Learning Enrichment

Documentation in Health Care

Alice S.M. TSANG

INTRODUCTION

Documentation in health care is the charting, recording and reporting of events which occurs during patients' hospitalization. It includes documenting admission, progress, responses to treatment and care, health education, discharge summary and incident reports.

The record serves as a legal document of the care and treatment provided to the patient. Moreover it is a means of monitoring and evaluating staff performance of patient care and thus reflects the standard of practice. Good charting must be concise, accurate, complete, legible, timely and logically organised. Concise and precise patient documentation is significant in providing quality care and ensuring continuity of care across disciplines.

With increasing patient awareness and expectations of the health care services, process-driven and outcome-oriented trends of care provision, and manpower problems in the health care system, nurses need to maintain high standards of practice. To meet these ends, nursing competence in patient documentation is important.

GUIDELINES FOR CLEAR, ACCURATE AND LEGALLY APPROPRIATE DOCUMENTATION

It is important that the nurse adheres to the following guidelines when documenting : -

1. Read and review the patient's chart and nursing records before caring for a patient and charting that care.

2. Do not remove a chart from the patient's room or bed, or begin to chart before checking the name on the chart. Patient's name and hospital number must be recorded on every sheet.

3. Record in narrative format, using concise phrases. Begin each sentence with a capital letter and each new topic on a separate line.

4. Nursing problem should be documented (e.g. an oozing wound) followed by the nursing actions. Avoid phrases which suggest a risk, an unsafe practice or an opinion (e.g. the patient was uncooperative, the ward is understaffed).

5. Avoid ambiguous terms and statements (e.g. "likely", "appears to be", "wound is healing"). In the records, use descriptive terms and substantiate with facts.

6. Document a patient's refusal of treatment, the teaching strategy related to the information given about the need for treatment and the possible consequences of refusal of treatment.

7. Sign each entry, post-script and addendum. Do not sign or document for other people.

Alice S.M. Tsang, *The Hong Kong Polytechnic University*
(Requests for reprints can be addressed to Alice S.M. Tsang, Department of Nursing and Health Sciences, The Hong Kong Polytechnic University).

8. Describe reported symptoms accurately. Use the patient's words, in quotation marks, when required.

9. Write legibly and neatly in the agreed colour ink, do not use pencil for documentation.

10. For incorrect entry : draw a line across the error and initial. Backdating, or add-onto previously written notes is not permitted. All notes, including those with an error must be kept in the patient's file.

11. Use standard abbreviations or symbols agreed by the institution.

12. Write entries in order of consecutive shifts and days, document date and time of each entry.

13. Chart any change in patient's condition, to whom you reported.

14. Document outcomes of nursing interventions to demonstrate the effectiveness of care.

15. Repetition of information written on any other form or chart is unnecessary unless further explanation is necessary.

SIGNING OF THE NURSING RECORDS

Each section of nursing notes must be signed at the end of the each entry. A nurse should write down the nursing title (e.g. RN, EN) immediately after the name. The use of full name is prefered. Initials and last name is only acceptable if the organisation's policy permits and no other staff member has the same initial and last name.

For example

Date/Time	Progress notes
9:15 am	Patient complained of fatigue and difficult with respiration. Respiration : 32/min, Pulse : 102/min. Dr. Tong informed and visited, Oxygen 2L/min prescribed and given at 9:25 am ----------*Mabel Lai* (RN)
10:00 am	Patient states that she is less anxious - ---------------------- *Mabel Lai* (RN)

ADDITIONAL RECORDS

All notes should be charted on every line with no space left between entries. If postscript is needed after signing an entry, the nurse must sign again at the end of the addendum.

For example

Date/Time	Progress notes
9:15 am	Patient complained of fatigue and difficulty with respiration. Respiration : 32/min, Pulse : 102/min. Dr. Tong informed and promised to visit.--------------------*Mabel Lai* (RN)
9:25 am	Dr. Tong visited. Oxygen 2L/min prescribed and given at 9:25 am -------- ------------------------ *Mabel Lai* (RN)
10:00 am	Patient states that she is less anxious. -- ------------------------- *Mabel Lai* (RN)

BASIC CATEGORIES OF FORMS FOR DOCUMENTATION

Patient information is recorded on a basic set of forms including assessment and data base forms, plan of care forms, progress notes, and continuity of care forms.

