

# ***CHARTING AND DOCUMENTATION***

***1.5 Contact Hours***

***Presented by:***

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# CHARTING AND DOCUMENTATION

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## Objectives

1. List and describe the six different documentation systems
2. List the six elements that should be addressed in a facility's policy regarding what constitutes a complete medical record
3. Name the four elements that govern the frequency of documentation
4. Describe how late entries should be made

The patient's medical chart is a legal document used to protect the patient and the practice of healthcare professionals. It is a composition of a patient's past and present health history. Proper documentation is extremely important, as it helps to meet credentialing and regulatory demands as well as provides professional accountability. Whether or not documentation is by paper charting or electronic, it is essential for effective, ethical nursing practice. It also provides an account of the critical thinking essential to the nursing process: assessment, diagnosis, planning, intervention, and evaluation.

## Charting Systems

Charting comes in various formats in different healthcare facilities. Some are still paper documentation, others are electronic, and still others are a mixture of the two. Each institution has its own way of charting. A variety of formats are used to document care including hand-written flow sheets, worksheets, Kardexes, assignment sheets, shift reports, nurses' notes, care maps, and clinical pathways. If the facility utilizes a paper-based system, entries should be written legibly in black ink, according to facility policy.

Acceptable terminology and correct spelling should be used. Misspelled words give the impression of lack of attention to detail and can be misinterpreted.

There are different documentation systems in place across the country based on facility needs. There is no one best system, and sometimes elements of systems are combined in one healthcare facility. Some of these include:

- Written Narrative – nursing interventions and responses are recorded in chronological order. It allows space for documentation that is not captured elsewhere in the medical record and detailed explanations. It can be used alone or in combination with other methods
- Charting by Exception – abbreviated approach to documenting normal assessment and responses. Only out-of-the-ordinary events are charted. Utilizes care plans and significant findings or unanticipated responses. It assumes standards are met with normal responses unless otherwise charted
- Problem-oriented Documentation – data is organized by diagnosis or problem. The nurse identifies the problem, and documents the care provided, the intervention and the response
- SOAP – subjective, objective, assessment and plan
- Focus Charting – supports outcome-based care and is structured according to patient problem
- PIE Charting – problem-oriented approach: problems, interventions, evaluations.

Healthcare facilities should have policies in place that specify what constitutes a complete medical record. In general, policies should address:

- What is an acceptable method of documentation
- Frequency of documentation
- Recording of late entries
- Acceptable abbreviations
- Receipt of verbal orders
- Storage, transmittal and retention of patient information (usually regulated by state and federal laws, and included in the Health Information Services [Medical Records] Department, as opposed to Nursing).

Only facility-approved forms should be used for documentation. Forms should be regularly evaluated and revised for relevance and effectiveness. This ensures consistency. Patient identification should be clearly noted on each and every form. There should be no blank spaces in paper-based documents, as it enables other providers to add information without the knowledge of the original author. If there are blank spaces, a single line should be drawn completely through the space. Never remove pages from a medical record.

## **Privacy**

Patients have the right to the privacy and security of their medical record. The Health Information Portability and Accountability Act of 1996 (HIPAA) governs the access, storage, retrieval and transmittal of medical records in the United States. Patients have a

right to receive copies of the records for a reasonable fee, and with a signed Medical Records Release form and proof of identification. The healthcare facility is the legal owner of the medical record; however the information in the record belongs to the patient. Facility policy governs who may access the medical record according to state and federal regulations. When a patient is in the hospital, the nurse should release confidential information only according to the facility's policy.

### **Charting Characteristics**

Charting should be:

- Chronological
- Objective
- Comprehensive
- Relevant
- Specific
- Standard and consistent
- Thorough
- Timely
- Complete
- Concise
- Descriptive
- Factual
- Legally aware
- Legible

And:

- Include assessment of the patient's health status, nurses' actions or interventions, and patient response or outcome
- Include assessment data (e.g. monitoring strips or photos, clearly identified).
- Describe the patient care plan, including needs and goals, as well as changes to the care plan as needed
- Describe environmental factors, self-care and patient education

- Occur when a patient is transferred - before, during, and after - to another unit in the facility, or to and from another facility. The facility's policy should clearly outline what is necessary during patient transport, whether intra- or inter-facility
- Include anything reported to the patient's physician(s), or communication with other healthcare providers, including times and dates, and the elements of the discussion.
- Occur for discharge planning and discharge instructions. Documentation should include if the patient/family is adequately prepared for discharge
- Include any significant events; frequent documentation for seriously ill or high risk patients, and those with complex health problems
- Include a patient's refusal of care and/or treatment, as well as the education about the consequences of the refusal
- Documentation of patient/family concerns
- Include date and time the care is provided, as well as the identifiable signature and designation of the person providing the care, according to facility policy

Charting is objective. This means objective data such as what you see, hear, feel, measure, and count - that which is observed. It means charting facts without interpretation. Documentation should not include comments about the patient, family or other healthcare providers, and should not be biased. Subjective charting is that which is perceived. Quotation marks should be used when quoting actual statements, as well as identifying the individual who made the statement. Words such as *appears*, *seems*, and *apparently* should be avoided as they show uncertainty. Generalizations should be

avoided also, as well as vague phrases such as, “status unchanged,” “assessment completed,” “slept well,” and “had a good day,” because they are not based on fact. Charting should include not only changes in status, but what was done about the changes. For instance, consider a patient whose condition is deteriorating and the nurse charts her observations and discussion with the primary care physician. However, the physician fails to take corrective action and the patient deteriorates further. The nurse takes no further action. Should the case go to court, it may be concluded that though evaluation and documentation of the patient’s condition occurred, the nurse had a further duty to the patient to report her observation and the lack of medical intervention to the supervisor, who should then have consulted the chief of medical staff.

