Documentation
Objectives

- Define the documentation concept
- Discuss the purpose of documentation in the patient record.
- Describe factors that impact on documentation.
- Discuss the "who, what, when, where, why, and how" of nursing documentation.
Continuation...

• Documentation may be the least favorite part of your job—but it's also one of the most important aspects.
• Incomplete or improper poses legal and compliance threats.
• accurate documentation is an essential for safe and reliable patient care.
Documentation

Any written or electronically generated information about a client that describes the care or service provided to that client.
Documentation

Written evidence of:

• The interactions between health care professionals, clients, their families, and health care organizations.

• The administration of tests, procedures, client education, and treatments.

• The results of, or client’s response to, diagnostic tests and interventions.
Documentation

Nursing documentation clearly describes:-

• assessment of the client’s health status,
• nursing interventions carried out,
• and the impact of these interventions on client outcomes;
• a care plan or health plan reflecting the needs and goals of the client;
Remember

“IF IT’S NOT DOCUMENTED IT’S NOT DONE”
In Brief (Documentation As Communication)

- Communicates that the care provided
- Avoids duplication
- Outlines all important information
- Maintains continuity and consistency
Purpose of Documentation Accountability

• Health record demonstrates accountability and gives credit for professional practice.

• Determine responsibility and concerns about provision of care.

• Legal proceeding like lawsuits.
Purpose of Documentation Quality Improvement

• Evaluate professional practice during quality improvement process:
  - Performance Review
  - Chart audit
  - Accreditation
  - Legislations inspections
Purpose of Documentation Education

- The medical record can be used by health care students as a teaching tool.
- It is a main source of data for case studies.
Purpose of Documentation Research

• A valuable source of data for research.

• Accurate records is essential to provide accurate research data.

• Through research, evidence based practice can be strengthen.
Purpose of Documentation
Legal Protection

Right documentation = legal protection to you, the patient’s other caregivers, the hospital, and the patient.

- Not documented = not done.

- Adhere to documentation policy in all situations.
Purpose of Documentation
Legal & Practice Standards

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.
Purpose of Documentation
Legal Aspects of Charting

• All patient information considered confidential.

• Sign every entry (a master list matching the initials to the caregiver is needed).

• Write neatly and legibly.
Continuation...

- Use proper spelling, grammar, and appropriate medical phrases.
- Document in blue or black ink and use military time.
- Use authorized abbreviations.
- Fill in blanks on chart forms single line to the end of the line.___________ M. Ata SN 215946
Continuation...

- Chart only care you provide or supervise
- Record only accurate information.
- Do not omit significant information from the chart.
- Record the patient’s name on every page
- Chart after delivery of care
Continuation...

• Correct mistaken entries properly. Single line, ‘error’ and sign off.

• Any form of masking or obscuring (correction fluid, self adhesive labels, scratching , erasure or other means of obscuring) of what was originally written is not permitted
Continuation...

- Do not rewrite the record
- Do not lose or destroy medical records.
- Do not add to the notes of others.
- Do not use the medical record to criticize others.
Trends in Charting

• Reduction in duplicate charting
• Multidisciplinary charting
• Clinical pathways
• More uniformity in documentation
• Computerized documentation
• Fax machines
Documentation
Nurse’s Progress Notes

- Client’s condition, problems, and complaints.
- Interventions.
- Client’s response to interventions.
- Achievement of outcomes.
Documentation Clinical Pathway

- A comprehensive, standard plan of care for specific case situations.

- The pathway is monitored to ensure that interventions are performed on time and client outcomes are achieved on time.
Documentation

Computerized Documentation:

- Decreased documentation time.
- Increased legibility and accuracy.
- Clear, decisive, and concise words.
- Statistical analysis of data.
- Enhanced implementation of the nursing process.
- Enhanced decision making.
- Multidisciplinary networking.
Don’t document value judgment

Student uncooperative document students refused vaccine, shouts and shake fists
Documentation Content

- **Telephone Nursing care:**
  - Nurse who provide telephone nursing care should document Tel. Interaction.
  - Document date and time of incoming calls including voice message, and returning calls.
  - Document name and Tel. # of the caller.
  - Reason for call, assessment, advise, follow up and signature and initials.
Documentation Content

- **Date, Time, Signature and Designation**
  - Date and time supporting communication and continuity of care.

  - Signature supporting accountability (master list should be issued)

  - Designation indicates accountable regulated health professional provided care. (SN/PN) standard list of designation abbreviation is useful.
Methods of Documentation

Regardless the method of Documentation used, Health Record must present Nurses assessment, action, and outcomes.

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

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.
Methods of Documentation

Source-Oriented Charting

• A narrative recording by each member (source) of the health care team on separate records.
Methods of Documentation
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
Methods of Documentation

PIE Charting

• PROBLEM
• INTERVENTION
• EVALUATION
Methods of Documentation
Focus Charting

• A documentation method that uses a column format to chart data, action, and response (DAR).
Methods of Documentation
Charting by Exception

• A documentation method that requires the nurse to document only deviations from pre-established norms.
Security and confidentiality

• Clients entrust personal information to be safeguarded and shared only as necessary to serve his/her interests.

• Nurses have professional obligation to protect client confidentiality.
Retention of health records

- Nurses need to be aware of facility policy affecting retention periods.
- Retaining health records for the required period of time
- Ensuring that records are stored securely during the retention period
Transmission of health information

- Potential loss of confidentiality because of transferring information
- Email
  - nurses should avoid transmitting client information by unsecured e-mail.
  - Subject line to alert the recipient that the message is confidential, states that the message is only to be read by the intended recipient and must not be copied or forwarded to anyone else.
Transmission of health information

Facsimile

- Ensuring the fax number used is correct and current
- Confidentiality warning on the cover sheet (information is confidential, if misdirected, requesting to be destroyed immediately without being read)
- Making a reasonable effort to ensure that the fax will be retrieved immediately by the intended recipient or will be received in a secure area until collected
Transmission of health information

- Mail
  - Information sent via regular mail or courier should be sealed envelope and clearly identified as confidential.
  - The delivery of the information should be tracked
Incident reports

• Unusual occurrences, such as client falls; harm to clients, staff or visitors; or medication errors.

• Nurses have a professional requirement to document in the health record incidents involving clients.
Incident reports

• Documentation should include the nature of an incident, assessment and care provided

• Simply documenting that an incident report was completed, does not meet requirement
Thank You

Documentation is a Professional Requirement.
References

• College of Nurses of Ontario, Documentation Practice Standards, 2008