Documentation & Reporting

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PRINCIPLES OR GUIDELINES

❖ Principles / Guidelines of Reporting:

▪ Factual	▪ Timing
▪ Legibility	▪ Permanence
▪ Accepted terminology	▪ Correct signature
▪ Spelling	▪ Accuracy
▪ Sequence	▪ Appropriate
▪ Complete	▪ Concise
▪ Legal prudence	

PRINCIPLES OR GUIDELINES

❖ Factual

- A factual record contains descriptive, objective information about what a nurse sees, hears, feels, and smells.
- Avoid vague terms such as appears, seems, or apparently because these words suggest that you are stating an opinion, which do not accurately communicate facts.
- Objective documentation includes observations of a patients behaviors.
- For example, instead of documenting “the patient seems anxious,” provide objective signs of anxiety and document “the patients pulse rate is elevated at 110 beats/min, respiratory rate is slightly labored at 22 breaths/min, and the patient reports increased restlessness.”
- The only subjective data included in the record are what the patient says. When recording subjective data, document the patients exact words within quotation marks whenever possible

PRINCIPLES OR GUIDELINES

❖ Date and Time

- Document the date and time of each recording.
- This is essential not only for legal reasons but also for client safety.
- Record the time in the conventional manner (e.g., 9:00 AM or 3:15 PM) or according to the 24-hour clock (military clock), which avoids confusion about whether a time was AM or PM.
- Follow the agencies policy about the frequency of documenting, and adjust the frequency as a clients condition indicates.
- For example, a client whose blood pressure is changing requires more frequent documentation than a client whose blood pressure is constant.
- As a rule, documenting should be done as soon as possible after an assessment or intervention.
- No recording should be done before providing nursing care

PRINCIPLES OR GUIDELINES

❖ Legibility

- Writing must be clear and easily read by others.
- If writing is not legible, then print.
- Records are written continuously with no blank spaces. If any space is left out, it should be crossed out, dated and signed. A horizontal line should be drawn to fill up a partial line. This is to prevent other persons from adding information in the nurses notes.
- E.g. Needs attended. Referred accordingly.-------Mrs. Preethi Ramesh, RN.

PRINCIPLES OR GUIDELINES

- **Permanence**

- All entries on the clients record are made in dark ink so that the record is permanent and changes can be identified.
- Avoid pencil for permanence of data, because the clients chart can be used as an evidence in legal court.
- Follow the agencies policies about the type of pen and ink used for recording

PRINCIPLES OR GUIDELINES

❖ Accepted Terminology

- People in the 21st century are often in a hurry and use abbreviations when texting .
- Even though using abbreviations is convenient, medical abbreviations have been responsible for serious errors and deaths .
- Use only the standard and recognized abbreviations.
- Ambiguity occurs when an abbreviation can stand for more than one term leading to misinterpretation.
- For example CP stand for chest pain, cerebral palsy, cleft palate, creatinine phosphate, and chickenpox

PRINCIPLES OR GUIDELINES

- **Correct Spelling**

- Use correct spelling while documenting.
- Correct spelling is essential for accuracy in recording. Avoid spelling mistakes
- If unsure how to spell a word, look it up in a dictionary or other resource .
- Two absolutely different medications may have similar spellings; for example, Fosamax and Flomax

PRINCIPLES OR GUIDELINES

- **Signature**

- Each recording on the nursing notes is signed by the nurse making it.
- The signature includes the name and title; for example, “M.S. REDDY, RN”
- With computerized charting, each nurse has his or her own password, which allows the documentation to be identified.

PRINCIPLES OR GUIDELINES

❖ Accuracy

- ➢ The clients name and identifying information should be stamped or written on each page of the clinical record. Each page of the record should be properly identified with the name, age, I.P. No, Bed No, ward, date etc
- ➢ Do not identify charts by room number only; check the clients name. Special care is needed when caring for clients with the same name.
- ➢ Write observations the individual has seen, heard, spelled or left. Sometimes for adequacy a photograph can be utilized. For eg:

✓ Ate 50% of the food served.

× Ate with poor appetite.

✓ Refused medications.

× Uncooperative.

✓ Seen crying.

× Depressed.

PRINCIPLES OR GUIDELINES

❖ **Accuracy cont…**

- When a recording mistake is made, draw a single line through it to identify it as erroneous with your initials or name above or near the line (depending on agency policy).
- Do not erase, blot out, or use correction fluid.
- With computerized charting, each nurse has his or her own password, which allows the documentation to be identified.

