CHAPTER 6
Documentation

Purposes of Patient Records

• Five Basic Purposes for Written Records
  – Written communication
  – Permanent record for accountability
  – Legal record of care
  – Teaching
  – Research and data collection

• Auditors
  – People appointed to examine patients’ charts and health records to assess quality of care

• Quality Assurance/Assessment/Improvement
  – An audit in health care that evaluates services provided and the results achieved compared with accepted standards
• Diagnosis Related Groups (DRGs)
  – A system that classifies patient by age, diagnosis, and surgical procedure; producing 300 different categories used in predicting the use of hospital resources, including length of stay
  – This is the basis for cost reimbursement rates for Medicare and Medicaid
  – Many private insurance companies use similar illness categories when setting hospital payment rates

Medicare’s prospective payment system (PPS), implemented October 1, 1983, uses fixed prices that depend largely on the category in which the hospitalized patient is placed. The diagnosis-related groups (DRGs), are defined by diagnosis and other factors. Each of the 474 DRGs has an official weight that, in a relative sense, determines payment.

• Pits the government against hospitals
• Studies reveal costs of providing care for a specific Diagnosis did not cover the costs using the government’s DRG weighting
• Hospitals were forced into pushing patient’s out of the hospital or lose money
• Many Doctor’s would no longer accept Medicare Patient’s
Purposes of Patient Records

- Interdisciplinary Notes
- IDN's
  - The form on the patient's chart on which caregivers record their observations, care given, and the patient's responses
  - Institutions reimbursed by insurance companies or government programs only for the patient care documented

Common Medical Abbreviations and Terminology

- A PT cannot effectively and efficiently use a health record until some understanding and knowledge of common abbreviations and medical terms have been developed.
- Most facilities have a published list of generally accepted medical abbreviations and terms approved for use in charting.

Methods of Recording

- Traditional Chart
  - Chart is divided into specific sections or blocks.
  - Emphasis is placed on specific sheets of information.
  - Typical sections are admission sheet, physician's orders, progress notes, history and physical examination data, nurse's admission information, care plan and nurse's notes, graphics, and laboratory and x-ray reports.
Methods of Recording

• Traditional Chart
  – Narrative Charting
    • Recording of patient care in descriptive form
    • Includes the basic patient need or problem data, whether someone was contacted, care and treatments provided, and the patient’s response to treatment
    • Written in an abbreviated story form

Methods of Recording

• Problem-Oriented Medical Record
  – This is based on the scientific problem-solving system or method.
  – Principal sections are database, problem list, care plan, and progress notes.
  – Database
    • The accumulated data from the history and physical examination, and diagnostic tests are used to identify and prioritize the health problems on the master medical and other problem lists.

Methods of Recording

• TURN TO PAGE 104
• Problem-Oriented Medical Record
  – Problem List
    • Active, inactive, potential, and resolved problems serve as the index for chart documentation.
    • A care plan with nursing diagnosis is developed for each problem by disciplines involved with the patient’s care.
**Methods of Recording**

- **TURN TO PAGE 106 OF YOUR BOOK**
- **Problem-Oriented Medical Record**
  - SOAPIER is an acronym for seven different aspects of charting.
  - **S** – Subjective information
  - **O** – Objective information
  - **A** – Assessment
  - **P** – Plan
  - **I** – Intervention
  - **E** – Evaluation
  - **R** – Revision

**Methods of Recording**

- **PAGE 106**
- **Focus Charting Format**
  - What is the problem
  - Treatment plan (nursing care plan) to assist client overcome problem
  - Implement nursing interventions
  - Documentation of nursing interventions.
  - This format uses the nursing process and the more positive concept of the patient’s needs rather than the medical diagnoses and problems.

**Alternative Record-Keeping Forms**

- **PG. 107, 108**
- Facilities may use a variety of forms to make medical record documentation easy and quick, yet comprehensive.
- Many forms eliminate the need to duplicate repeated data in the nurse’s notes.
- It is unnecessary to chart a narrative note each time a medication or a bath is given or vital signs are assessed.
Basic Guidelines for Documentation

- The quality and accuracy of the caregivers notes are extremely important.
- Correct spelling, grammar, and punctuation, as well as good penmanship and other writing skills, are important in documentation.
- Information recorded in the chart should be clear, concise, complete, and accurate.
- The registered nurse (RN) has primary responsibility for the initial admission nursing history, physical assessment, and development of the care plan based on the nursing diagnoses identified.

Basic Guidelines for Documentation

- Complete physical assessments, observations, vital signs, IV site and rate, and other pertinent data are charted at the beginning of each shift.
- During the shift, only additional treatments given or withheld, changes in patient condition, and new concerns are charted.
- More detailed flow sheets, which reduce the time needed to chart, are used with this method.

Charting Rules

- Basic Rules for Charting
  - All sheets should have the correct patient name, date, and time.
  - Use only approved abbreviations and medical terms.
  - Be timely, specific, accurate, and complete.
  - Write legibly.
  - Follow rules of grammar and punctuation.
  - Fill all spaces; leave no empty lines. Chart consecutively, line by line. Do not indent left margin.
  - Chart after care is given, not before.
Charting Rules

• Basic Rules for Charting (continued)
  – Chart as soon and as often as possible.
  – Chart only your own care, observations, and teaching; never chart for anyone else.
  – Use direct quotes when appropriate.
  – Describe each item as you see it.
  – Be objective in charting; write only what you hear, see, feel, and smell.
  – Chart facts; avoid judgmental terms and placing blame.

