Documentation

Dr. Sabah Abbas Ahmad

College of Nursing \ university of Baghdad

Sabah.abbas@ymail.com

COMPETENCIES:

1. Explain the purposes of documentation in health care.

2. Discuss the principles of effective documentation.

3. Describe various methods of documentation.

4. Describe the latest advances in computerized documentation

5. Discuss the Trends in documentation,

6. Explain the Reporting

Documentation

The documentation systems in use today reflect the specific needs and preferences of the numerous health care agencies.
Throughout the development of modern nursing, a variety of documentation systems have emerged in response to changes inherent in health care delivery. Changes in consumer and legal expectations, federal and state regulations, accreditation standards, and research findings direct provider accountability for the documentation of services. Systems of recording and reporting data pertinent to the care of clients have evolved primarily in response to the demand for health care practitioners to be held accountable to societal norms, professional standards of practice, legal and regulatory standards, and institutional policies and standards. As with all facets of health care, advanced technology has affected the expectations for documentation. Benchmarking activities in quality improvement and cost containment have also increased the demands on health care practitioners to create efficient documentation systems. Efficiency is measured in terms of time, thoroughness, and the quality of the observations being recorded..

Documentation Defined:

Documentation is defined as written evidence of:

1. The interactions between and among health professionals, clients, their families, and health care organizations
2. The administration of tests, procedures, treatments, and client education
3. The results or client's response to these diagnostic tests and interventions
Documentation provides written records that reflect client care provided on the basis of assessment data and the client's response to interventions.

Nurses rely on documentation tools that support the implementation of the **nursing process.** Systematic documentation is critical because it presents the care administered by nurses in a logical fashion, **as follows:**

1. Assessment data (obtained by interviewing, observing, and inspecting) identifies the client's specific Alterations and provides the foundation of the nursing care plan.
2. The risk factors and/or the identified alteration in the functional health pattern direct the formulation of a nursing diagnosis.
3. Identifying the nursing diagnosis promotes the development of the client's short-term goals, long-term goals, and expected outcomes, and also triggers the nursing interventions. These activities occur during the planning and implementation phases of the nursing process.
4. The plan of care identifies the actions necessary to resolve the nursing diagnosis.
5. Implementation is evidenced by actions the nurse performed to assist the client in achieving the expected outcomes.
The effectiveness of the nursing interventions in achieving the client's expected outcomes becomes the criterion for evaluation which determines the need for subsequent reassessment and revision of the plan of care.

- Purposes of Health Care Documentation

-Professional responsibility
and **accountability** are two primary reasons why practitioners document. Other reasons to document include communication**, education, research**, meeting legal and practice standards, and **reimbursement**. Documentation is the professional responsibility of all health care practitioners. It provides written evidence of the practitioner's accountability to the client, the institution, the profession, and society.

Communication

Recording is a method of communication that validates the care provided to the client. It should clearly communicate all important information regarding the client.
Thorough documentation provides:
• Accurate data needed to plan the client's care in order to ensure the continuity of care
• A method of communication among the health care team members responsible for the client's care
• Written evidence of what was done for the client, the client's response, and any revisions made in the plan of care
• Compliance with professional practice standards (e.g., American Nurses Association)

• Compliance with accreditation criteria (e.g., the Joint Commission on Accreditation of Healthcare
Organization [JCAHO])
• A resource for review, audit, reimbursement, education, and research
• A written legal record to protect the client, institution, and practitioner

The client's medical record contains documents for record keeping. The type of document that constitutes the medical record is determined by the health care institution.

Education

The documentation contained within the client's medical record can be used for the purpose of education. Health care students use the medical record as a tool to learn about disease processes, complications, medical and nursing diagnoses, and interventions. The results of physical examination and laboratory and diagnostic testing provide valuable information regarding specific diagnoses and interventions.

Research

Researchers rely heavily on clients' medical records as a clinical data source to determine if clients meet the research criteria of a study. Documentation also can validate the need for research. For example, if documentation demonstrates an increased infection rate with intravenous catheters, researchers can identify and study the variables that may be associated with the increased infection rate.

Legal and Practice Standards

"Failure to document appropriately is a key factor in what happened to a client. In 80% to 85% of malpractice lawsuits involving client care, the medical record is the determining factor in providing proof of significant events the legal issues of documentation require:

• Legible and neat writing
• Proper use of spelling and grammar
• Use of authorized abbreviations
• Factual and time-sequenced descriptive notations

Nurses are responsible for the care the client receives and can be held liable if appropriate interventions are not implemented in a timely manner when information is available that would dictate otherwise.

