Chapter (9)

Recording and Reporting

- NURSES must communicate information clearly وضوح , concisely مختصر , and accurately صحيح, both when writing and when speaking.
- **Medical records or client record or health record** السجل الطبي are written collections of information about a person's health, the care provided by health practitioners, and the client's progress.
- The hard copy paper forms are placed in **a chart** ملف المريض : binder or folder مجلد that promotes the orderly collection جمع مرتب , storage مخزن , and safekeeping حفظ آمن of a person's medical records.
- The paper forms in the chart are color coded معلمة بألوان or separated by tabbed sheets صفحات مبوبة.
- A computerized medical record is accessed by using a password and selecting the desired form from a menu قائمة . Computerized records can be printed if a hard copy is desired.
- Process of entering information is called **charting, recording, or documenting تدوين**

Uses of medical recording:

1. Permanent Account حساب دائم

- The medical record is a written, chronologic متسلسل زمنيا account حساب of person's illness or injury and the health care provided from the onset بداية of the problem through discharge الخروج or death.

2. Sharing Information تبادل للمعلومات

- Because it is impossible for all health care workers to meet and to exchange information on a personal basis at the same time, the written record becomes central to communication.
- Sharing information prevents duplication ازدواجية of care and helps to reduce تقليل the chance of error الخطأor omission النسيان .

3. Quality Assurance ضمان للجودة

Reviewing of medical records to ensure يضمن the quality of care جودة الرعاية provided is one method of quality assurance in health care agencies.

4. Accreditation الاعتماد و الترخيص

There are many criteria معايير for documentation should be evaluated for accreditation by accreditation agency وكالة الاعتماد .

5. Reimbursement سداد تكاليف العلاج

- Undocumented, incomplete, or inconsistent غير متسق documentation of care may result in a denial رفض of payment by insurance companies.

6. Education and Research للتعليم و البحث

- Client records used in research but confidentiality السرية should be protected.
- Formal permission اذن رسمي must be obtained from the client, the health agency's المؤسسة administrator ادارة , or other authority whenever a client's record is used for a purpose other than treatment and record keeping.

7. Legal Evidence: دليل قانوني

- The medical record is considered a legal document وثيقة قانونية .
- Each person who writes in the client's medical record is responsible مسئول for the information he or she records and can be summoned استدعاء as a witness شاهد to testify concerning what has been written.
- Any writing that cannot be clearly read or that is vague غامض , scribbled through مخربش عليها , or erased ممحي , written over مكتوب فوقها , whited out ممحي بالمزيل الابيض makes for a poor legal defense دفاع قانوني ضعيف .

Criteria for legally defensible charting:

- Ensure that the client's name appears on each page.
- Never chart for someone else.
- Use specified color of ink and ballpoint pen, or enter data on a computer.
- Date and time each entry as it is made.
- Chart promptly after providing care
- Make entries in chronologic order بترتيب زمني

Record facts, not subjective interpretations.

Identify documentation that is out of chronologic sequence with the words "late entry." حدد التوثيق الخارج عن التسلسل الزمني بجملة

- Never scribble تخربش over entries or use correction fluid سائل التصحيح to obliterate لمحو what has been written.
- Draw a single line through erroneous information so that it remains readable, add the date, initial, and then document the correct information ارسم خطًا عبر المعلومات الخاطئة بحيث تظل قابلة للقراءة ، وأضف التاريخ والتوقيع ثم قم بتوثيق المعلومات الصحيحة

~~Patient is unconscious~~

- Quote the client's verbal comments اقتبس كلمات المريض

(إدخال المتأخر)

- Write or print legibly بشكل مقروء .
- Reflect the plan of care اعكس خطة الرعاية
- Describe the outcomes of care اوصف نتائج الرعاية
- Use only approved abbreviations الاختصارات المعتمدة
- Record relevant details سجل التفاصيل المناسبة للحدث
- Never imply criticism of another's care لا تنتقد عمل الاخرين
- Use correct grammar and spelling املاء و قواعد صحيحة
- Leave no empty spaces between entries and signature لا تترك فراغات بين الكتابة و التوقيع

Document the circumstances for notifying a physician, the specific data reported, and the physician's recommendations اكتب كل ما يتعلق باستدعاء الطبيب و الوقت و توصيات الطبيب بخصوص الحالة

- Identify specific information provided when teaching a client and the evidence that indicates the client has understood the instructions اكتب ما تم تعليمه للمريض و الدلائل عل فهمه لها
- Sign each entry by name and title وقع في بعد كل عملية توثيق بالاسم و المسمى

Types of Client Records

1.Source-Oriented Records:

- **Source-oriented records** is organized منظمة according حسب to the source مصدر of documented information المعلومات الموثقة .
- The record contains separate forms نماذج منفصلة on which physicians الاطباء , nurses, dietitians اخصائي التغذية , physical therapists اخصائي العلاج الطبيعي , and other health care providers make written entries about their own specific activities in relation to the client's care.
- Frequently the fragmented documentation التوثيق المجزأ gives the impression انطباع that each professional is working independently of the others كل مهنة تعمل بمعزل عن الاخرى .