Charting Rules

• Basic Rules for Charting (continued)
  – Sign each block of charting or entry with full legal name and title.
  – Write only what you observe, not opinions.
  – When the patient leaves a unit, chart the time and method of transportation on departure and return.
  – Chart all ordered care as given or explain deviation.
  – Note patient response to treatments and response to analgesics or other medications.

Charting Rules

• Basic Rules for Charting (continued)
  – Use only hard-pointed, permanent black ink pens; no erasures or correcting fluids are allowed on charts.
  – If charting error is made, draw one line through the faulty information, mark error, initial if required, and make the correct entry.
  – When making a late entry, note it as a late entry and then proceed with your notation.
  – Follow each institution’s policy and procedures for charting.
Charting Rules

- Basic Rules for Charting (continued)
  - Avoid using generalized empty phrases such as "status unchanged"
  - " appears to be normal" or " had a good day"
  - If order is questioned, record that clarification was sought.

Other Documentation Forms and Examples

- Pg. 114
- Kardex/Rand
  - Card system used to consolidate patient orders and care needs in a centralized, concise way
  - Kept at the nursing station for quick reference

Other Documentation Forms and Examples

- Pg. 105
- Nursing Care Plan
  - Preprinted guidelines used to care for patients with similar health problems
  - Developed to meet the nursing needs of a patient
  - Based on nursing and treatment teams assessment and nursing diagnosis
- Incident Report
  - Form that is filled out with any event not consistent with the routine care of a patient
  - Used when patient care was not consistent with facility or national standards of expected care
  - Give only objective, observed information
  - Do not admit liability or give unnecessary details
  - Do not mention the incident report in the nurse’s notes

- 24-Hour Patient Care Records and Acuity Charting Forms
  - Consolidation of the nursing records into a system that accommodates a 24-hour period is often done.
  - This aids in the elimination of unnecessary record-keeping forms.
  - Accurate assessment information and documentation of activities of daily living are more easily obtained with 24-hour notations.

- Discharge Summary Forms
  - Information is provided that pertains to the patient's continued health after discharge.
  - Discharge summary forms make the summary concise and instructive.
DISCHARGE PLANNING PROCESS

- In addition to the patient and his or her family (or friends), a variety of hospital staff can be involved in the discharge planning process.

- The physician – Only a physician can authorize discharge from the hospital.

- The discharge planner – This may be a nurse case manager, social worker or another individual identified as the discharge planner. It is the discharge planner’s responsibility to help the patient and/or family make any arrangements for continued care such as home care, nursing home care or outpatient treatment.

- The primary nurse – The nurse who coordinates the care the patient receives while in the hospital.

- The rehabilitation therapists – If any were involved in the patient’s care, for example physical therapists, occupational therapists, speech therapists, respiratory therapists, etc.

 Documentation and Clinical (Critical) Pathways

- Clinical (Critical) Pathways
  - Managed care is a systematic approach that provides a framework to target the coordination of medical and nursing interventions.
  - Allows staff from all disciplines to develop integrated care plans for a projected length of stay for a specific case type.
  - The nurse and other team members use the pathways to monitor a patient’s progress and as a documentation tool.

Long-term Health Care Documentation

- Omnibus Budget Reconciliation Act (OBRA) of 1987 regulated standards for resident assessment, individualized care plans, and qualifications for health care providers.

- Long-term care documentation supports a multidisciplinary approach in the assessment and planning process of the patients.
Special Issues in Documentation

• Record Ownership and Access
  – The original health care record or chart is the **property** of the **institution or physician**.
  – The patient usually **does not have immediate access** to his or her full record.
  – Patients have gained **access rights** to their records in most states but only if they follow the **established policy of each facility**.
  – A lawyer can gain access to a chart with the patient’s written permission.

Special Issues in Documentation

• Confidentiality
  – Health care personnel must respect the confidentiality of the patient’s record.
  – The **Patient’s Bill of Rights** and the law guarantee that the patient’s medical information will be kept private, unless the information is needed in providing care or the patient gives permission for others to see it.
  – The PT should not read a record unless there is a clinical reason and should hold the information regarding the patient in confidence.

Special Issues in Documentation

• Use of Computers
  – Many institutions have mainframe computers for data processing tasks.
  – Most billing is now stored and processed on this type of computer.
  – Many progressive hospitals have installed computers that can handle physician orders; pharmacy, laboratory, and diagnostic imaging orders; central supply requests; care planning; documentation; and billing.
  – The most efficient computer systems have bedside or handheld terminals for data entry.
Special Issues in Documentation

- Use of Computers (continued)
  - The password should not be shared with another caregiver.
  - Never leave the computer terminal unattended after being logged on.
  - Follow the correct protocol for correcting errors.
  - Make sure that stored records have backup files.
  - Do not leave information about a patient displayed on a monitor where others can see it.

Special Issues in Documentation

- Use of Facsimile Machines
  - Fax machines quickly transmit information between offices, hospitals, and other facilities.
  - Fax machines are a vital channel for rapid information transmission and are as important as computers for documentation and data handling.

IF YOU HAVE NOT MEMORIZED EVERY SLIDE YOU WILL BE SUBJECT TO A PUBLIC FLOGGING