1. Assessment and data base forms include admission form, nursing assessment, medical history and test results.

2. Forms for planning of care include medical records, care plan, progress notes and nursing kardex.

3. Forms for recording progress include progress notes, medication record and discharge summary.

4. Continuity of care forms include progress notes, transfer notes and discharge summary.

5. Special types of charts include flow charts and graphs.

DOCUMENTATION FORMATS

The following case example illustrates different documentation formats:-

> ***Case A***
>
> *Heather was admitted with diagnosis of asthma and upper respiratory tract infection. She was short of breath, anxious and withdrawn. Her mother stated she has lost all interests in activities and her performance in school has deteriorated since her respiratory condition. On examination, Heather complained of fatigue and difficult in respiration.*

I. Problem identification, Interventions and Evaluation (PIE) format

The PIE format is a process-oriented approach to documentation emphasising nursing process and nursing diagnosis. In PIE format, the care plan is incorporated in the nursing progress notes.

<u>The advantages and disadvantages of the PIE format</u>

Advantages

- Patient's progress can be traced easily.
- Time saving systems once accustomed to the format.
- It identifies patient problems and nursing intervention, thus promotes continuity of care.

Disadvantages

- The use of integrated charting is difficult.
- It may be impractical to eliminate the use of care plan in some situations.

Example, referring to case A

Date/Time	Progress notes	
7.10.1995 9:15 am	P:	Ineffective breathing effort related to decreased energy and fatigue.
	I :	Administer 2/L oxygen via nasal canula. Provide a quiet environment. Prop up with pillows.
10:00 am	E :	Patient states that she is less anxious. Respiration : 24/min, Pulse : 90/min.

II. Problem Oriented Record (POR)

The problem oriented record was developed and later modified. The POR has four components which include data base, problem list, initial plan and progress notes. The progress notes are written as SOAP, SOAPIE or SOAPIER formats.

The SOAPIER format

S Subjective data as expressed by patient;

O Objective data as observed or assessed including laboratory results;

A Assessment and conclusion regarding patient's condition based on the subjective and objective data;

P Plan or action to address the problem;

I Intervention

E Evaluation of the plan and/or intervention

R Revision of plan

The advantages and disadvantages of POR format

Advantages

- The problems list at the front of the chart remind the care providers about patient's current problems and needs.
- Focused care on problems and documentation of care.
- The listing and numbering of problems with numbers facilitate easy retrieval for monitoring patient's progress.
- Reflect outcome- oriented care.

Disadvantages

- The successful use depends on the ability and consistency of care providers to organise information into the SOAP format.
- It requires constant review to maintain a neat and up to date problem list.

Example, referring to the case A :

Problems list	
Problem #1	*Ineffective airway clearance related to tenacious secretion*
Problem #2	*Ineffective breathing pattern related to decreased energy and fatigue*
Problem #3	*Impaired adjustment related to disability requiring change in lift style*

With SOAPIER format on Problem #2

Date/Time		Progress note
7.10.1995 10:00 am	S	Patient complained of fatigue and difficult in respiration
	O	Respiratory rate : 32/min, pulse : 102/min. Use of accessory muscles. Impaired arterial blood gas.
	A	Ineffective breathing pattern related to decreased energy and fatigue.
	P	Provide Oxygen 2 L/min via nasal canula. Encourage patient to practise breathing and relaxation technique Administer Aminophylline infusion as prescribed.
	I	Administer 2L Oxygen via nasal canula. Provide a quiet environment. Prop up patient with pillows. Monitor Aminophylline influsion.
	E	Patient states that she is less anxious. Respiration : 24/min, pulse : 90/min.
	R	Continue present intervention. Review in one hour.

III. Focus charting : Data Action Response (DAR) format

This format for documentation was developed in mid 1980's to improve both the existing documentation system and the documentation of nursing practice.

