Charting

Reporting and Recording
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Learning Objectives:

- Define the following terminology chart, charting, patient record
- Discuss the purpose of the patient record
- List principles of charting.
- Identify contents of patient's hospital record
- List symptoms that require reporting
- Discuss descriptive terms commonly used in charting
Report:

Is oral, written, or computer-based communication intended to convey information to others.
Reporting

- Oral or written
- Change of shift
- Nurse to nurse
- Promotes continuity
- Report on client health status, care required for next shift, significant facts, head to toe assessment, pertinent labs, priority needs, treatments, family issues
Patient's Record or Chart:

- Is an account of the patient's health history, current health status, treatment and progress.

- It is a formal, legal document that provides evidence of a client’s care.

- Reporting and recording are the major communication techniques used by health care providers.
Purposes of Client's Record:

**Communication:**
Patient's record serves as the vehicle by which different members of the health team communicate and share information with each other.

**Assessment:**
Nurses and other team members gather assessment data from the patient's record.
**Planning Patient Care:**

The entire health team uses data from the patient's record to plan care for the patient.

**Education:**

- Nursing students, medical students and other health team members often use patient records as educational tools.
- It provides a comprehensive view of the patient's health status.
**Research:**
- The information contained in a record can be a valuable source of data for research.

**Legal Documentation:**
- It serves as a legal document of the patient's health status and the care given.
**Statistics:**

Statistical information from patients' record can help an agency to anticipate and plan for people's future needs.

**Auditing:**

Patient's record is used to monitor the care received by the patient and the competence of people giving that care.
Principles Of Good Charting Include:

**Conciseness:**
- Write concise and brief information.
- Use abbreviation only accepted and approved by all.
- Use scientific terminology.
- Write in descriptive terms e.g. generalized pallor.
- Write meaningful statement.
**Accuracy:**

- Write only observation that he or she has seen, heard, smelled or felt.
- Use correct spelling and grammar.
- Correct use of medical terms.
- Write complete sentences.
- Precise measurements and time should be used as possible e.g. wounds should be described as 3cm by 0.5cm rather than small.
Completeness:

*The following information is essential when charting:*

- Any new or changed information.
- Any signs and symptoms.
- Any nursing interventions.
- Medications given.
- Physician's orders.
- Patient teaching.
- Patient responses.
Organization:

- Information is grouped by problem or occurrence and flows in a logical format e.g. assessment is recorded with subjective data nursing intervention and patient's response.
- Start every entry with the date and time.
- Chart in a timely fashion to avoid omissions.
- Chart medications immediately after administration.
- Sign your name after each entry.
Legibility:
- Clear and easily read by others (readable).
- Write in ink.
- Use printing letter,
Timeline:

Documentation should occur in a timely manner to:

■ Avoid errors.
■ Avoid forgetting important information.
■ Protect the nurse from negligence or mal practice
Confidentiality:

- Never leave patient's chart in public area or where it could be read by unauthorized individual.

- Its content should not be discussed or shared involved in patient's care.
Documenting a Medication Error

Document in the nurses’ progress notes:

- Name and dosage of the medication
- Name of the practitioner who was notified of the error
- Time of the notification
- Nursing interventions or medical treatment
- Client’s response to treatment
Principles of Effective Documentation

Elements of nursing process needed to be made evident in documentation include:

- Assessment.
- Nursing Diagnosis.
- Planning and outcome identification.
- Implementation.
- Evaluation.
- Revisions of planned care.
Contents of Patient's Record:

**Admission sheet:**
- It contains client's name, address, age, sex, occupation, employee, religion, data and hour of admission, phone condition upon admission, e.g., conscious, unconscious, ambulance brought by ambulance, and history of previous hospitalization.
- The admission records also contain a list of patient's belonging upon admission.
Medical history and physical examination sheet:

Filled by attendant physician, it summarizes vital signs upon admission, condition of heart, lungs, chest, abdomen, level of consciousness, presence of burns, vomitus, bleeding, summary of client's medical history, preliminary diagnosis, and tentative plan of care and signature of attendant physician.
Physician's order sheet:

It contains specific order for
- medication,
- treatment
- diagnostic tests,
- diet,
- x-ray, and
- referral to other specialties.
Graph/flow sheet:

Include temperature, pulse, respiration, blood pressure, daily weight, intake and output measurements, urine sugar and acetone, daily activity, routine treatments performed.
Medication sheet:

Contains name, dosage, route and time of medication given with initials and signature of nurse who gave it.
Physician's progress notes:

Contain assessment and interpretation of client's progress with revisions of plan care.
Nurse's notes:

- Contain ongoing assessment, nursing diagnosis, outcome criteria, planning, intervention and evaluation of care.

