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## The "Art" of the Chart

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## THE “ART” OF THE CHART

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Providing excellent patient care is the most important aspect of being a veterinary technician. As with human nurses, veterinary technicians are often over-burdened with patient load exceeding what would be ideal to provide exceptional care. While nurses have been required to provide extensive documentation in their patient’s charts, veterinary practices have been allowed to be more lenient with documentation. With legal implications becoming more of a factor in veterinary medicine, it is important that veterinary technicians become proficient in the art of maintaining a patient chart. Most nurses dislike the paperwork more than any other aspect of their duties; however, it is essential that it be done and done very well. As with every aspect of patient care, chart documentation should be exceptional. The chart is a legal medical record and provides a means to record and communicate crucial patient information to all members of the team providing care. An accurate chart is essential to determine the patient’s current and previous status and to assess the patient’s future needs.

In human nursing, there is a saying, “If it isn’t charted, it didn’t happen.” From a legal standpoint, without documentation, there is no evidence that something was done. Failure to chart, omitting information, and poor communication are very hard to defend, either to the veterinarian or to an attorney. Explaining that the ECG looked normal or the correct medication was given is not sufficient for proof and will not hold up in court.

When charting in the medical record, just the facts should be stated, not opinions. Stick to signs, symptoms and statements. Be objective and document what you see, hear and feel. Entries should be detailed and straightforward with statements that stick purely to medical facts and observed signs and behaviors. Entries in the medical record should be legible and free from spelling and grammatical errors. Erasing an entry is not allowed and if a mistake is made during entry, a single line should be marked through the error with the technician’s initials near the correction. Attention to detail with respect to accuracy is essential. If you chart information incorrectly, it is perceived as done so. Medical records should only be written in blue or black ink. Each practice should develop a list of what they consider to be acceptable abbreviations.

Check boxes are often used to record information. While checkboxes do save time and are adequate to record that a medication or procedure was done, they lack the ability to accurately describe a patient’s signs and symptoms. When using checkboxes, initials should be placed in the box, never checkmarks or an X. From a legal standpoint a checkmark does not allow tracking and accountability. Many practices have generic forms either on paper or incorporated into electronic medical records. While these are timesavers, they may not provide all the options needed to accurately describe a patient’s condition. Specifics should be noted to add accuracy to the assessment. A technician’s assessment of the patient is an integral part of the patient’s care and the notes written about the patient should reflect the quality of the care given.

Documentation in the chart should be done as soon as possible. Waiting until the end of the shift is risky practice in that crucial details can be omitted, especially when fatigue comes into play at the end of a shift. Patient status can change in a matter of moments and lack of prior documentation can be problematic. Immediate documentation of the administration of medication is essential to prevent unintentional re-dosing of a medication already given. Practices should develop late entry policies. Late entries may be made but should be documented as such. Conversely, there should not be any advanced entries made to a chart, even by a few minutes. A patient marked as stable ahead of time could arrest the next minute, which creates significant legal implications if challenged.

Detailed documentation of resuscitation efforts should be done immediately after the code with collaboration of all members of the team if possible.

Veterinary technicians not accustomed to detailed charting may believe they are too busy to chart. The argument can be made that during the busiest time with the most critical patients, the importance of documentation is most crucial. It is important to make sure that abnormal vital signs are noted and the fact that the veterinarian has been notified. Anytime a verbal order is taken from the veterinarian, the order should be written by the technician in the medical record or patient flow chart.

Avoid general statements when writing in the record. Consider the following example: “Dr. Hall called.” This statement is open for interpretation. Did you call Dr. Hall and are now waiting for a call back? Dr. Hall called you? Or, Did you call Dr. Hall and actually spoke to her. There is no way to tell. Instead, the entry should be more direct with more information given that is not open for interpretation. “Dr. Hall was called and assessment findings were discussed. There are no additional orders at this time.”

The veterinary technician profession needs to accept the fact that detailed charting is necessary and we must respect that. It is a step toward accepting professional responsibility for the care we provide.

**References available upon request.**

**Keywords:** assessment, charting, documentation, legal document, medical record