-Elements of Effective Documentation:

Effective documentation requires:

- Use of a common vocabulary.
- Legibility and neatness.
- Use of only authorized abbreviations and symbols.
- Factual and time-sequenced organization.
- Accurately including any errors that occurred.

The following discussion of effective charting refers to all nursing documents, such as **flow sheet**, **progress notes**, and so on. Add to the nursing documents when:

- A change occurs in the client's condition
- Measuring the client's response to an intervention or expected outcome
- The client or family voices a complaint

-Abbreviations and Symbols:

Facilities usually have a list of acceptable abbreviations and symbols, approved by the Medical Records Committee, to be used when documenting information in the client's record. Always refer to the facility's approved listing. Avoid abbreviations that can be misunderstood. Abbreviations are easily confused. Patients are still being overdosed with insulin and heparin because people use **"u**" for units. Another critical error can occur with the use of "***u*g**," for "microgram," which has been misinterpreted to mean **"mg**," for "milligrams." Errors such as these occur more frequently then we would like to admit, and all because someone used and unclear abbreviation.

-Assessment - Specific Documentation Guidelines:

- Record all data that contribute directly to the assessment (e.g., positive assessment findings and pertinent negatives).
- Document any parts of the assessment that are omitted or refused by the client.
- Avoid using judgmental language such as "good," "poor," "bad," "normal," "abnormal," "decreased," "appears to be," and "seems."
- Avoid evaluative statements (e.g., "client is uncooperative," "client is lazy"); cite instead specific statements or actions that you observe (e.g., "client said 'I hate this place' and kicked trash can").

• State time intervals precisely (e.g., “every 4 hours,” “bid,” instead of “seldom,” “occasionally”).

• Do not make relative statements about findings (e.g., “mass the size of an egg”); use specific measurements (e.g., “mass 3 cm · 5 cm”).

• Draw pictures when appropriate (e.g., location of scar, masses, skin lesion, decubitus, deep tendon reflex, etc.).

• Refer to findings using anatomical landmarks (e.g., left upper quadrant [of abdomen], left lower lobe [of lung], midclavicular line, etc.).

• Use the face of the clock to describe findings that are in a circular pattern (e.g., breast, tympanic membrane, rectum, vagina).

• Document any change in the client’s condition during a visit or from previous visits.

• Describe what you observed, not what you did.

-Methods (systems) OF Documentation:

There are many methods used for documentation, including:

- **Narrative charting**
- **Source-oriented charting**
- **Problem-oriented charting**
- **PIE charting**
- **Focus charting**
- **Charting by exception (CBE)**
- **Computerized documentation**

- Narrative charting, : the traditional method of nursing documentation, is a story format that describes the client’s status, interventions and treatments, and the client’s response to treatments. Narrative documentation is easy to use in emergency situations, in which a simple, chronological order is needed. However, in this type of documentation it is often difficult to avoid being subjective, and there is normally a lack of analysis and critical decision making on the part of the nurse. **Narrative charting is now being replaced by other formats because:**

• The flow of care is disorganized. It is difficult to show a relationship between data and critical-thinking skills. Each nurse writes with a unique style, making continuity of care difficult to identify.

• It fails to reflect the nursing process. The focus is on tasks without emphasis on assessment data or progress toward achievement of outcomes.

• It is time-consuming. The paragraphs are free-flowing, so it takes more time to record accurate data and for others to read it.

• The information is difficult to retrieve. The same problems may not be addressed from shift to shift, so it is difficult to track the client's progress.

-**Source-oriented (S.O.) charting:** is described as a narrative recording by each member (source) of the health care team on separate records. Because each discipline has a separate record, care is often fragmented and communication between disciplines becomes time-consuming. **S.O**. charting has similar advantages and disadvantages to narrative charting since nurses use an unstructured approach in documenting in the progress notes.

- **Problem-oriented medical record (POMR) :** was introduced in 1969 by Lawrence Weed, a physician at Case Western Reserve University. The focus of POMR documentation is on the client's problem, with a structured, logical format to narrative charting called **SOAP:**

• **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 problems or nursing diagnoses)

• **P**: plan (actions to be taken to relieve client's problem)

SOAPIE and **SOAPIER** refer to formats that add:

• **I**: intervention (measures to achieve an expected outcome)

• **E**: evaluation (effectiveness of interventions)

• **R**: revision (changes from the original plan of care)

The **POMR** system was modified by nonmedical caregivers and is referred to as problem-oriented record (**POR**). The system is used by hospitals, nursing homes, and home care agencies.

There are four critical components of POMR/POR:

• **Database**: Assessment data, representative of all disciplines (history, physical, nursing admit assessment, laboratory findings, educational and discharge needs), which become the basis for a problem list evaluation of the client's condition.

