



Nursing Documentation

Dr. Ali D. Abbas/ Instructor, Fundamentals of Nursing Department, College of Nursing, University of Baghdad, ali_dukhan@yahoo.com

LEARNING OBJECTIVES

After mastering the contents of this lecture, the student should be able to:

1. Define the terminologies.
2. Describe the effective documentation principles
3. Explain the effective documentation elements
4. List the systems of documentation
5. Describe the forms for documentation

TERMINOLOGIES

Care map

Critical pathways

Documentation

Kardex

Narrative recording

Nursing Audit

CONTENTS

1. Introduction	2
2. Purposes of Documentation	2
3. Effective documentation principles	5
4. Follow the nursing process	7
5. Effective documentation elements	7
6. Systems of documentation	10
7. Forms for documentation	14
8. References	16

Introduction

The methods of recording and reporting information relevant to client care have developed as a response to standards of practice, legal and regulatory standards, institutional standards and policies, and society's norms.

Recording and reporting are the major ways health care providers communicate. The client's medical record is a legal document of all activities regarding client care.

Documentation is any printed or written record of activities. In health care it should include:

1. Changes in the client's condition
2. The administration of tests, treatments, procedures, and client education, with the results of or client's response to them
3. The client's response to an intervention
4. The evaluation of expected outcomes
5. Complaints from client or family

Purposes of Documentation

The two primary purposes for documentation are professional responsibility and accountability.

The professional responsibility of all health care practitioners, documentation provides evidence of the practitioner's accountability to the client, the institution, the profession, and society.

Other purposes are communication, legal and practice standards, education, reimbursement, research, and auditing.

1. Communication

Documentation is a communication method that confirms the care provided to the client and clearly outlines all important information regarding the client.

Thorough documentation provides:

1. Accurate data to plan care and ensure continuity of care.
2. Communication to health care team members involved in the client's care.
3. Evidence of things done to or for the client, the client's response, and revisions made in the plan of care.
4. Evidence of compliance with professional practice standards.
5. Evidence of compliance with accreditation criteria (e.g., those of the Joint

Commission).

6. A resource for reimbursement, education, and research.
7. A written legal record to protect the client, institution, and practitioner.

The client's medical record contains documents for record keeping. The type of documents that constitute the medical record in a given health care institution is determined by that institution. The following table show outlines the content of the documents generally found in a client's record.

DOCUMENT	CONTENT
Face Sheet	<p><i>Demographic Data:</i> name, client's identifying number, address, telephone number, date of birth, place of birth, sex, race, marital status, religion, name and address of closest relative, social security number, admission date and hour, type of admission</p> <p><i>Financial Data:</i> expected payer(s), insured's name and sex, client relationship to insured, employer's name and location, group name, insurance group number, insured's policy number</p> <p><i>Clinical Data:</i> admitting diagnosis, admitting diagnosis-related group (DRG), client's advance directive (if has one)</p> <p><i>Discharge Data</i> (to be entered by the physician on discharge of client): name of attending physician, discharge date and hour, principal diagnosis and other diagnoses, external cause of injury code, procedures and dates, operating physician(s), disposition of client</p>
Medical History and Physical Examination	Client's description of chief complaint, present and past illnesses, personal and family histories, and review of systems as elicited by the physician, findings of physician's assessment of all body systems
Nursing Admission Assessment	Data from interview and physical assessment performed by the nurse
Prescriber's Orders	Physician's written or verbal orders to admit, to direct client's diagnostic and therapeutic course, and to discharge
Consultation Report	Findings of a physician whose opinion or advice is requested by another physician for evaluation and/or treatment of a client
Physician's Progress Notes	Provides a pertinent, chronologic report of the client's course in the hospital and reflects any changes in condition and response to treatment. May also contain notes by other members of the health care team (e.g., dietary or social service)
Laboratory Reports	Results from laboratory tests ordered by the physician
Radiology Reports	Radiologists interpretation of radiologic and fluoroscopic diagnostic services
Nuclear Medicine	Describes diagnostic studies and therapeutic procedures performed using radiopharmaceutical agents
Graphic Sheet	Various client parameters, most commonly: T, P, R, and BP. May also include weight, diet, I&O
Client Care Plan (Nursing Plan of Care)	Treatment plan including nursing diagnoses or problem list, client goals, nursing actions, and evaluation
Nurse's Progress Notes	Details care and treatments provided, client's response to care and treatments, achievement of expected outcomes that do not duplicate information on Flow Sheet (if used)