2. Problem-Oriented Records:

- **Problem-oriented record** is organized according to the client's health problems مشاكل المريض الصحية.
- In contrast to source-oriented records that contain numerous locations for information, problem-oriented records contain four major components:
  1. **Data base قاعدة البيانات :** Contains initial health information المعلومات الصحية الأولية

2. **Problem list قائمة المشاكل** : Consists of a numeric list of the client's health problems
3. **Plan of care خطة الرعاية :** Identifies methods for solving each identified health problem
4. **Progress notes ملاحظات تطور الحالة** : Describes the client's responses to what has been done and revisions to the initial plan

Method of charting طرق التوثيق

1. **Narrative charting التوثيق السردي :** style of documentation generally used in source-oriented records.
    - It involves writing information about the client and client care in chronologic order ترتيب زمني.
    - There is no established format for narrative notations; the content resembles a log or journal.
    - It is time-consuming to write and read تستغرق وقتا للكتابة و القراءة .
    - Depending on the skill of the person writing the entries, he or she may omit حذف pertinent documentation معلومات مهمة or include يدرج insignificant information معلومات غير مهمة.
2. **SOAP Charting:** documentation style more likely to be used in a problem-oriented record.

- Four essential components included in a progress note:

  S= Subjective data

  O= Objective data

  A= Analysis of the data

  P= Plan for care

- Some agencies have expanded the SOAP format to SOAPIE or SOAPIER (**I** = Interventions, **E** = Evaluation, **R**= Revision to the plan of care).
- SOAP charting also helps to demonstrate تظهر interdisciplinary cooperation التعاون بين التخصصات المختلفة because everyone involved in the care of a client makes entries in the same location in the chart.

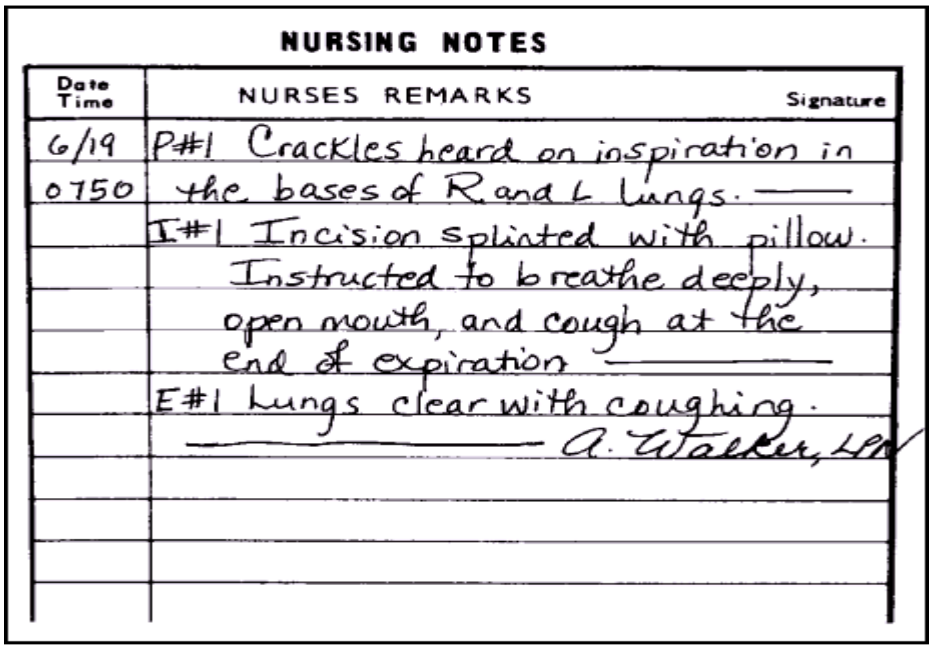
SOAPIER charting format

LETTER	EXPLANATION	EXAMPLE OF RECORDING
S = Subjective information	Information reported by the client	S–"I don't feel well."
O = Objective information	Observations made by the nurse	O–Temperature 102.4°F
A = Analysis	Problem identification	A–Fever
P = Plan	Proposed treatment	P–Offer extra fluids and monitor body temperature.
I = Implementation	Care provided	I–750 mL of fluid intake in 8 hours; temperature assessed every 4 hours
E = Evaluation	Outcome of treatment	E–Temperature reduced to 101°F
R = Revision	Changes in treatment	R–Increase fluid intake to 1000 mL per shift until temperature is ≤ 100°F.

