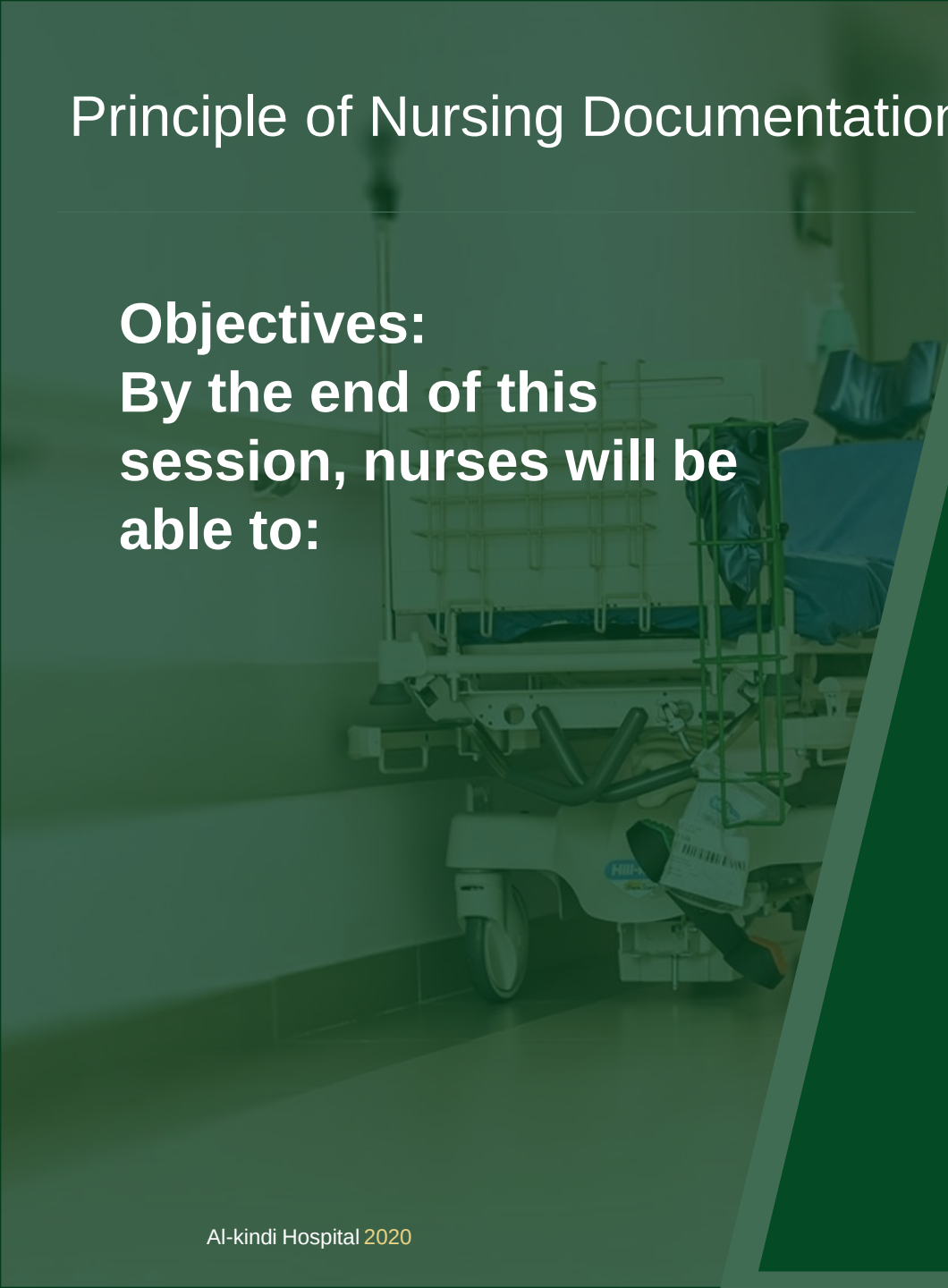
The Principle of Nursing Documentation

2021

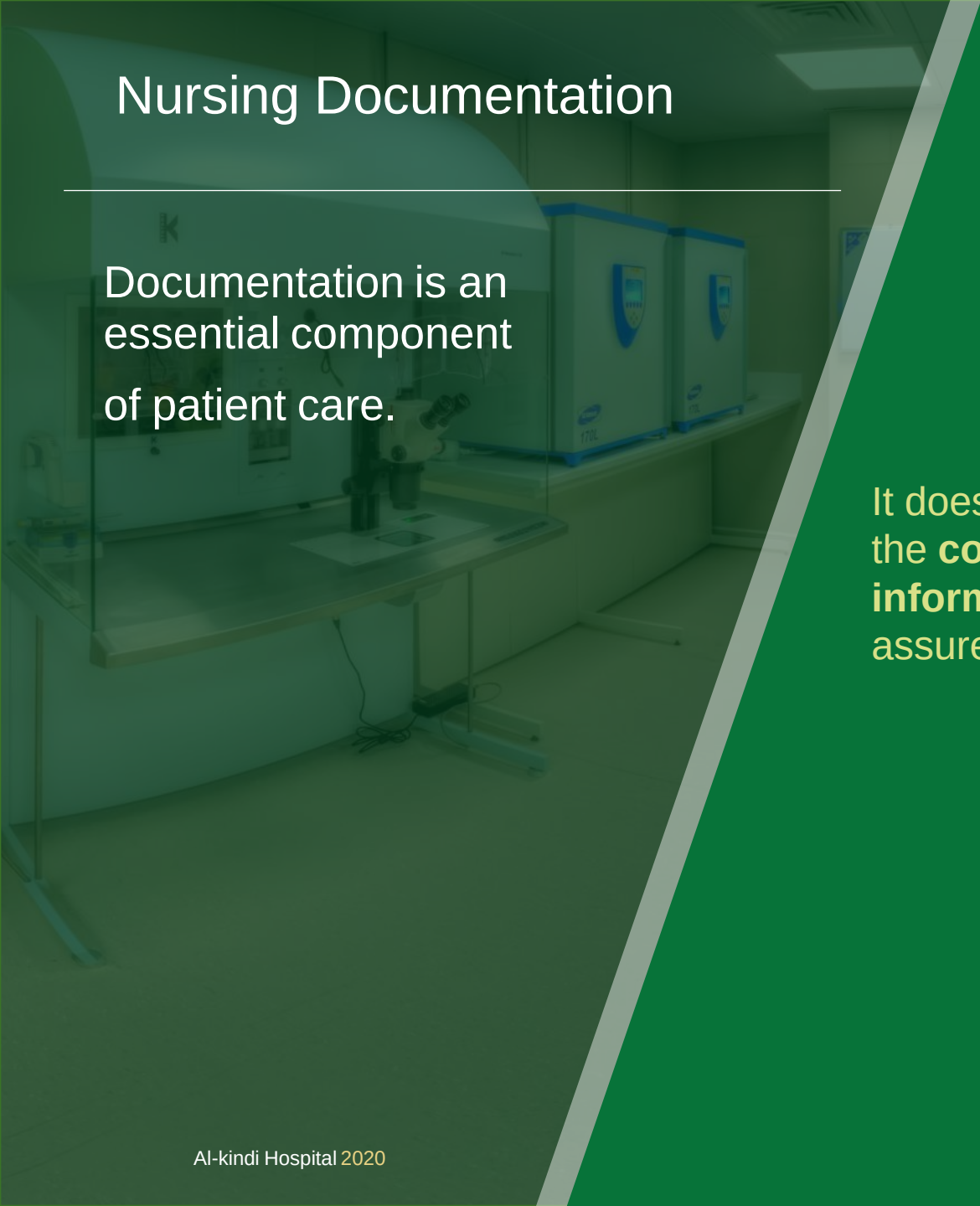
Principle of Nursing Documentation



Objectives:
By the end of this session, nurses will be able to:

►First :
►Define documentation
►Summarize the purpose of documentation in nursing
►Outline the tools of nursing documentation.
►Second :
►List general guidelines for documentation
►Identify ways for recording data errors in documentation
►Know the process for “Late Entry” in Documentation
►Recall the “Do Not Use” List
... according to Hospital policy & procedure

Nursing Documentation



Documentation is an essential component of patient care.