Flow Sheet	All routine interventions that can be indicated by a check mark or other simple descriptor
Medication Administration Record (MAR)	Contains all medications administered orally, topically, by injection, inhalation, and infusion in one place; includes date, time, dosage, route of administration, and name of professional administering the drug. Routine, PRN, and single dose orders generally have separate sections
Consent Forms	<p><i>Admission:</i> gives the institution and physician permission to treat</p> <p><i>Surgical:</i> explains the reason for and nature of the treatment, the risks, complications, alternate forms of treatment, no treatment, consequences of treatment or procedure. Sometimes surgical and anesthesia consents are separate so that responsibility is placed appropriately</p> <p><i>Blood Transfusion:</i> gives specific permission to administer blood or blood products</p> <p><i>Other:</i> procedure specific consent forms, participate in research project, photography</p>
Client Education Record	Describes the nurse's teaching to the client, family, or other caregiver and the learner's response
Health Care Team Record	Used by respiratory, physical therapy, dietary when physician's progress are used only by physicians
Nursing Discharge Summary	Contains brief summary of care provided, medications, teaching, and other instructions (e.g., return appointment, referrals), discharge status, and mode of discharge
Discharge Plan and Summary	Review of events describing the client's illness, investigation (diagnostic studies), treatment, response, and condition at discharge. Instructions to the client and plans for follow-up care as included
Advance Directive	Both a living will and a durable power of attorney for health care are considered advance directives. Federal law requires that all clients be given written information about their rights so they can make decisions concerning medical care. An advance directive is not required to be in a client's medical record
Other Documents	These may or may not be in a client's medical record: Operative report, Anesthesia report, Pathology report, Transfusion record, Rehabilitation report, Critical pathway, Restraint record, and Autopsy report

2. Practice and Legal Standards

Thoroughly documenting care in the medical record provides legal evidence that the care provided meets approved standards of care. *The medical record is a legal document, and in a lawsuit, it is the record that serves as the description of exactly what happened to a client.* In 80% to 85% of client care lawsuits, the determining factor in providing proof of significant events is the medical record.

The legal aspects of documentation require:

1. Writing, legible and neat
2. Spelling and grammar, properly used
3. Authorized abbreviations
4. Time-sequenced, and factual descriptive entries

3. Reimbursement

The federal government requires peer review organizations (PROs) to monitor and evaluate the quality and appropriateness of care provided. Medical records are reviewed for documentation of intensity of services and severity of illness.

4. Education

Health care students use the medical record as a tool to learn about disease processes, medical and nursing diagnoses, complications, and interventions. The results of laboratory and diagnostic testing and physical examinations provide valuable information about specific diagnoses and interventions.

Nursing students can enhance their critical-thinking skills by examining and analyzing the records of the health care team's plan of care, including the way the care plan was developed, implemented, and evaluated. All health care professionals including students must maintain confidentiality when reading any client's chart.

5. Research

The client's medical record is used by researchers to determine whether a client meets the research criteria for a study. Documentation can also indicate a need for research. For example, if documentation shows an increased rate of falls on certain nursing units, researchers can look for and study the variables associated with the increased fall rate.

6. Nursing Audit

A **nursing audit** is a method of evaluating the quality of care provided to clients. A nursing audit can focus on implementation of the nursing process, on client outcomes, or on both in order to evaluate the quality of care provided.

The nursing audit is follow-up evaluation that not only evaluates the quality of care of an individual client but also provides an evaluation of overall care given in that health care facility. During a nursing audit, the evaluators look for documentation of all five components of the nursing process in the client records.

Each health care facility has an ongoing nursing audit committee to evaluate the quality of care given.

The nursing audit committee reviews client records after discharge of the clients.

They examine the records for data related to:

1. Safety measures
2. Treatment interventions and client responses to them
3. Expected outcomes as basis for interventions
4. Client teaching
5. Discharge planning
6. Adequate staffing

Effective documentation principles

The health care facility (hospital, nursing home, home health agency), the setting within the facility (e.g., emergency room, perioperative unit, medical-surgical unit), and the specific client population (e.g., obstetric, pediatric, geriatric) determine different documentation requirements. Even so, the documentation of the client care provided must reflect the nursing process.