• **Problem list**: Derived from the database: a listing of the client's problems as identified, with each problem numbered and labeled as acute, chronic, active, or inactive. Nurses use NANDA terminology in writing client problems as nursing diagnoses; the list is revised as new problems arise and others are resolved.

• **Initial plan**: Based on problem identification; the starting point for care plan development with client participation in setting goals, expected outcomes, and learning needs.

• **Progress notes**: Charting based on the **SOAP, SOAPIE, or SOAPIER** format. The **POR** system uses flow sheets to record routine care and a discharge summary that addresses each problem on the list and notes whether it was resolved. **SOAP** entries are usually made every 24 hours on any unresolved problem or whenever the client's condition changes.

-PIE Charting:

After **SOAP** charting gained in popularity, the **problem, intervention, evaluation (PIE)** system was instituted at Craven Regional Medical Center in 1984 to streamline documentation. Whereas **SOAP** was developed on a medical model, **PIE** charting has a nursing origin. **PIE** is an acronym for problem, intervention, and evaluation of nursing care. The key components of this system are assessment flow sheets and nurses' progress notes with an integrated plan of care that eliminates the need for a separate care plan. Each client problem is labeled and numbered for easy reference. When interventions are implemented to manage the client's problem, the problem number is identified; this system eliminates the traditional care plan by incorporating an ongoing plan of care into the daily documentation.

-Focus charting: is a method of identifying and organizing the narrative documentation of client concerns to include data, action, and response. This method is not limited to client "problems" but allows for the identification of all "concerns" such as a significant event (e.g., results of a diagnostic test).

Focus charting uses a columnar format within the progress notes to distinguish the entry from other recordings in the narrative notes.

-Charting by exception (CBE): is a charting method that requires the nurse to document only deviations from preestablished norms. **CBE** was instituted in 1983 by St. Luke Medical Center in Milwaukee to overcome the recurring problem of lengthy, repetitive notes and to enable the identification of trends in client status. The **CBE** system has three key components:

1. Flow sheets: Highlight significant findings and define assessment parameters and findings.

2. Reference documentation: Is related to the standards of nursing practice.

3. Bedside accessibility: Is related to the documentation forms. **CBE** requires the nurse to document significant findings or exceptions to predefined norms.

- **Computerized Documentation:**

The contemporary health care system has directed nurse leaders to develop computerized records in response to the large demand for clinical, administrative, and regulatory information. "The health care industry has learned from other industries that computers facilitate speed in communication, accuracy in information, capability of information storage, data retrieval, and data revision". Nursing information systems (NIS) are being developed that will complement existing hospital information systems (HIS). The NIS will collect, store, process, retrieve, display, and communicate timely information that supports:

- Administration of nursing services and resources
- Management of standardized client care information
- Linkage of research resources and educational applications to nursing practice.

-TRENDS IN DOCUMENTATION:

"Health care is increasingly driven by information, and consequently, patient care will demand effective management of information. In the 21st century with complex clinical practice, nurses face escalating information challenges inherent in processing and communicating computerized information. Computerized nursing documentation requires the skills of technically competent nurses to improve client care and change the delivery of health care; however, technical competence includes not only equipment order for computerized nursing documentation to demonstrate the quality, effectiveness, and value of the services that nurses provide, standardized data bases have to be developed to ensure accuracy and precision in nursing information systems. . With the transition to managed care and the introduction of capitation by insurers, computerized charting is now prevalent in hospitals and is one of the strongest trends in documentation with home health agencies.

-Reporting

Reporting is the verbal communication of data regarding the client's health status, needs, treatments, outcomes, and the nursing process provides structure for an organized report, a challenge inherent in verbal communications. In order to verbally

communicate an efficient and well-organized report, the nurse must consider outcomes, and responses

- What needs to be said?
- Why it needs to be said
- How to say it

1- Summary reports summarize pertinent client information that focuses on the client's needs as identified by the nursing process for the new caregiver. Summary reports commonly occur at the change of shift and when the client is transferred to another area.

2-. Walking rounds is a reporting method used when the members of the care team walk to each client's room and discuss care and progress with each other and with the client

3- Telephone Reports and Orders:

Telephone communications are another way nurses report transfers, communicate referrals, obtain client data, solve problems, and inform a physician and/or client's family members regarding a change in the client's condition.

4- Incident reports**, or** occurrence reports, are used to document any unusual occurrence or accident in the delivery of client care, such as falls or medication errors.

References:

-Leahy,J. Kizilay,P.: **Foundations of Nursing Practice: Nursing Process Approach,** New York,W.B. Saunders.2005.

-White, L.: **Foundations of Nursing: Caring the Whole Person**, NewYork, Thomson Learning, 2001