It does not only **provide information** about the care and the **condition** of your patient, but it also **communicates information** to other health care professionals to help assure both quality and continuity

Responsibility

Responsibility

- Applies to all Registered Nurses/ Midwives at our hospital

- All Registered Nurses/ Midwives are required to document the care they provided demonstrating accountability for their actions and decisions

Definition: Documentation

Documentation is any written or electronically generated information about a patient that describes the care or service provided to that patient

Through documentation, nurses communicate

- their observations
- decisions
- actions and
- outcomes of these actions for clients

Documentation is also known as reporting, charting or recording

Purposes for Documentation

Facilitate communication between health professionals and the continuity of care

Quality improvement

Following documentation are used to evaluate professional practice as a part of quality assurance such as:

- performance reviews
- Audits
- Accreditation processes
- Critical incident reviews

Legal issue

The client’s record is a legal document and can be used as:

- evidence in a court

Patient’s record are used to reconstruct events, establish time and dates and to justify and / or resolve conflicts

Valuable source for data research

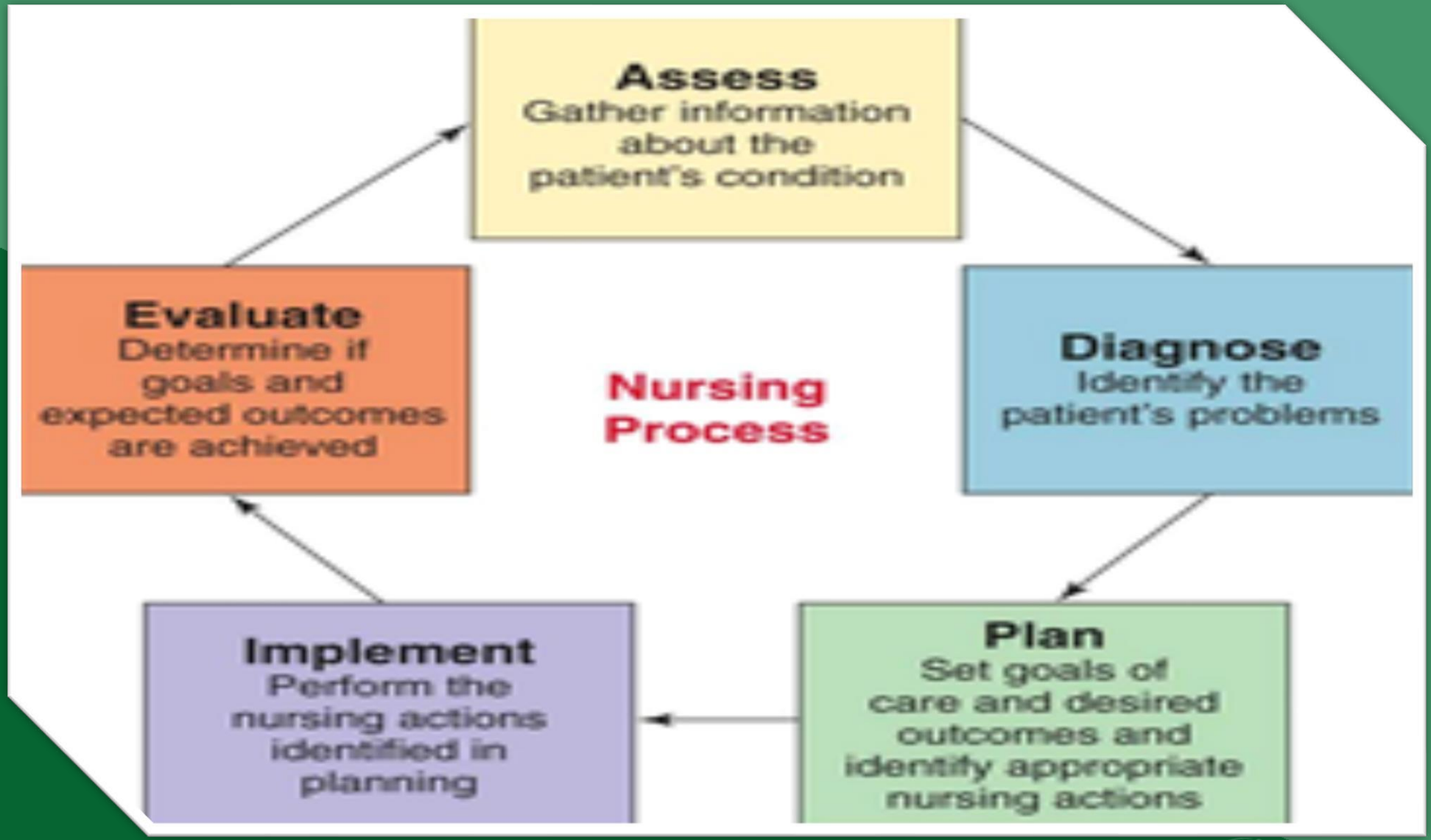
Health record documentation serves as a valuable and major source of data for nursing and health related research