PRINCIPLES OR GUIDELINES

- **Sequence**

- Document events in the order in which they occur; for example, record assessments, then the nursing interventions, and then the clients responses.
- Avoid squeezing information to a space because you forgot to chart it earlier. Add the information on the first available line. Write the time the event occurred, not the time you entered the information.

PRINCIPLES OR GUIDELINES

- **Appropriateness**

- Record only information that pertains to the clients health problems and care.
- Any other personal information that the client conveys is inappropriate for the record.
- Recording irrelevant information may be considered an invasion of the clients privacy.

PRINCIPLES OR GUIDELINES

❖ Completeness

- Not all data that a nurse obtains about a client can be recorded. However, the information that is recorded needs to be complete and helpful to the client and health care professionals.
- Nurses' notes need to reflect the nursing process.
- Record all assessments, dependent and independent, nursing interventions, client problems, client comments and responses to interventions and tests, progress toward goals, and communication with other members of the health team.

PRINCIPLES OR GUIDELINES

❖ Conciseness or Brevity

- Recordings need to be brief as well as complete to save time in communication.
- Repeated usage of the clients name and the word ‘client’ are omitted.
- Use partial sentences and phrases. Nurses must utilize correct terminology and use only standard abbreviations.
- Start each entry with a capital letter and end the entry with a period, even if the entry is a single word or phrase.

PRINCIPLES OR GUIDELINES

❖ Legal Prudence

- Accurate, complete documentation should give legal protection to the nurse, the clients other caregivers, the health care facility, and the client.
- Admissible in court as a legal document, the clinical record provides proof of the quality of care given to a client.
- For the best legal protection, the nurse should not only adhere to professional standards of nursing care but also follow agency policy and procedures for intervention and documentation in all situations—especially in high-risk situations.

METHODS OF RECORDING

- Source - Oriented Narrative Charting
- Problem - Oriented Charting
- PIE Charting
- Focus Charting
- Charting by Exception
- Graphic Sheets and Flow Sheets
- Computerized documentation

Source Oriented Narrative Charting

- **Source Oriented Narrative Charting**

It is a traditional method for recording nursing care provided. Organized according to the source of information. It is a story like format to document information specific to client conditions and nursing care. Most flexible of all methods and is usable in any clinical setting.

Advantages & Disadvantages

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

Source Oriented Narrative Charting

Nurses' Notes

NANDA Dx	Date & Time	Documentation
2 3 1	3/21/11 0800	*(2)* Mrs. GH alert, awake, and oriented to person and situation but is **confused as to time and place.** She is able to state her name and that she is in the hospital but states that it is afternoon and that she is in the long-term care facility. Was reoriented to time and place. *(3)* Skin, warm, dry, pale but without pallor or cyanosis. Bilateral arms have purpura but skin remains intact and without skin tears. No noted decubitus ulcers on coccyx, hips, or heels. Respirations regular and non-labored. *(1)* Lung sounds clear except for **crackles noted in left lower lobe** but improved when compared to earlier assessment. Encouraged to cough and deep breathe; crackles lessened after use of incentive spirometer, coughing, and deep breathing. Pulse ox on right index finger showing saturation of 96% on 2 liters O_2 by nasal cannula. Ears and nares checked and are clear of irritation from cannula. Heart rate regular. S_1 and S_2 apical heart sounds clearly heard. Peripheral pulses are +2 at radius and +1 at dorsalis pedis pulses. Equal hand grips; left pedal push is weaker but unchanged since admission. Per graphic flow sheet, voided clear amber urine at 0715. C/O abdominal pain of 7 on 0–10 pain scale. **Abdomen firm, distended, and tender to slight touch. Bowel sounds hyperactive in RUQ and absent in remaining quadrants. States she does not know when she last had a bowel movement. No indication of BM on graphic flow sheet since admission. Refuses breakfast stating that she is nauseous. VS 148/92, 100.6° F, 114, 24. Charge RN notified of nausea, abdominal pain, and distention.** ----------E. Darwin, LVN

Note to student: For instructional purposes, the abnormal findings are put in bold here. Notice that any abnormal finding must include nursing intervention(s) that indicate what nursing actions address that problem/concern.

NANDA Diagnoses are listed in the NANDA column and, for our example, within the nurses' notes.

PROBLEM – ORIENTED CHARTING

❑ Problem - Oriented Charting

Descriptive recording done by each member of health care team on separated parts. One of the most prominent features of this problem-orientated method of documentation is the structured way in which narrative progress notes are written by all health-care team members, using the SOAP, SOAPIE OR SOAPIER format.