General Documentation Guidelines:

1. Ensure that you have the correct client record or chart and that the client's name and identifying information are on every page of the record.
2. Document as soon as the client encounter is concluded to ensure accurate recall of data .
3. Date and time each entry.
4. Sign each entry with your full legal name and with your

- professional credentials, per your institutional policy.
5. Do not leave space between entries.
 6. If an error is made while documenting, use a single line to cross out the error, then date, time, and sign the correction (follow institutional policy); avoid erasing, crossing out, or using correction fluid.
 7. Never change another person's entry, even if it is incorrect.
 8. The first entry of the shift should be made early (e.g., at 7:30 A.M. for the 7-3 shift, as opposed to 11:30 A.M. or 12 P.M.). Chart at least every 2 hours, or per institutional policy.
 9. Use quotation marks to indicate direct client responses (e.g., "I feel lousy").
 10. Document in chronological order; if chronological order is not used, state why.
 11. Write legibly.
 12. Use a permanent-ink pen (black is usually preferable because it photocopies well).
 13. Document in a complete but concise manner by using phrases and abbreviations as appropriate.
 14. Document all telephone calls that you make or receive that are related to a client's case.
 15. Nursing documentation based on the nursing process facilitates effective care because client needs can be traced from assessment, through identification of the problems to the care plan, implementation, and evaluation. A brief outline of the elements of the nursing process as they relate to documentation follows:
 - a. *Assessment*: Assessment data related to an actual or potential health care need are summarized without duplication. With reassessment, any new findings or any changes in the client's condition (e.g., increased pain) are highlighted.
 - b. *Nursing diagnosis*: NANDA-International terminology is used to identify the client's problem or need.
 - c. *Planning and outcome identification*: The expected outcomes and goals of client care, as discussed with the client and communicated to members of the multidisciplinary team, should be documented on the care plan or critical pathway rather than in the progress notes.
 - d. *Implementation*: After an intervention has been performed, observations, treatments, teaching, and related clinical judgments should be documented on the flow sheet and progress notes. Client teaching should include learning needs, teaching plan content, methods of teaching, which was taught, and the client's

response.

- e. *Evaluation*: The effectiveness of the interventions in terms of the expected outcomes is evaluated and documented: progress toward goals; client response to tests, treatments, and nursing interventions; client and family response to teaching and significant events; and questions, statements, or complaints voiced by the client or family.
- f. *Revisions of planned care*: The reasons for the revisions along with the supporting evidence and client agreement are documented.

Follow the nursing process

Nursing notes must be:

1. Logical, focused,
2. Relevant to care,
3. The outcomes must represent each phase in the nursing process.

Effective documentation elements

If documenting on paper forms, the elements for effective documentation are:

1. Document accurately, completely, and objectively including any errors that occurred
2. Note date and time
3. Use appropriate forms
4. Identify the client
5. Write in ink (Usually all charting is written with black ink, but each agency determines protocol.)
6. Use standard abbreviations
7. Spell correctly
8. Write legibly
9. Correct errors properly
10. Write on every line
11. Chart omissions
12. Sign each entry

If documenting electronically, the guidelines are the same in documenting accurately, completely, and objectively. However, many of the issues of paper charting are completed automatically on an electronic health record, such as not

needing to use ink to chart, writing legibly, and signing each entry. A nurse cannot obtain a client's electronic health record without logging on to the computer, which automatically signifies the writer, date, time, and entry.

1. Accurate, Complete, and Objective

1. Record just the facts exactly what you see, hear, and do.
2. Chart relevant information relating to client care and reflecting the nursing process.
3. Document information promptly; the information is more likely to be accurate and complete.
4. Important details may be forgotten if charting is left until the end of the shift, and those details may later become a legal issue.
5. Chart medications immediately *after* administration. This prevents errors such as another nurse administering pain medication when the first dose was not charted.
6. Avoid subjective statements such as "client is uncooperative." Record the client's exact words using quotation marks, for example, *Client stated, I don't want to take a bath, and I don't want any breakfast.*"

2. Date and Time

Be sure each entry is dated and has a specific time. Especially note the exact time of sudden changes in a client's condition, nursing actions, and other significant events. Do not chart in blocks of time, such as 7 A.M. to 11 A.M. This is vague and sounds like the client has had no attention during that time frame.

3. Use Appropriate Forms

Use the appropriate forms as required by the facility's policy manual. The forms used are not the same in every facility. Some facilities use flow sheets instead of progress notes.

4. Identify the Client

Each page of the client's record should have the client's name on it. This aids in preventing confusion and helps ensure that information is charted on the correct record.

5. Write in Ink

The client's record is a permanent document, and information should be charted in ink or printed out from a computer. Only black ink should be used because it will photocopy well.

6. Use Standard Abbreviations

Each health care facility has a list of approved abbreviations and symbols for documenting information on its client records.