For Accreditation

Definition: Nursing Process

The nursing process is one of the major guidelines (framework) for providing professional quality nursing care

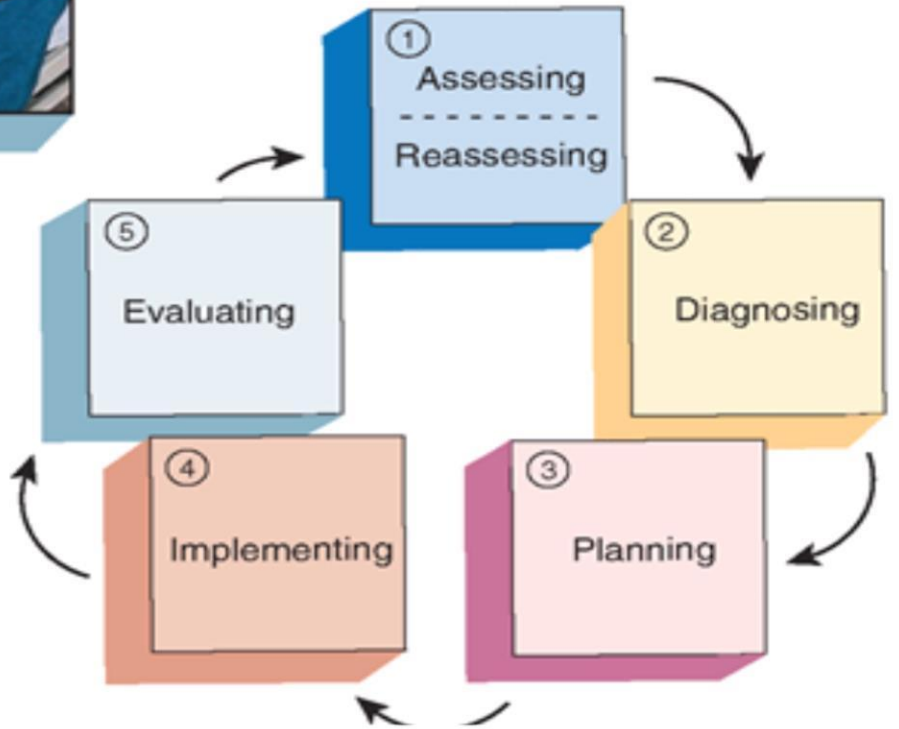
It is a systematic method, problem-solving approach to meeting the health care and caring needs of patients in order to provide a quality of care


Assess
Gather information about the patient's condition
Diagnose
Identify the patient's problems
Plan
Set goals of care and desired outcomes and identify appropriate nursing actions
Implement
Perform the nursing actions identified in planning
Evaluate
Determine if goals and expected outcomes are achieved
Nursing Process

The Nursing Process

Nurses and clients work together as partners to

- promote health
- prevent disease/illness
- restore health
- facilitate coping with altered functioning



The Nursing Process
Assessment –
Data Collection

Assessing

- Identifying priorities.
- Collecting client data through observation, interview, and physical examination.
- Continuously updating the database of information.
- Analyzing data
  - -Recognizing significant data.
  - -Validating observations.
  - -Recognizing patterns or clusters.
  - -Identifying strengths and problems.
  - -Analyzing data to reach conclusions.

Diagnosing

Planning

Implementing

Evaluating

The Nursing Process – Nursing Diagnosis

Assessing

Diagnosing

- Identification of client's or actual potential health problems
- Problems can be managed by independent nursing actions
- Guide for identifying nursing priorities and directing nursing

Planning

Implementing

Evaluating

The Nursing Process – Planning

Assessing

Diagnosing

Planning

- Setting priorities
- Establishing expected outcomes (goals/objectives)
- Selecting nursing interventions
- Writing a nursing care plan

Implementing

Evaluating

The Nursing Process – Implementation

Assessing

Diagnosing

Planning

Implementing

- Performance of nursing actions
- Continued data collection
- Communication with healthcare team
- Documentation

