible for the accuracy and quality of care.
- Write legibly or print.
- After the note is complete, sign with one initial plus last name and title (e.g., J. Jones, LPN; M. White, SVN). Many agencies ask students to add "student" or their school initials behind their title.
- Chart objective data after completing each task. Nothing is ever charted before it is actually done.
- No blank lines are left in the charting. Draw a horizontal line through the center of an empty line or part of a line. Draw a line through a space or write "N/A" (not applicable) if information asked for on forms does not apply to the patient. For EHR documentation, follow hospital policy for amending the record.
- A late entry may be made if something has been forgotten. Write the time of the entry, circle it, and write "late entry" and your initials above the time.

Example of a late entry:

Date	Time	Problem	Nurse's Notes
8/22/13	0900	#2	Voided 450 mL clear, straw-colored urine. States no "burning,
			urgency," or $\uparrow$ frequency of voiding.--------------------------------
	0930	#2	Amb to door of room and back c̄ assistance. States caused no
			pain.--
	0945	Late entry for (0900)	Clean catch urine collected and sent to lab for UA.--J. Biggs, LPN

- Clearly identify care given by another health care team member.
- When a patient refuses a medication, place a circle on the medication administration record around the time the medication was to be given, and record an explanation for the refusal in the progress notes. Any refusals of treatments are also recorded in the chart. The exact words the patient uses when refusing to comply with the treatment regimen should be documented. Document any instructions given to the patient and any patient behaviors that are against the instructions.
- Spell chart entries correctly. Use a dictionary to check words you are unsure how to spell.
- Use only ink on the medical record. Entries should never be erased or obliterated with liquid correction fluid. Deleted entries may be questioned if the chart is used later in a court of law. If you suspect that a medical order or progress note is incorrect, seek clarification from the person who wrote the order or the note. If you make an error when charting, draw a line through the incorrect word or phrase and write the word "error" above it; add the date and your initials. Some agencies require the words "mistaken entry" or "incorrect entry" rather than "error."

Example of error correction:

DATE	HOUR	FOCUS	PATIENT PROGRESS
7/22/13	12^{45}	Impaired skin	error I. Harper D. Slt. ~~sanguineous~~ serous drainage
		integrity rt.	on dressing. Wound 1x2 cm. c̄ lt.
		ankle.	red border; no odor; states
			hurts "a bit." ————
			A. Cleansed c̄ sterile saline. Duoderm
			thin applied. ————
			R. Wound healing. I. Harper RN

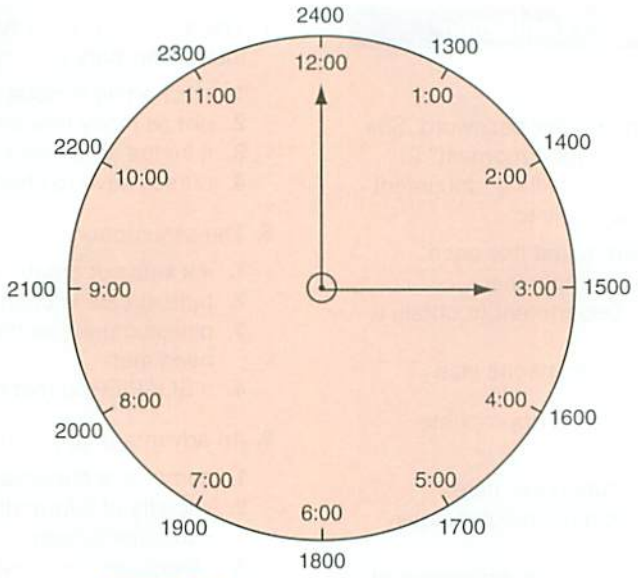

FIGURE 7-13 Military time versus civilian time.

Get Ready for the NCLEX® Examination!

Key Points

- Documentation provides a communication tool for the health care team; maintains a written record of the history, care, and treatment of the patient; is a legal record; is a quality assurance tool; and provides a basis for reimbursement of services.
- The nursing care plan is the framework for nursing documentation.
- Evaluation data that are documented must show progress toward expected outcomes.
- Information in the medical record must be kept confidential, and only those health professionals directly involved in the patient's care should have access to the record.
- There are six main methods of charting: (1) source-oriented (narrative) style, (2) POMR style, (3) focus charting, (4) charting by exception, (5) computer-assisted charting, and (6) case management system charting.
- Besides nurses' and physicians' progress notes, many flow sheets are used to document patient information.
- An advantage of the source-oriented method is that information on the patient's condition and care is listed in chronologic order.
- An advantage of the POMR system is that it improves continuity of care by keeping data relevant to a problem all in one place.
- An advantage of focus charting is that it shortens charting time by using many flow sheets and checklists.
- Although charting by exception highlights abnormal data and patient trends, it presents problems if called into court because only abnormal findings are documented in writing.
- Computer charting is expensive to institute but saves considerable nursing time.
- Case management system charting tracks variances from the care map.
- Documentation should show the application of the nursing process, and present a snapshot of the patient's condition and care.
- Charting must be objective, accurate, brief, and complete.
- Chart the patient's behaviors and statements, not your opinions or conclusions.
- The list of activities and data that must be charted about the patient each day is extensive.
- Guidelines for charting tell the nurse when, what, and how to document patient assessments, activities, and interventions.