The nurse's notes supplies the following information:

- Drug administration
- Treatment applied.
- Nursing care given.
- Fluid intake and output record.
- Routine care.
- Specific care measure e.g. scheduled deep breathing exercises, scheduled tube suctioning.
- Description of patient's reaction to therapy e.g. in case of I.V. infusion or enema.
- Description of physical and emotional signs and symptoms.
- Recording of unusual manifestation e.g. fever, dyspnea, bradycardia.
- Miscellaneous forms: Include laboratory reports, x-ray reports, consultations, respiratory therapy notes, physical therapy notes, social service notes.

- Discharge sheet: Contains physician's summary of patient's course of illness, response to treatment, prognosis status at discharge and plan for rehabilitation or follow up.

- Informed consent.
Informed Consent

- A competent client’s ability to make health care decisions based on full disclosure of the benefits, risks, and potential consequences of a recommended treatment plan.

- The client’s agreement to the treatment as indicated by the client’s signing a consent form.
Methods of Documentation

- Narrative Charting
- Source-oriented charting
- Problem-oriented charting
- PIE charting
- Focus charting
- Charting by exception
- Computerized documentation
- Critical pathways
Narrative Charting

- This traditional method of nursing documentation takes the form of a story written in paragraphs.

- Before the advent of flow sheets, this was the only method for documenting care.
Source-Oriented Charting

- A narrative recording by each member (source) of the health care team on separate records.
Problem-Oriented Charting

Focuses on the client’s problem and employs a structured, logical format called **SOAP** charting:

- **S**: Subjective data (what the client states)
- **O**: Objective data (what is observed/inspected)
- **A**: Assessment
- **P**: Plan
PIE Charting

P  Problem
I  Intervention
E  Evaluation
Focus Charting

- A documentation method that uses a column format to chart data, action, and response (DAR).
  
  Data, Action, and Response
Charting by Exception (CBE)

- A documentation method that requires the nurse to document only deviations from pre-established norms.
Computerized Documentation: Advantages

- Decreased documentation time.
- Increased legibility and accuracy.
- Clear and concise words.

- Statistical analysis of data.
- Enhanced implementation of the nursing process.
- Enhanced decision making.
- Multidisciplinary networking.
Point-of-Care System

- A handheld portable computer is used for inputting and retrieving client data at the bedside.
- Provides each health care practitioner with all pertinent client data to ensure continuity of care without duplication.
- Provides crucial client information in a timely fashion.
Case Management Process

- A methodology for organizing client care through an illness, using a critical pathway.
- A critical pathway is a monitoring and documentation tool used to ensure that interventions are performed on time and that client outcomes are achieved on time.
Forms for Recording Data

- Kardex
- Flow Sheets
- Nurse’s Progress Notes
- Discharge Summary
Kardex

A summary worksheet reference of basic information that traditionally is not part of the record, *usually contains*:

- Client data (name, age, marital status, religious preference, physician, family contact).
- Medical diagnoses: listed by priority.
- Allergies.
- Medical orders (diet, IV therapy, etc.).
- Activities permitted.
Flow Sheets

Vertical or horizontal columns for recording dates and times and related assessment and intervention information.

Also included are notes on:
- Client teaching.
- Use of special equipment.
- IV Therapy.
Nurse’s Progress Notes

Used to document:

- Client’s condition, problems, and complaints.
- Interventions.
- Client’s response to interventions.
- Achievement of outcomes.
Discharge Summary

Highlights client’s illness and course of care. Includes:

- Client’s status at admission and discharge.
- Brief summary of client’s care.
- Intervention and education outcomes.
- Resolved problems and continuing care needs.
- Client instructions regarding medications, diet, food-drug interactions, activity, treatments, follow-up and other special needs.