Evaluating

The Nursing Process – Evaluation

Assessing

Diagnosing

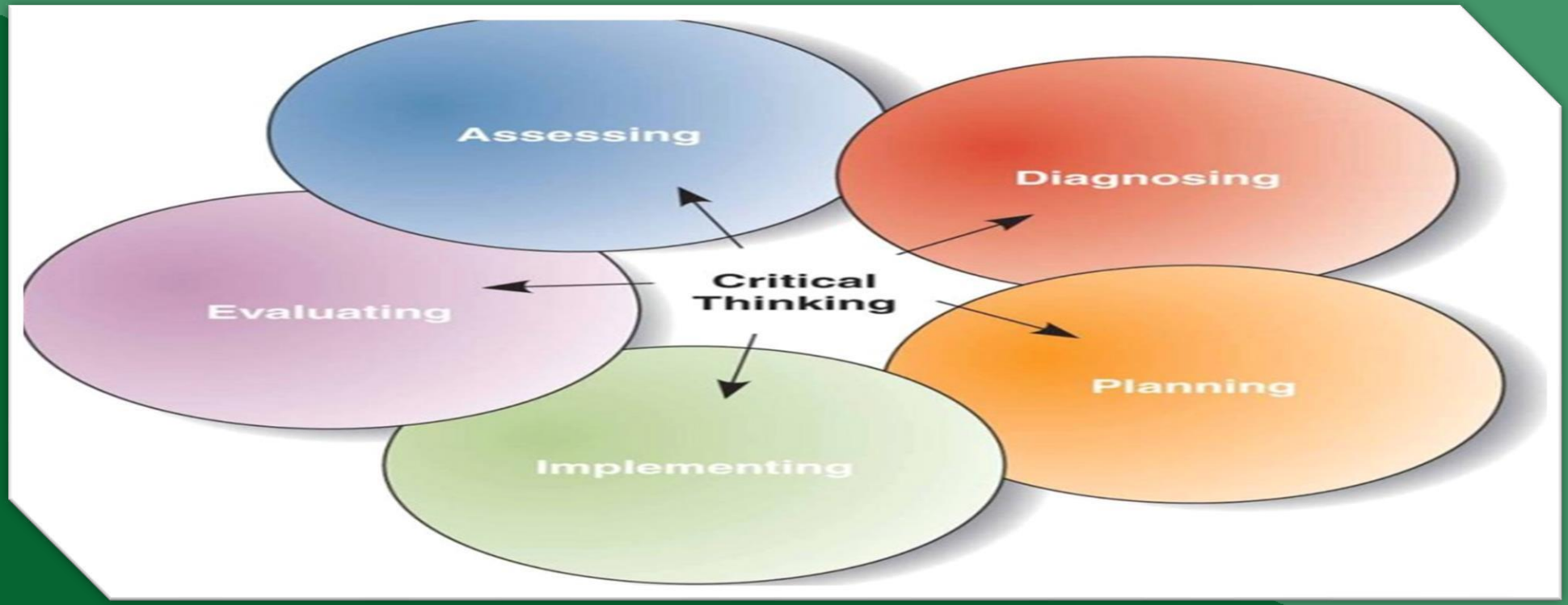
Planning

Implementing

Evaluating

- Successful responses to goals, interventions: Yes or No?
  - If "No", modify the goals and/or the interventions and rewrite the care plan
  - If "Yes", the goals and/or the interventions were successful and can be removed from an updated care plan
- Identification of factors contributing to success or failure
- Future care planning

The Nursing Process provide the foundation for critical thinking in nursing



Tools of Nursing Documentation

- **Nursing Assessment**
- **Nursing Notes**
- **Flow Sheets**
- **Medication Form**
- **Discharge Form**
- **Patient Education Form**

The Principle of Nursing Documentation

- General Guidelines for Documentation
- “Do Not Use List” Abbreviation

General Guidelines for Documentation

- Ensure that you have the correct patient record/ file before you begin charting and the Patient's name with the identifying information are on every page of the record/file

- Document/Chart as close as possible to the time care was performed

  Important details may be forgotten if charting is left until the end of the shift

- Enter information in a complete, accurate & concise
- Date and Time in each entry
- Use military time/24-hour time cycle, to avoid confusion between the two 12- hour cycles a.m. and p.m. times