- ❖ Subjective : the clients observation.
  Objective : the care providers observations.
- ❖ Assessment : the care providers understanding of the problem.
- ❖ Plans Goals : action, advice intervention when an intervention was identified and changed to meet clients needs.
- ❖ Evaluation : how outcomes of care are evaluated.
- ❖ Revision : when changes to the original problem come from revised.

PROBLEM – ORIENTED CHARTING

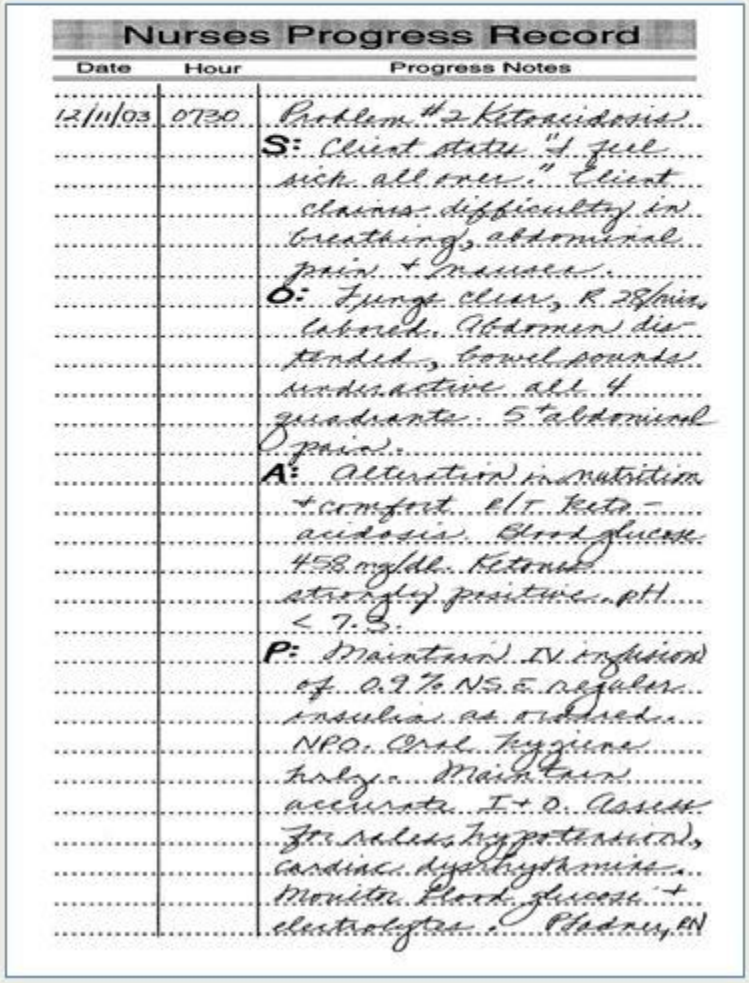
❑ Problem - Oriented Charting

This record integrates all data about the problem, gathered by the members of the health team.

Four basic components of POMR / POR

- ❖ Database.
- ❖ Problem list.
- ❖ Initial list of orders or care plans.
- ❖ Progress notes:
- ❖ The nursing process forms the basis for the POMR method of documenting clients problems - Subjective, Objective, Analysis, Planning, Intervention, Evaluation

Problem-Oriented Charting (POMR)



Nurses Progress Record

Date	Hour	Progress Notes
12/11/03	0730	Problem #2 Ketoacidosis **S:** Client states "I feel sick all over." Client claims difficulty in breathing, abdominal pain + nausea. **O:** Lungs clear, R 28/min, labored. Abdomen distended, bowel sounds hyperactive all 4 quadrants. 5+ abdominal pain. **A:** Alteration in nutrition + comfort r/t keto-acidosis. Blood glucose 458 mg/dl. Ketones strongly positive. pH < 7.2. **P:** Maintain IV infusion of 0.9% NS c regular insulin as ordered. NPO. Oral hygiene. Keep warm. Maintain accurate I + O. Assess for rales, hypotension, cardiac dysrhythmias. Monitor blood glucose + electrolytes. P Fadner, RN

12/11/03	0730	**I:** Called Dr Smith, blood glucose 458 mg/dl. IV bolus regular insulin given as ordered. 1000 ml 0.9% N.S. infusing c 17/4 central line #1 via infusion pump. 50u regular insulin in 500 ml NS infusing c 50ml/H, central line #2 via infusion pump. EKG taken, placed on telemetry.
12/11/03	0835	**E:** Lungs clear, R 24/min, non-labored. NSR. 3+ abdominal pain. Urinary output 750 ml/hr. Blood glucose 360 mg/dl. – P Fadner RN

PIE CHARTING

❑ PIE Charting

- ❖ Similar to SOAP charting
- ❖ Both are problem-oriented
- ❖ PIE comes from the Nursing Process, SOAP comes from a Medical Model.
  - ➢ P-Problem
  - ➢ I-Intervention
  - ➢ E-Evaluation

Eg: P - Risk for trauma related to dizziness.