Additional Learning Resources

SG Go to your Study Guide for additional learning activities to help you master this chapter content.

evolve Go to your Evolve website (http://evolve.elsevier.com/deWit/fundamental) for the following FREE learning resources:

- Animations
- Answer Guidelines for Think Critically boxes and Critical Thinking Questions and Activities
- Answers and Rationales for Review Questions for the NCLEX® Examination
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions for the NCLEX® Examination and more!

Online Resources

- *Informatics KSAs for prelicensure nurses,* www.qsen.org/ksas_prelicensure.php#informatics

Review Questions for the NCLEX® Examination

*Choose the **best** answer for each question.*

1. The nurse has misplaced her computer password. She asks if she can borrow yours "just for a moment" to view patient data and promises she will not document anything. Your best course of action is to:
   1. allow her to use your password, just this once.
   2. sit with her and access the data together.
   3. inform her to contact the IT Department to obtain a new password.
   4. tell her you're busy, and to ask someone else.

2. Which is the most precise example of appropriate charting?
   1. "Aggressive and combative during A.M. care."
   2. "Received 250 mL tube feeding during shift, tolerated well."
   3. "Ambulated 2X during shift, 50 ft with assistance of one. Pre-activity vs: 85, 18, 110/70; post-activity vs: 95, 22, 120/76."
   4. "Ambulated to nurses station and back, tol well."

3. Patients frequently request copies of their medical records. You understand that:
   1. they have a right to a copy of their record after discharge.
   2. only health care staff have the right to read the record.
   3. the patient and family have a right to read the record.
   4. the physician must write an order for the release of the record.

4. One characteristic differentiating source-oriented (narrative) charting from POMR charting is:
   1. a specific order of forms in the chart.
   2. a focus on the patient's problems.
   3. the separation of notes on medical care and nursing care.
   4. patient identification stamped on each form.

5. When charting, it is wise to always:
   1. include the names of all visitors with the time of the visit.
   2. check that you are on the right chart or screen and on the right date.
   3. sign your full name, date, and time on each sheet.
   4. use acronyms you are familiar with to shorten notes.

6. When a patient's medical record is needed as evidence for a legal action, you are aware that the record is the property of:
   1. the patient.
   2. the patient's lawyer.
   3. the court.
   4. the health care agency.

7. The advantage of POMR charting when using an interdisciplinary care system is that:
   1. all charting is done on flow sheets.
   2. not as many flow sheets are used.
   3. it keeps all relevant data in one place.
   4. nurses have to chart only on flow sheets.

8. The assumption in charting by exception is that:
   1. if it was not charted, it was not done.
   2. patient care is charted chronologically.
   3. unless otherwise documented, all standards have been met.
   4. a SOAPIER format note must be made each shift.

9. An advantage of computer charting is that:
   1. computers are always up, running, and available.
   2. security of information is guaranteed with the computer system.
   3. others can see what is being input as the nurse works with the charting screens.
   4. it is cost-effective because it saves nursing time compared with writing out notes.

10. When charting the patient's condition and nursing care, the nurse records: *(Select all that apply.)*
    1. activities planned for a later date.
    2. goals for the medical treatment and evaluation.
    3. the interventions performed and the patient's responses.
    4. patient statements and behaviors that are observed.
    5. clinical data measurements.

Critical Thinking Activities

Read each clinical scenario and discuss the questions with your classmates.

Scenario A

Read the following scenario and then write out a POMR progress note and a focus charting note using the data given.

Marvin Barnes was admitted with the diagnosis of Impaired gas exchange r/t excessive pulmonary secretions. When you go to assess him, you discover that his temperature is 102.6° F (39.2° C), pulse 77 beats/min, respirations 26 breaths/min and shallow, and blood pressure 147/92 mm Hg. He is coughing and produces yellow-green sputum. He is having difficulty stopping the cough. He has oxygen via nasal cannula running at 3 L/min. He has acetaminophen ordered for fever over 100.2° F (37.9° C). You tell him that you will be back with medicine for his fever and that you will call the physician for an order for some cough medicine to relieve the cough.

Scenario B

Discuss the guidelines that will help you chart so that you would be protected if there were a lawsuit involving a patient to whom you had given care.