The advantages and disadvantages of DAR format

Advantages

- It facilitates documentation of all nursing process components.
- It groups nursing diagnosis and functional status together and allows a variety of solution to problems.
- The construct promotes concise recording.
- It promotes recording of psychosocial information.

Disadvantages

- The evidence of chronological order is not always present.
- The process notes do not always relate to the care plan.
- Careful monitoring for quality improvement is necessary

Example, referring to case A :

Date/Time	Focus	Progress notes
7.10.95 9:15 am	Ineffective breathing effort	D : Patient complained of fatigue and difficult in respiration. Use of accessory muscles. Respiration : 32/min, Pulse : 102/min. Impaired arterial blood gas.
		A : Oxygen 2L/min via nasal canula. Provide a quiet environment. Prop up with pillows.
10:00 am		R : Patient states that she is less anxious. Respiration : 24/min, Pulse : 90 min.

IV. Charting by Exception (CBE)

Charting by exception was developed in USA. The recording is used solely for the purpose of documenting abnormal and significant findings.

<u>The advantages and disadvantages of CBE format</u>

Advantages

- Patient data can be recorded on the patient's chart promptly.
- Fewer pages are needed for nursing documentation.
- The nursing care plan may be kept as a permanent record.

Disadvantages

- The records may be brief and too much reliance may be placed on the checklists.
- There is potential for absence of charting for long intervals of time.
- As routine care is intentionally omitted in recording care standards, the need for care planning and care delivery may be omitted.
- Record of nursing outcomes are not available for future reference.
- Documentation of unexpected events may be inadequate.
- Integrated or multidisciplinary charting is not possible.

Example, referring to case A :

Date/Time	Progress notes
7.10.1995 9:15 am	Patient complained of fatigue and difficult in breathing. On examination, respiration : 32/min, pulse : 102/min. Using accessory muscle to breathe. Dr. Tong informed and visited. Oxygen 2L/min prescribed and given. Breathing and relaxation exercise encouraged.

V. Outcome / Narrative charting

Outcome charting was developed in the early 1970s. It is a process-oriented approach of recording which provides a written record of the patient's condition as compared with pre-determined outcomes in the care plan. Progress notes are recorded in narrative format.

<u>The advantages and disadvantages of outcome / narrative documentation</u>

Advantages

- Outcome auditing is possible.
- Patients' progress are recorded in chronological order.
- It provides evidence of outcomes from prescribed nursing and medical interventions.

Disadvantage

- Satisfactory implementation of this format of documentation can be difficult if the nursing process is not consistently used.
- It's time consuming to examine narrative notes for a specific problem, treatments and patient's response as there is no indication where these information can be traced.

Example, referring to example A

Date/Time	Progress Notes
7.10.1995 9:15 am	Patient complained of fatigue and difficulty in breathing. Oxygen 2L/min given. Breathing and relaxation exercise reinforced. At 10:00 am, patient states that she is less anxious. Respiration : 24/min, Pulse : 90/min.

CHARTING FREQUENCY

The frequency of documentation should be determined by the health organisation's policies, or according to nursing guidelines or protocols regarding the management of the problem. Based on the acuity level of the patient, nurses assess and decide on how often

a patient should be observed and the assessments and interventions be documented.

Guidelines for frequency of documentation are as follows :

1. The frequency of nursing actions as prescribed on the care plan.

2. Time indicated in expected outcome. For example, by first post-operative day, before discharge, or within half an hour .

3. As according to the adopted documentation format.

4. The designated time on the special forms i.e. flow charts.

5. Charting per shift.

6. Topic-a-day charting. To chart focusing on particular needs of the patient, i.e. progress of rehabilitation and exercise on one day and focused on other needs the next day.

7. Topic a shift charting. The recording will be broken down into more frequent topic changes and with more frequent observation.

8. Time entry. This type of charting requires more time to document than other methods.

Bibliography:

Eggland, E.T. & Heineman, D.S. (1994) *Nursing documentation. Charting, recording and reporting*. Philadelphia: J.B. Lippincott.

Fischbach, F.T. (1991) *Documentating care. communication, the nursing process and documentation standards*. Philadelphia: F.A. Davis.

Exercise:

Select one incident related to a case at work and document the incident with the charting format of your choice.