It is also prudent for nurses to read the nurses’ notes at the beginning of the shift before assessing the patient or charting. This will help determine changes in the patient’s condition, and will enhance any information gleaned from hand-off communication obtained at changed of shift.

Charting should be completed chronologically, and as close to events as possible, but after, never in advance of, the event. This assures accuracy and clarity of the entry. Results of a treatment or medication are not always what were intended, and if completed in advance, it will be an error in documentation. For example, the nurse may have to immediately respond to another patient’s need for assistance and the treatment or medication already charted, was never completed. Always chart with objective terms so as not to cast doubt on the entry. The frequency of documentation is governed by:

- Policies and procedures of the healthcare facility
- The complexity of the patients' health problems
- The degree to which a patient's condition puts him/her at risk
- The degree of risk involved in a treatment or component of care (College of Registered Nurses of Nova Scotia, 2005).

### **Errors and Late Entries**

When an error in charting has been made, changes should be made according to facility policy. In general, a single line should be drawn through the error, the correct entry placed above, or next to, the error and initial or sign, and date the correction. Finally, never alter a record at someone else's request, identify yourself after each entry, and chart on all lines in sequence to ensure that additional entries cannot be inserted at a later date. Correcting, modifying or altering someone else's documentation is illegal and considered to be professional misconduct (College of Registered Nurses of Nova Scotia, 2005).

Defensive charting is utilized to protect healthcare professionals and the patient. All healthcare professionals should be familiar with their facility's policies and procedures with regard to charting, as well as the federal and state regulations.

Late entries should be made according to facility policy, but still must be complete and accurate. Late entries should be:

- Made on a voluntary basis, with accurate recall by the healthcare provider
- Clearly identified, individually dated, referencing the actual time recorded and the time the care or event occurred, and signed by the nurse involved

- Charted on the same shift the care was provided
- Recorded as a late/delayed entry

### **Principles**

Any healthcare professionals who provide care for the patient should document, as the medical record is an interdisciplinary means of communication among caregivers, and provides for continuity of care. The chart also identifies who provided the patient care, and the healthcare professional that provided the care should be the one to document as he or she is the one who has firsthand knowledge.

Always chart only your own observations and assessments. Co-signing or charting for others makes the nurse potentially liable for the care as charted. Two signatures may lead to difficulties in determining who actually provided the care. Under most circumstances, when two nurses are involved in the care of a patient, only one nurse needs to document, which will include the intervention, response of the patient, and the assistance and identification of the other healthcare provider. The healthcare facility should have policies and procedures in place clearly describing how documentation should be completed, and include what is required if two nurses are providing care. If you must co-sign charts for someone else, always read what has been charted before doing so.

Documentation of the care you give is proof of the care you provide. It shows a clear picture of what was done for the patient. Any attorney or risk manager should be able to reconstruct the care the patient received after reviewing a chart. Attorneys consider the patient's complete and accurate medical record the most reliable source of information on

the care of that patient. Risk Management programs are utilized across the United States to assure quality of care and patient safety. It is the process of making and carrying out decisions that will assist in prevention of adverse consequences and minimize the adverse effects of accidental losses upon an organization; it is a systematic approach to identify, evaluate, and reduce or eliminate the possibility of an unfavorable patient outcome to prevent a financial loss as a result of patient injury (CPHRM Exam Prep Guide, 2006). Documentation is a tool used by risk managers to evaluate the patient's progress, identify care issues, and recommend improvements or changes. For liability purposes, the medical chart is a legal record of the care provided to the patient, and is usually the first thing attorneys request as evidence in a malpractice lawsuit. Nursing care is measured according to the standard of care of what a reasonably prudent nurse would have done in the same or similar circumstances. Therefore, thorough and accurate documentation is one of the best defenses against a claim or lawsuit.

The medical record can be used to:

- Refresh a nurse's memory in preparation for deposition
- Determine if physician's orders were carried out
- Determine if the care provided was appropriate and timely
- Determine if standards of care were met and if they were in accordance with the standards of the time
- Reinforce testimony and uphold the credibility of the nurse/healthcare facility
- Show whether a client was compliant

- Determine whether reactions to medication/treatments were communicated (College of Registered Nurses of Nova Scotia, 2005).

Always follow the facility's policy with regard to charting and documentation. All nurses know that if it wasn't charted, it wasn't done. Proper nursing documentation prevents errors and facilitates continuity of care.

**Resources:**

American Society for Healthcare Risk Management. (2006). *CPHRM Exam Prep Guide*. Chicago, IL: ASHRM.

Documentation Guidelines for Registered Nurses. (2005). College of Registered Nurses of Nova Scotia.

Guido, G. (2001). *Legal and ethical issues in nursing*. Upper Saddle River, NJ: Prentice-Hall, Inc.

Schiavenato, M. (2004). *Quick-E charting: Documentation and medical terminology – Clinical nursing reference*. Orlando, FL: Bandido Books.