3. **Focus charting**: modified form of SOAP charting which uses the word focus rather than problem because some believe that the word problem carries negative connotations.
    - Instead of using the SOAP format to make entries, focus charting follows a **DAR model** (**D** =data, **A**=action, **R** =response).
    - DAR notations tend to reflect the steps in the nursing process.

6/30/2007	D(ata) –	Bladder distended 2 fingers above pubis.
1015		Has not urinated in 8 hrs. since
		catheter was removed. ——
	A(ction) –	Assisted to toilet. Water turned on at
		faucet. Instructed to press over bladder
		with hands. ——
	R(esponse) –	Voided 525 mL of clear urine. L.Cass, SN

4. **PIE charting**: method of recording the client's progress under the headings of problem, intervention, and evaluation.
    - When nurses use the PIE method, they document assessments on a separate form نموذج منفصل and give the client's problems a corresponding number.
    - They use the numbers subsequently in the progress notes when referring to interventions and the client's responses



NURSING NOTES

Date Time	NURSES REMARKS	Signature
6/19 0750	P#1 Crackles heard on inspiration in the bases of R and L lungs. ——	
	I#1 Incision splinted with pillow. Instructed to breathe deeply, open mouth, and cough at the end of expiration ——	
	E#1 Lungs clear with coughing. —— A. Walker, LPN	

5. Charting by exception التوثيق بالاستثناء : is a documentation method in which nurses chart only abnormal assessment findings or care that deviates from the standard.

- Charting by exception provides quick access وصول سريع to abnormal findings للنتائج الغير طبيعية because it does not describe normal and routine information.

6. Computerized charting: documenting client information electronically.

- It is most useful for nurses when a terminal شاشة الادخال is available at the point of care or bedside.

Advantages of computerized charting:

- The information is always legible مقروءة.
- It automatically تلقائيا records تسجل the date and time of the documentation.
- The abbreviations and terms are consistent متماشية with agency- approved lists.
- It eliminates trivia الأشياء البسيطة الغير مهمة.
- Omissions النسيان are fewer because the computer prompts the nurse to enter specific information.
- It saves time توفر الوقت because it eliminates delays in obtaining the chart.
- It reduces overtime العمل الاضافي costs تكاليف for uncompleted end-of-shift charting للتوثيق الغير مكتمل في نهاية فترة الدوام.
- Electronic data require less storage space اقل مساحة تخزين and are quickly retrievable سهلة الاسترجاع.

The major disadvantages computerized charting :

- The initial expense المصاريف الاولية of purchasing لشراء computer system and training تدريب personnel to use it.
- Power failure انقطاع التيار الكهربائي or electronic malfunction الاعطال الكهربائية
- Passwords must be changed regularly يجب تغيير كلمات المرور بانتظام
- Temporary use of paper charting when electronic system is failed استخدام الاوراق في حال فشل النظام
- Information is scattered among various files المعلومات مبعثرة في اكثر من ملف
- Promotes double charting (repetitious entry of same information) الادخال المتكرر لنفس المعلومات
- Confidentiality of information may be compromised قد يتم اختراق سرية المعلومات

Protection health information:

- The names of clients on charts can no longer be visible to the public يجب اخفاء اسماء المرضى عن الملف الطبي
- White boards الالواح البيضاء must be free of information linking تربط a client with a diagnosis التشخيص, procedure الاجراء , or treatment العلاج .
- Computer screens شاشات الكمبيوتر must be oriented away موجهة بعيدا from public view; flat screen شاشات مسطحة monitors are recommended because they are more difficult to read at obtuse angles زاوية منفرجة .
- Conversations الحوارات regarding clients عن المرضى must take place in private places اماكن خاصة where they cannot be overheard.
- Facsimile (fax) machines, filing cabinets خزانات الملفات , and medical records must be located in areas off-limit to the public محظورة على الجمهور .
- A cover sheet ورقة الغلاف and a statement جملة بيان indicating that faxed data المعلومات المرسلة بالفاكس contain confidential information معلومات سرية must accompany ترفق electronically transmitted information بالمعلومات المنقولة الكترونيا .
- Light boxes جهاز الاضاءة for examining x-rays or other diagnostic scans on which the client's name appears must be in private areas.
- Documentation must be kept of people who have accessed مسموح لهم بالخول a client's record.