7. Spell Correctly

Misspelled words on client records may be confusing and certainly convey a sense of unprofessionalism. They may generate questions about the quality of the care provided, increase the chance of liability, and produce a loss of the writer's credibility.

8. Write Legibly

Legible handwriting is imperative for effective documentation. Sloppy writing hinders communication, and errors in client care can occur. Trying to decipher illegible writing wastes time, also creates a poor impression of the person who did the writing and damages that person's credibility. Print rather than use cursive writing; it is usually easier to read.

9. Correct Errors Properly

Promptly correct any error you make in documenting on a client's record. Know and follow your facility's policy for correcting errors. Generally, it is acceptable to draw a single line through the mistaken entry so that what was written can still be read.

10. Write on Every Line

Fill each line completely. Leave no blank lines or partially blank lines. Draw a line through the empty part of the line. This prevents others from inserting information later that may change the meaning of the original documentation.

11. Chart Omissions

Charting is supposed to show implementation of the medical and nursing plans of care. Whenever a part of the plan is omitted, document the reason for the omission. For example, a treatment is not provided or medication is not administered

because the client was in x-ray.

12. Sign Each Entry

Each entry on the nurse's notes (progress notes) is to be signed with your first name or initial, full last name, and professional licensure (i.e., LVN, LPN, RN). The signature should be at the end of the entry on the far right side.

13. Documenting a Medication Error

The medication given in error should be recorded on the Medication Administration Record (MAR) and in the nurse's progress notes. Remember, the purpose of the medical record is to report any care or treatment the client receives; this includes any errors made. Document in the nurse's notes the name and dosage of the medication, time it was given, client's response to the medication, time and name of the practitioner notified of the error, nursing interventions or medical treatment to counteract the error, and client's response to treatment.

Systems of documentation

Systems of recording and reporting data pertinent to client care have evolved primarily in response to demands that health care practitioners be held to societal norms, professional standards of practice, legal and regulatory standards, and institutional policies and standards. The documentation systems used today reflect specific needs and preferences of the many health care agencies.

Among the many systems used for documentation are the following:

1. Narrative charting
2. Source-oriented charting
3. Problem- oriented charting
4. PIE charting
5. Focus charting
6. Charting by exception
7. Computerized documentation
8. Critical pathways

1. Narrative charting:

Traditional method of nursing documentation is a chronologic account written in paragraphs that describe client status, interventions and treatments, and the client's

response to treatments.

Features:

- a. Narrative documentation is the most flexible of all systems and is usable in any clinical setting.
- b. The relationship between nursing interventions and client's responses is clearly shown.

Defects:

- a. Client problems may be difficult to track because the same information may not be consistently documented.
- b. The client's progress may be difficult to identify.
- c. Narrative charting often fails to reflect the nursing process.

2. Source-oriented charting:

Narrative recording by each member (source) of the health care team on separate documents.

Features:

- a. Each discipline uses a separate record.

Defects:

- a. Often resulting in fragmented care.
- b. Time-consuming communication between disciplines.

3. Problem-oriented medical record (POMR):

Employs a structured, logical format and focuses on the client's problem.

There are four critical components of POMR:

- a. Database (assessment data)
- b. Problem list (client's problems numbered according to when identified)
- c. Initial plan (outline of goals, expected outcomes, and learning needs and further data, if needed)
- d. Progress notes (charting based on the **SOAP**, SOAPIE, or SOAPIER format)

The format in which progress notes are written includes SOAP, SOAPIE, or

SOAPIER:**S:** subjective data (what the client or family states)**O:** objective data (what is observed/inspected)**A:** assessment (conclusion reached on the basis of data formulated as client problem or nursing diagnosis)**P:** plan (expected outcomes and actions to be taken)

SOAPIE and SOAPIER refer to formats that add the following:

I: implementation**E:** evaluation**R:** revision**Features:**

- a. An entry need not be made for each component of SOAPIER) at every documentation.
- b. Each problem must have a complete note every 24 hours if unresolved or whenever the client's condition changes.
- c. Continuity of care is shown when the plan of care and interventions performed are documented together.
- d. Some physicians use this format when writing progress notes.

4. PIE charting:

System was developed to streamline documentation. The main parts of this system are an integrated plan of care, assessment flow sheets, and nurse's progress notes.