I - Instructed to call for assistance when getting OOB. Call light in reach.

E - Consistently call for assistance before getting OOB. Continues to experience dizziness

PIE CHARTING

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

FOCUS CHARTING

❑ Focus Charting

- ❖ Uses narrative documentation (DAR)
  - ➢ Data – subjective or objective that supports the focus (concern)
  - ➢ Action – nursing intervention
  - ➢ Response – pt response to intervention

    Eg:

    D – complaining of pain at incision site , ps: 7/10

    A – repositioned for comfort. demerol 50mg im given.

    R – states a decrease in pain, “feels much better.”

FOCUS CHARTING

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

❑ Charting by Exception

This is a charting method that requires nurse to record only deviation form established norms.

Key elements required for CBE are:

- ❖ Practice setting documentation policies and protocols.
- ❖ Assessment norms, standards of care.
- ❖ Individualized care plans.
- ❖ Unique flow sheet.

Beside accessibility of documentation forms it is not acceptable to use documentation by exception unless these exist.

CHARTING BY EXCEPTION

Nurses' Notes

NANDA Dx	Date & Time	Documentation
1 4	03/21/11 0800	Continued from Flow Sheet. *(1)* Left lower lobe crackles noted, cleared by 50% after encouraged to cough and deep breathe. *(4)* Significant change in status r/t abdominal pain, stated to be a 7 on 0–10 pain scale. Abdomen tender to touch, distended, and firm. Hyperactive bowel sounds in RUQ, no bowel sounds in other quadrants. ----------Wendy Winters, LVN
4	0815	*(4)* Dr. Smith notified of change in status of abdomen. Diagnostic studies ordered.----------Wendy Winters, LVN

GRAPHIC & FLOW SHEETS

- **Graphic Sheets and Flow Sheets**

Health care record entries should reflect the most recent assessment, as they are done, to ensure treatment decisions are based on accurate information. If documenting on a flow sheet or checklist, check marks may be used as long as it is clear who performed the assessment or intervention. The meaning of check mark or symbol used must be identified in the practice setting policy.

