Documentation and Recordkeeping

BELMATT
HEALTHCARE TRAINING

Learning outcomes

This session will develop your knowledge and skills in:

- Understand the importance of documentation
- Documenting in a structured logical manner
- Importance of communication and documentation
- Consent and documentation
- Ethical and Legal issues

Recordkeeping

- Good record keeping is a vital part of effective communication in nursing and integral to promoting safety and continuity of care
- Nursing staff need to be clear about their responsibilities for record keeping in whatever format records are kept.

Why document nursing interventions

Written evidence of:

- The interactions between and among health care professionals, clients, their families, and health care organizations.
- The administration of tests, procedures, treatments, and client education.
- The results of, or client's response to, diagnostic tests and interventions

Purposes of Documentation

- Professional responsibility
- Accountability
- Communication
- Education
- Research

Importance of Documentation

- Documentation is a communication method that confirms the care provided to the client.
- It clearly outlines all important information regarding the client.
- The medical record can be used by health care students as a teaching tool.
- It is a main source of data for clinical research
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Legal Implications

- Nurses are responsible for assessing and documenting that the client has an understanding of treatment prior to intervention.

- Two indicators of the above are Informed Consent and Advance Directives.

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Consent and Documentation

- . Important to document the consent process particularly if the intervention is invasive, complex or involves significant risks/consequences for the person.

- Consent generally need not be given in writing, but if given verbally should be recorded in the person's notes.

Legal & Practice Standards

- Nurses are responsible for assessing and documenting that the client has an understanding of treatment prior to intervention.

- Two indicators of the above are Informed Consent and Advance Directives.

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.

Advanced Directives

- Written instructions about a client's health care preferences regarding life-sustaining measures. (e.g. living will and durable power of attorney for health care).

- Allows clients, while competent, to participate in end-of-life decisions.

Documentation & Reimbursement

- Accreditation and reimbursement agencies require accurate and thorough documentation of the nursing care rendered and the client's response to interventions.

Principles of Effective Documentation

Elements of nursing process needed to be made evident in documentation include:

- Assessment.
- Nursing Diagnosis.
- Planning and outcome identification.
- Implementation.
- Evaluation.
- Revisions of planned care.

Elements of Effective Documentation

To ensure effective documentation, nurses should:

- Use a common vocabulary.
- Write legibly and neatly.
- Use only authorized abbreviations and symbols.
- Employ factual and time-sequenced organization.
- Document accurately and completely, including any errors.

Methods of Documentation

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

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.

Source-Oriented Charting

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

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

PIE Charting

- PROBLEM
- INTERVENTION
- EVALUATION

Focus Charting

- A documentation method that uses a column format to chart data, action, and response (DAR).

Charting by Exception

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

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Computerized Documentation: Advantages

- 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.

Critical Pathways

- 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.

Forms for Recording Data

- Kardex
- Flow Sheets
- Nurse’s Progress Notes
- Discharge Summary

Kardex

- A summary worksheet reference of basic information that traditionally is not part of the record. Usually contains:
  - Client data (name, age, marital status, religious preference, physician, family contact).
  - Medical diagnoses: listed by priority.
  - Allergies.
  - Medical orders (diet, IV therapy, etc.).
  - Activities permitted.

Flow Sheets

- Vertical or horizontal columns for recording dates and times and related assessment and intervention information. Also included are notes on:
  - Client teaching.
  - Use of special equipment.
  - IV Therapy.

Nurse's Progress Notes

- Used to document:
  - Client's condition, problems, and complaints.
  - Interventions.
  - Client's response to interventions.
  - Achievement of outcomes.

Discharge Summary

Highlights client's illness and course of care.

Includes:

- Client's status at admission and discharge.
- Brief summary of client's care.
- Intervention and education outcomes.
- Resolved problems and continuing care needs.
- Client instructions regarding medications, diet, food-drug interactions, activity, treatments, follow-up and other special needs.

Documentation

- Anything written or printed that is relied on as a record of proof for authorized persons
- Reflects quality of care
- Provides evidence of healthcare team members care rendered