  9:00 a.m. = 09:00

  9:00 p.m. = 21:00

- Sign each entry with your full legal name
- Do not leave space between entries
- Avoid duplication of information
- Documentation should record the nursing and midwifery actions, care and information provided to the client/family
- It should also include the patient's needs,

  their response to illness or any refusal

  of treatment

Cont.…

- Never change another person’s entry,
  even if it is incorrect
- Use a permanent blue ink pen
- Use correct grammar and spelling
- Use quotation marks to indicate direct client responses (e.g., “I feel terrible”)
- Document in chronological order, if chronological order is not used, state why

- ❑ Write legibly
- ❑ Document all telephone/phone calls that you make or receive that are related to a client's case (exact time, message and response)
- ❑ Avoid use of abbreviations

  (other than those approved by the organization)

Cont…

- Following Information should be included when documenting any procedures:

  - What kind of procedure(s) was performed
  - Date and time procedure was performed
  - Who performed the procedure
  - How it was performed
  - How well the patient tolerated the procedure and adverse reactions to the procedure,

- When documentation continues from one page to the next write following:

  At the bottom of the first page ***(“continued on next page”)*** write your name and sign your entry
- At the top of the next page, write following: ***(“continued from previous page”)*** at the end you write your name, title, employee number and sign your entry
- Be sure that the name of the patient is present on the next page

NURSES' PROGRESS RECORD

DATE	HOUR	PROGRESS NOTES
2/3/02	1300	to assess client's knowledge of diabetes (Continued on next page) L. White, RN

NURSES' PROGRESS RECORD

DATE	HOUR	PROGRESS NOTES
2/3/02	1300	(Continued from previous page) on the 3rd or 4th day post op L. White, RN

Figure 8-6 Entry Continues on Another Page

- Do not enter personal opinions
- Document refusal of treatment or medication and the reason why it was refused
- Document omissions (medication not given or treatment not completed) , reason & action taken

- Document only for your self
- For computer documentation keep your password to yourself and Log off when not using the system

Recording **Errors** in Documentation

Process for Recording Errors in Documentation

- Do not use correcting fluids, black marker, tape or scratch out- technique to hide a documentation error
- Draw a single line through the entry so that it is still readable
- Write “error” above the original words, place your name, Title and ID number
- The entry should be then rewritten correctly

- Do not ask other nursing staff members to leave some blank lines so that you can insert your progress note
- Do not squeeze in a late entry, delete or change previously made entries
- It is better to add this information as a Late Entry
- Add the entry to the first available line, labeling as “Late entry” to indicate that it is out of sequence

- Write the date and time, **Late Entry**
- - the time and date when you performed the intervention (in brackets) then record your information

Process for Late Entry

NURSES' PROGRESS RECORD

DATE	HOUR	PROGRESS NOTES
2/3/02	1100	Late Entry (2/3/02—0900) Client crying after talking to mother on the telephone. —L. White, RN

Figure 8-2 Recording a Late Entry

Official "Do Not Use" List[1]

Do Not Use	*Potential Problem*	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

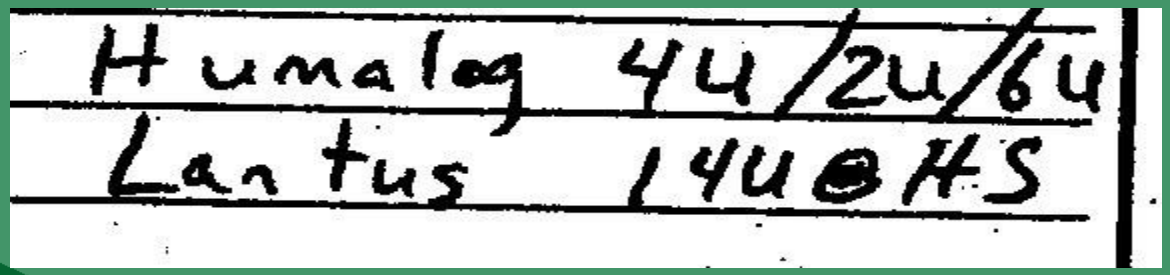
***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Additional Abbreviations, Acronyms and Symbols
(For possible future inclusion in the Official "Do Not Use" List)