GRAPHIC & FLOW SHEETS

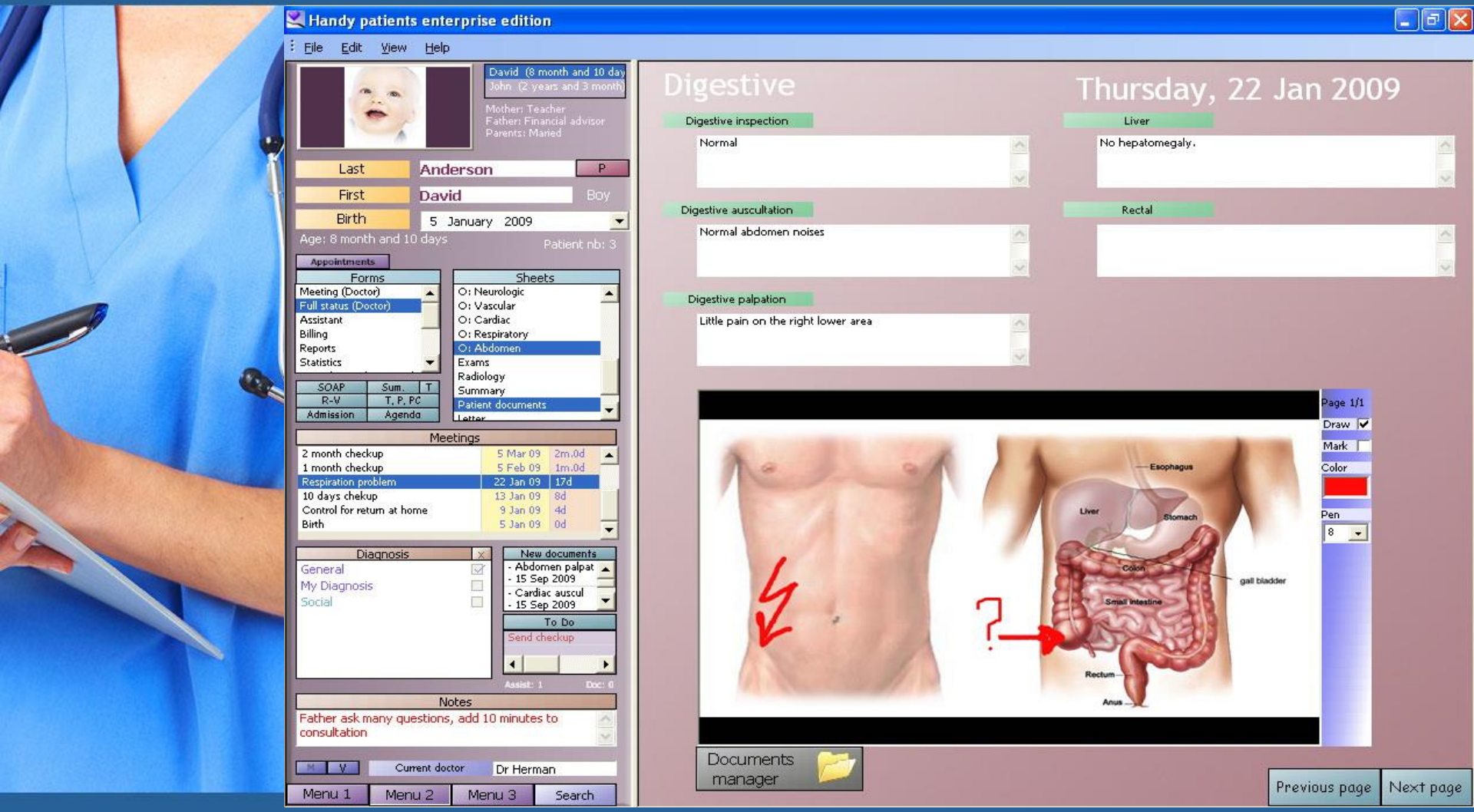
	Date	5-19-11						5-20-11						5-21-11									
Days After	Admission	0						1						2									
	Operation	n/a						n/a						n/a									
	Time	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12
TEMPERATURE / RADIAL PULSE-APICAL PULSE	Pulse ✕ • Temp.																						
	140 / 106°																						
	130 / 105°																						
	120 / 104°																						
	110 / 103°																						
	100 / 102°																						
	90 / 101°				Admit											0900							
	80 / 100°																						
	70 / 99°																						
	60 / 98°																						
	50 / 97°																						
	40 / 96°																						
Respirations																							
Blood Pressure	Time	4A		8A			12A	4A			8A		12A	4A		8A			12A	4A			8A		12A
	Systolic			138				140					140			148			144						
	Diastolic			58				58					90			92			94						
Blood Pressure	Time	4P		8P			12P	4P			8P		12P	4P		8P			12P	4P			8P		12P
	Systolic			136				136					142												
	Diastolic			90				78					58												
Height & Weight		5'3" 165 lbs																							
Diet		Reg - 75%						Reg - 95%						Reg - Refused											
Calorie Count		—						—						—											
		12M-8A		8A-4P			4P-12M	12M-8A			8A-4P		4P-12M	12M-8A		8A-4P			4P-12M	12M-8A			8A-4P		4P-12M
FLUID INTAKE	Blood Transfusion			n/a							n/a														
	Plasma Transfusion			↓							↓														
	Fluid																								
	Oral Formula																								
	Gastric Fluid															0900									
	Tube Feeding Formula			↓							↓					Start NG inserted									
	Intravenous			D5 1/2 NS							D5 1/2 NS														
				1100							500														
	Total Fluid Intake			750							1000														
	24-Hour Total			1850							1500														
FLUID OUTPUT	Emesis			NA							NA					c/o Nausea									
	Gastric Aspiration															—									
	Aspiration, Other															—									
	Drainage															—									
	Urine–Volume			1900							2000					See Nurses' Notes									
	Stool & No.			∅							∅														
	Total Fluid Output			1900							2000														
	24-Hour Total			−50cc							+200cc														

COMPUTERIZED DOCUMENTATION

❑ Computerized documentation

- ❖ Never share password. Change frequently.
- ❖ It should be legible
- ❖ It can be voice-activated, touch-activated.
- ❖ Date and time automatically recorded.
- ❖ Abbreviations and terms are selected by a menu provided by the facility.
- ❖ Terminals are usually easily accessible, in pt rooms, in convenient hallway locations.
- ❖ Make sure terminal cannot be viewed by unauthorized persons.

COMPUTERIZED DOCUMENTATION



THANK YOU CONTINUES…