

## **Chapter 6 Documentation**

### **Chart**

Health care record.

Legal record used to meet demands of health, accreditation, medical insurance & legal systems.

Adding written information to the chart-called charting, recording, or documenting.

### **Documentation**

Part of the implementation phase of Nsg. Process & necessary for evaluation of pt. care & care cost reimbursement.

Documentation involves recording the interventions carried out to meet pt's needs.

When charting interventions document type of intervention, time, & signature of person providing care.

5 basic purposes for written pt. records:

- 1.) Written communication
- 2.) Permanent record for accountability
- 3.) Legal record of care
- 4.) Teaching
- 5.) Research & data collection

Pt's chart provides permanent record of past & current medical & nursing problems, plans for care, care given & pt's responses to various Tx.

The record facilitates accurate communication & continuity of care. May also be used by various government agencies to evaluate the institutions pt. care.

### **Peer Review**

Appraisal by professional co-workers of equal status, appraises the manner in which an individual nurse conducts practice, education, or research.

Facilities have specific procedures to provide for quality assurance/assessment/improvement.

An audit in health care that evaluates services provided & the results achieved compared with accepted standards. Records are only means facilities have to prove they are providing care to meet pt's needs & established standards.

### **DRG ( Dx. Related Groups)**

System that classifies pts. by age, dx., & surgical procedure

### **Traditional Chart**

Narrative documentation- describes occurrences in chronological order.

Narrative charting easier to complete if remember the steps of nsg. Process followed.

Narrative charting includes basic pt. need or problem data (subjective/objective or both), Whether someone was contacted, care & tx. Provided (implementation) & pt's response to tx.(evaluation).

### **POMR (problem-oriented medical record)**

Based on scientific problem-solving system or method.

Problem List-serves as index for chart documentation.

Care plan with nsg. Dx. Is developed for each problem by disciplines involved with pt's care (Fig.6-3. P.105).

### **SOAPE-SOAPIER-acronym**

S-subjective

O-Objective

A-Assessment-Dx. Of cause of pt's problem

P-Plan

I- Intervention/implementation-specific care or action given.

E- Evaluation-appraisal of response & effectiveness of plan.

R- Revision-changes that may be made to original plan of care.

### **Focus Charting format**

Instead of problem lists, a modified list of nsg. Dx. Is used as an index for nsg. Documentation.

A focus is not a medical dx.

### **DARE-**

Acronym for 4 aspects of charting using focus format.

D-data-Subjective/objective is equal to assessment step of nsg. Process

A-action-combination of planning & implementation

R-Response of pt.-same as evaluation of effectiveness.

E- education/pt. teaching

Not all dare steps must be used each time.

Quality & accuracy of nsg.'s note are very important.

Correct spelling, grammar, & punctuation.

Clear, concise, complete, & accurate.

Nsg. Notes should always correlate with the medical orders, Kardex information, & Nsg. Care plan.

Some Facilities require a minimum 3 entries per shift on narrative notes/flow sheets to show care given or not given.

### **CBE-Chart By Exception**

Only additional Tx. done or withheld, changes in pt. condition, & new concerns charted.

### **PIE Format**

Problem, intervention, evaluation can be used for CBE.

Similar to SAOPE.

Problem-solving approach.

PIE-arose from nsg. Process.

Soape-documentation of problems, interventions, & evaluations of nsg. Care.

On going plan of nsg. Care with daily documentation.

### **PIE**

Each shift evaluates each pt. problem @ least once & if unresolved, carried until resolved.

Variation of pie to include assessment data-**APIE**.

Assessment includes subjective/objective data.

Accurate documentation is one of best defenses for legal claims associated with nsg. Care.

### **KARDEX**

Card system used to consolidate pt's orders & care needs.

Kept @ Nsg. Station for quick reference.

### **Nursing Care Plan**

Preprinted guidelines used to care for pts. with similar health problems.

Developed to meet nsg. Care needs of a pt.

Based on Nsg. Assessment & nsg. Dx. & developed by nurses.

### **Incident Report**

Any event not consistent with routine operation of a health care unit or the routine care of a pt.

Information helps facility risk manager & unit managers prevent future problems through education & other corrective measures.

Give only objective/observed information when filling out incident report.

Do not admit liability or give unnecessary details.

When charting the incident in nsg. Notes, don't mention the incident report- makes easier for attorney to request document for court.

### **Clinical (Critical) Pathways**

Allow staff from all disciplines to develop integrated care plans for a projected length of stay for pts. of a specific case type.

Contents include: care plan, interventions specific for each day hospitalized & documentation tool.

Nurse & other team members use pathways to monitor pt's progress & as documentation tool.

CBE is frequently used with pathways.

### **Home Health Care Documentation**

Has different implications than other areas of Nsg.

Documentation is both the quality control, & justification for reimbursement.

Home Health documentation has unique problems because of need for different health care providers to access medical records.

### **Long-Term Health Care Documentation**

Omnibus Budget Reconciliation Act(OBRA) 1987

Medicare/Medicaid legislation for LTC documentation.

Standards for LTC documentation regulated by OBRA.

Record or chart is property of institution or physician.

### **Confidentiality**

Pt's Bill of Rights & Law guarantee pt's medical information will be kept private unless information is needed in providing care or pt. gives permission for others to see it.

Nurse should not read a record unless clinical reason.

### **Documentation by Computer**

Major concerns-confidentiality, access to information, inappropriate alterations in pt's records.

Log-in password should not be shared with anyone.

Should log off computer before leaving the terminal to ensure information not displayed on monitor.