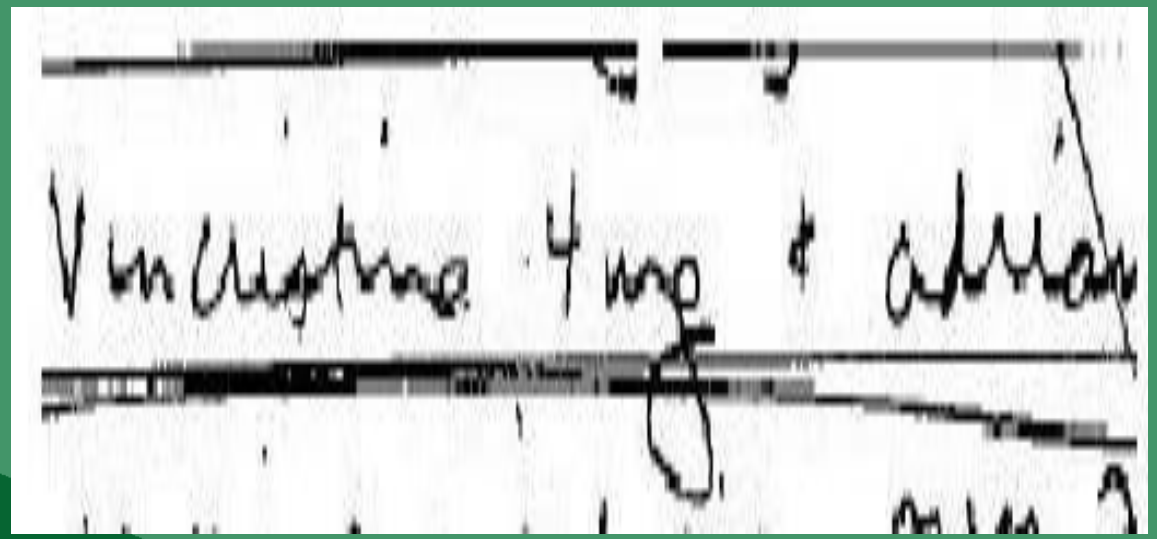
Do Not Use	*Potential Problem*	Use Instead
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for U (units) when poorly written	Write "mL" or "ml" or "milliliters" ("mL" is preferred)
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

Examples:

Examples



- **Intended dose of 4 units in patient history interpreted as 44 units. “U” should be written out as “unit.”**



- **Intended dose of ".4 mg" interpreted as 4 mg from medication order. Should be written as "0.4 mg."**

Intended recommendation of “less than 10” was interpreted as 4.

“<” should be written out as “less than.”

Each medical record contains at least the following:

- ✓ Patient information and authorized representative.
- ✓ Legal status, for mental health services.
- ✓ Emergency care prior to arrival.
- ✓ Record and findings of the patient assessment.
- ✓ Conclusion/impressions from history and physical.
- ✓ Diagnosis or diagnostic impression.
- ✓ Reason(s) for admission or treatment.
- ✓ Goals of treatment and treatment plan.

- ✓ Evidence of informed consent if required.
- ✓ Diagnostic and therapeutic procedures/tests performed and results.
- ✓ All operative and other invasive procedures performed.
- ✓ All progress notes.
- ✓ All reassessments.
- ✓ Clinical observations.
- ✓ Response to care provided.
- ✓ Consultation reports.
- ✓ Every medication ordered/prescribed for inpatients.
- ✓ Each medication dispensed/prescribed for ambulatory patient or inpatient on discharge.

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- The [organization] can quickly assemble and have access to all relevant information from components of a patient's record, when the patient is admitted or is seen for ambulatory or emergency care."

- "The medical record, computer system, or organization policy indicates when part of the record has been filed elsewhere."

- **Medical Record Review:**

- Problem List IDs significant illnesses & medical conditions.
- Medication allergies/adverse reactions are noted.
- Past medical Hx easily Identified.
- Cigarette, drugs noted.
- Progress notes identify subjective & objective info pertinent to complaint.
- Lab ordered as appropriate.
- Working dx consistent with findings.

- Tx plan consistent with diagnosis.
- Follow-up care, calls or visits are noted.
- Unresolved problems addressed in subsequent visits.
- Consults requested as appropriate.
- If consult requested, note from consultant in record.
- Immunization record up-to-date on children/adults immunization hx noted.
- Preventive screening and services offered as appropriate.
- Notes of phone calls include advice given

Which patients are at high risk for falling