NB: <u>Maintaining confidentiality is more difficult with computerized data keeping.</u>

Documenting information

- Each agency مؤسسة sets its own documentation policies سياسات .
- In addition to identifying the method for charting, such policies generally indicate the type of information recorded on each chart form, the people responsible for charting, and the frequency عدد for making entries on the record.

Content of Nursing Documentation

Nurses or those to whom they delegate client care are responsible for documenting

- Assessment data
- Client care needs
- Routine care such as hygiene measures
- Safety precautions that have been used احتياطات السلامة التي تم استخدامها
- Nursing interventions described in the care plan
- Medical treatments prescribed by the physician
- Outcomes of treatment and nursing interventions
- Client activity
- Medication administration
- Percentage of food consumed at each meal نسبة المواد الغذائية المستهلكة في كل وجبة
- Visits or consults by physicians or other health professionals
- Reasons for contacting the physician and the outcome of the communication
- Transportation نقل to other departments, like the radiography department, for specialized care or diagnostic tests, and time of return
- Client teaching and discharge instructions
- Referrals to other health care agencies

Using Abbreviations

Abbreviations shorten the length of documentation and the time required for this task.

abd.	Abdomen	**OOB**	out of bed
a.c.	before meals	**OR**	operating room
approx.	Approximately	**per**	by or through
b.i.d.	twice a day	**P**	pulse
BM	bowel movement	**p.c.**	after meals
BP	blood pressure	**p.o.**	by mouth
bpm	beats per minute	**Postop.**	postoperative
c̄	With	**Preop.**	preoperative
C	Centigrade	**pt.**	patient
CCU	coronary care unit	**PT**	physical therapy

c/o	complains of	**q**	every
dc	Discontinue	**q.i.d.**	four times a day
ED	emergency department	**s̄**	Without
H2O	Water	**stat**	Immediately
I & O	intake and output	**t.i.d.**	three times a day
IM	Intramuscular	**TPR**	temperature, pulse, respirations
IV	Intravenous	**UA**	Urinalysis
kg	Kilogram	**via**	by way of
NPO	nothing by mouth	**WC**	Wheelchair
NS	normal saline solution	**WN**	within normal limits
O2	Oxygen	**Wt.**	Weight
OB	Obstetrics		

Communication for Continuity and collaboration

- Although the record serves as an ongoing source of information about the client's status, nurses use other methods of communication to promote continuity of care and collaboration among the health personnel involved in the client's care. These methods are in **written** or **verbal** form.

Written forms of communication:

1) Nursing care plan خطة الرعاية التمريضية
2) Nursing Kardex كاردكس
3) Checklists قوائم فحص
4) Flow sheets

1. Nursing care plan

- **A nursing care plan** is a written list of the client's problems, goals, and nursing orders for client care.
- The written components are clear, concise, and legible. The information is never obliterated لا تمحى; only approved abbreviations are used.

2. Nursing Kardex

- **The nursing Kardex is** a quick reference مرجع سريع for current information about the client and his or her care.
- The information in the Kardex changes frequently تتغير بشكل دائم , sometimes several times in one day. The Kardex form **is not** a part of the permanent record. Therefore, nurses can write information in pencil قلم رصاص and erase يمحي .
- The Kardex forms for all clients are kept تحفظ in a folder مجلد that allows caregivers to flip ينتقل from one to another.

- **The Kardex has the following uses:**
    - Locate clients by name and room number تحديد موقع المرضى بالاسم ورقم الغرفة
    - Identify each client's physician and medical diagnosis
    - Serve as a reference for a change of shift report كمرجع تقرير تغيير المناوبة
    - Serve as a guide for making nursing assignments دليل لتحديد مهام التمريض
    - Provide a rapid resource for current medical orders on each client مصدر سريع للاوامر الطبية لكل مريض
    - Specify the client's code or DNR (do not resuscitate) status يحدد امر لا تحاول انعاش قلب المريض
    - Check quickly on a client's diet مراجعة سريعة لغذاء المريض
    - Alert nursing personnel to a client's scheduled tests or test preparations تنبيه التمريض إلى الاختبارات المجدولة للمريض أو التجهيزات المطلوبة للاختبار
    - Inform staff of a client's current level of activity تحديد مستوى النشاط للمريض
    - Identify comfort or assistive measures a client may require تحديد وسائل الراحة المطلوبة للمريض
    - Provide a tool for estimating the personnel-to-client ratio for a nursing unit يوفر أداة لتقدير نسبة التمريض إلى المرضى

3. Checklists

- **A checklist** is a form of documentation in which the nurse indicates with a check mark or initials the performance of routine care. شكل من أشكال التوثيق يشير فيه الممرض بعلامة اختيار أو بالأحرف الأولى إلى أداء الرعاية الروتينية
- It is an alternative to writing a narrative note. بديل للطريقة السردية
- Nurses use checklists primarily to avoid لتجنب documenting types of care that are regularly repeated such as bathing and mouth care.