5. Focus charting:

System using a column format to chart Data, Action, and Response (DAR). Usually the focus is a nursing diagnosis, but it may also be:

- a. A sign or symptoms (e.g., abnormal vaginal bleeding)
- b. An acute change in the client's condition (e.g., sudden increase in blood pressure)
- c. A patient behavior (e.g., crying after talking on the phone)
- d. A treatment of procedure (e.g., dressing change with wound drainage)
- e. A special need (e.g., a discharge referral)

Focus charting reflects the stages of the nursing process:

- a. Data are the subjective and objective information describing the focus.
- b. The data information corresponds to assessment in the nursing process.
- c. Action is the nursing interventions and mirrors the planning and implementation stages of the nursing process.
- d. Response is the client's response to the interventions reflecting the evaluation stage of the nursing process.

The column format of this system is used within the progress notes but is easily distinguished from other entries.

6. Charting by exception (CBE):

System using standardized protocols stating what the expected course of the illness is, and only significant findings (exceptions) are documented in a narrative form. It assumes that client care needs are routine and predictable and that the client's responses and outcomes are also routine and predictable.

7. Computerized documentation:

Health care facilities have been using computers for many years to order diagnostic tests and medications and to receive results of diagnostic tests.

Issues to be addressed when considering computerized client records include:

- a. Data standards—include length of fields, how dates and times are shown, and ASCII or binary data
- b. Vocabularies—the most commonly used are the combination of the NANDA-International nursing diagnoses, Nursing Interventions Classification (NIC) nursing interventions, and **Nursing Outcomes Classification (NOC)** nursing outcomes
- c. Security—includes privacy, confidentiality, who has access to which data, how errors are to be corrected, and protection against data loss
- d. Legal issues—electronic signatures
- e. Costs—include planning, hardware, software, and training for all users

Features:

- 1) Reducing documentation time
- 2) Increasing accuracy,
- 3) Computerized charting increases legibility,
- 4) Stores and retrieves information quickly and easily,

- 5) Helps link diverse sources of client information,
- 6) Uses standardized terminology,
- 7) Planners for health care, researchers, lawyers

Defects:

- 1) Used incorrectly,
- 2) Client information may be mixed up.
- 3) Security measures are neglected,
- 4) Client confidentiality may be compromised.
- 5) Users (e.g., nurses, physicians) should never share computer ID numbers or passwords with anyone.

8. A critical pathway:

(Care map) is a comprehensive preprinted interdisciplinary standard plan of care reflecting the ideal course of treatment for the average client with a given diagnosis or procedure, especially those with relatively predictable outcomes.

Forms for documentation

Forms for recording data include Kardex, flow sheets, nurse's progress notes, and discharge summaries. They are designed to facilitate record keeping and allow quick, easy access to information.

1. A Kardex:

A brief worksheet with basic client care information that traditionally is not part of the medical record.

The Kardex is used as a reference throughout the shift and during change-of-shift reports.

It comes in various sizes, shapes, and types, including computer-generated.

The Kardex usually contains the following information:

- a. Client name, age, marital status, religious preference, physician, family contact with phone number
- b. Medical diagnoses: listed by priority
- c. Nursing diagnoses: listed by priority
- d. Allergies

- e. Medical orders: diet, medications, intravenous (IV) therapy, treatments, diagnostic tests and procedures (including dates and results), consultations, DNR (do-not-resuscitate) order (when appropriate)
- f. Activities permitted: functional limitations, assistance needed in activities of daily living, and safety precautions

2. Flow sheets:

With vertical or horizontal columns for recording date, time, and assessment data and intervention information, make it easy to track the client's changes in condition. Special equipment used in client teaching and IV therapy are other parts of the flow sheet. These forms usually contain legends identifying the approved abbreviations for charting data because they have small spaces for recording.

3. Nurse's progress notes:

Used to document the client's condition, problems, and complaints; interventions; the client's response to interventions; and achievement of outcomes.

Documents falling under the general heading of nurse's progress notes include:

- a. Nurse's notes,
- b. Personal care flow sheets,
- c. Teaching records,
- d. Vital sign records,
- e. Intake and output forms,
- f. Specialty forms (e.g., diabetic flow sheet or neurologic assessment form).

4. Discharge summary

The client's illness and course of care are highlighted in the discharge summary. A narrative discharge summary in the progress notes includes:

- a. Client status on admission and discharge
- b. A brief summary of the client's care
- c. Intervention and education outcomes
- d. Resolved problems and continuing care needs for unresolved problems, including referrals
- e. Client instructions about medications, diet, food-drug interactions, activity, treatments, follow-up, and other special needs

References:

White, L.; Duncan, G.; and Baumle, W.: **Foundation of Nursing**, 3rd ed.,
2011, Australia: CENGAGE, P.P.173-190.