4. Flow Sheets

- **A flow sheet** is a form of documentation with sections for recording frequently repeated assessment data. شكل من أشكال التوثيق لتسجيل بيانات التقييم المتكررة
- It enables nurses to evaluate trends because similar information is located on one form.

Interpersonal Communication

- In addition to using written resources (e.g., the medical record) to exchange information, communication also takes place during personal interactions التواصل الفردي among health professionals.
- Some examples are as follows:
    1) **Change of shift reports**
    2) **Client assignments**
    3) **Team conferences**
    4) **Rounds**
    5) **Telephone calls**

1) Change of shift reports

Is s a discussion between a nursing spokes person from the shift that is ending and personnel coming on duty.

A change of shift report usually includes:

- Name of client, age, and room number
- Name of physician
- Medical diagnosis or surgical procedure and date
- Range in vital signs
- Abnormal assessment data
- Characteristics of pain, medication, amount, time last administered, and outcome achieved
- Type of diet and percentage consumed at each meal
- Special body position and level of activity, if applicable
- Scheduled diagnostic tests
- Test results, including those performed by the nurse, such as blood glucose levels
- Changes in medical orders including newly prescribed drugs
- Intake and output totals
- Type and rate of infusing intravenous fluid السوائل الوريدية
- Amount of intravenous fluid that remains
- Settings اعدادات on electronic equipment such as amount of suction
- Condition of incision جرح and dressing الغيار , if applicable
- Color and amount of wound or suction drainage

2. Client Care Assignments توزيع المهام لرعاية المريض

- Client care assignments are made at the beginning of each shift. Assignments are posted تنشر , discussed تناقش with team members, or written on a worksheet. يتم نشر الواجبات أو مناقشتها مع أعضاء الفريق أو كتابتها في ورقة عمل.
- Each assignment identifies the clients for whom the staff person is responsible and describes their care. Meals and break times also may be scheduled as well as special tasks such as checking and restocking supplies.

3. Team Conferences اجتماعات الفريق

- **Conferences** commonly are used to exchange information.
- **Topics generally include:**
  - Client care problems
  - Personnel conflicts
  - New equipment or treatment methods
  - Changes in policies السياسات or procedures الاجراءات .
- Team conferences often include the nursing staff, staff from other departments involved in client care, physicians, social workers, personnel from community agencies, and, in some cases, clients and their significant others.

4. Client Rounds مرور المرضى

- **Rounds** is visit to clients on an individual basis or as a group
- Rounds are used as a means of learning firsthand about clients. The client is a witness شاهد to and often an active participant مشارك نشط in the interaction التفاعل .
- Some nurses use walking rounds as a method of giving a change of shift report.
- **Advantages of giving a change of shift report in the client's presence:**
  - Enables oncoming staff with an opportunity to survey لتقصى the client's condition
  - Enables oncoming staff to determine the status of equipment معدات used in client's care
  - Increases the client's confidence ثقة and security شعوره بالأمان in the transition of care.
- However, agencies avoid this type of communication if another client shares the room or if the client has not authorized family members or friends who may be visiting to have access to their health information.

5. Telephone

Nurses use the telephone to exchange information when it is difficult for people to get together or when they must communicate information quickly.

When using the telephone, the nurse does the following:

- Answers as promptly as possible الاجابة في اسرع وقت
- Speaks in a normal tone of voice تحدث بنبرة صوت عادية
- Identifies himself or herself by name, title, and nursing unit تعريف عن النفس و المسمى الوظيفي و القسم
- Obtains or states the reason for the call اوضح السبب من الاتصال
- Discretely identifies the client being discussed to avoid being publicly overheard يحدد بسرية المريض الذي تتم مناقشة حالته لتجنب سماعه علنًا
- Spells the client's name if there is any chance of confusion تهجئة اسم المريض إذا كان هناك أي احتمال للشك
- Converses in a courteous and business-like manner يتحدث بطريقة مهذبة ورسمية
- Repeats كرر information to ensure لضمان it has been heard accurately