POLICY ON DOCUMENTATION

POLICY NO: NSO-021

DIVISION: NURSING SERVICE DIVISION

POLICY REVIEW DATE: July 12, 2016

Reviewed by:		
Juliet S. Condes, RN CQI Committee Chair	Nestor O. Beato, RN QA- Committee Chair	Angeline L. Brillante, RN, MAN Assistant Chief Nurse
Reviewed by:		Approved by:
Arleen G. Herrera, RN, MAN OIC- Nursing Division	Lea Grace M. Vasquez, MD Chief of Clinics	Ephraim Neal C. Orteza, MD,MHA Hospital Director

OBJECTIVES:

I. To provide legal records that can be used to protect the patient, health professionals and health facilities that provide care.
II. To provide a way for a health team professionals to communicate with each other.
III. To provide data needed for effective interdisciplinary care and to ensure continuity of care.
IV. To furnish written record of quality care.
V. To provide a record of services rendered to the patient

RESPONSIBILITIES:

I. It shall be the responsibility of the Head of every Division, to orient all their staff with regard to this policy and to monitor the compliance.
II. It shall be the responsibility of all staff to follow set standard policy on documentation.

POLICY:

This policy shall enforce that all abide with the guidelines incorporated into it.

Legal guidelines in Documentation

DO's in Documentation:

1. Write legibly or present neatly, illegibly entries can cause misunderstanding leading to error.
2. Use permanent ink, the used of colored ink depends on hospital policy.

3. Write entries in constructive and chronological order as soon as case has been provided. Be factual and specific.
4. Give the date and time of every entry, sign your entry with your full signature. The signature clarifies who is responsible for the care.
5. Describe the care provided and the patient's response to it. Include the patient and family's response to health teaching.
6. Promptly document any changes in patient's condition and the action taken based on that change. Use patient and family quotes.
7. Chart only for yourself. Do not chart in advance as patient condition may change anytime.
8. Correct error promptly as these may lead to error in treatment. To correct an error, simply draw a line through that error and write the word "ERROR" above it. Sign your name and write the date and time this was done.
9. Review notation before signing them. This helps minimize the need for subsequent corrections or addenda.
10. Draw a line through an empty space at the end of an entry or at the bottom of the page.
11. Complete all boxes or blanks if forms are used. If no information is available or an item on the form is not applicable, indicate this in the box or blank so that it is clear that you didn't disregard the item.
12. Stick to the facts and choose your words carefully if a mishap occurs. Do not argue your case in the medical record. Defensive entries can damage the credibility of the entire record.
13. Use only hospital-approved abbreviations and symbols.

DONT's in Documentation:

1. Relying on memory. Facts may be forgotten or distorted with the passage of time.
2. Making retaliating remarks or critical comments regarding the patient or any member of the health team. These may be used against health team member for unprofessional conduct or poor quality care.
3. Erasing or applying correction fluid or crossing out words beyond recognition. It may seem to be an attempt to cover up incriminating evidence.
4. Leaving gaps or blanks spaces on narrative notes between entries and your signature. Another person may add incorrect data.
5. Using abbreviation except where they are clear and appear on the hospital's list of accepted abbreviation.
6. Using generalized empty phrase such as " Status unchanged" or " patient had a good day"

12 Rights in giving the medications:

1. Right Drug
2. Right patient
3. Right dosage
4. Right route
5. Right time and frequency
6. Right Expiration
7. Right Assessment

8. Right education and information (teach the patient about the drug he is taking)
9. Right to Refuse
10. Right documentation
11. Right Evaluation
12. Right Reason

COMMON ABBREVIATION GUIDE TO NURSES ON CHARTING

ABBREVIATION	STANDS FOR	MEANS
a.c.	antecebos	before food or meals
abd	abdomen	abdomen
amp	amperage	ampule
amt.	-	amount
ASAP	-	as soon as possible
b.i.d.	bis indie	two times a day
BMR	-	basal metabolic rate
B.P.	-	blood pressure
C	-	centigrade
CR	-	cardiac rate
Cap.	capsula	capsule
Cath	cathartic	catheter
DAT	-	diet as tolerated
ECG	-	electro cardiogram
I.Q.	-	intelligence quotient
I.U	-	international units
ID	-	intra dermal
IM	-	intra muscular

IV	-	intravenous
OD	on diem	once a day/daily
Inj.	Injection	injection
I&O	-	intake and output
KUB	-	kidney, ureter, bladder
Liq.	Liquor	liquid
Meq.	-	milliequivalent
N.I.H.	-	National Institute of Health
NPO	-	nothing per orem
O2 Sat	-	oxygen saturation
pc.	Post cibum	after meal
p.o.	per orem	by mouth
p.r.n.	pro re nata	according as circumstances require
q.h	quaque hora	every hour
q.2h	quaquesegunda hora	every 2 hours
q.3h	quaquetertia hora	every 3 hours
q.4h	quaquequarta hora	every 4 hours
q.i.d.	quarter in del	4 times a day
RR.	-	respiratory rate
r.b.c.	-	red blood cell
SC	sub cutem	under the skin, subcutaneously
Sig.	signa	write, signature
Sol.	Solution	solution, soluble
Stat.	statim	immediately
Supp.	Suppositorium	suppository
Syr.	Syrupus	syrup

TB	tubercle baccilus	tuberculosis
TID	tur in dei	3 times a day
Ugm	-	microgram
TPR	-	temperature, pulse, respiration
Tab.	Tablet	tablet
Tinct.	Tincture	tincture
v.d.	-	venereal diseases
v/s	-	vital signs
v/v	-	volume in volume
v/w	-	volume in weight
w.b.c.	-	white blood cell

Special Considerations:

1. The initial dose of newly ordered medications should be started as soon as drug is available unless a specified times for starting it is given. The next dose should be given according to standard practice.
2. Standing order medications and treatments are cancelled/discontinued under the following circumstances:
    a. When a patient goes to surgery, laboratory, delivery

STANDARD HOURS OF ADMINISTERING DRUGS:

OD - 8AM

BID - 8AM – 6PM

TID - 8AM – 1PM – 6PM

QID - 8AM – 12PM – 4PM – 8PM

AC - 30 minutes before meal

PC - one hour after meal

HS - 9PM or at bedtime

Q

Q2hrs - 8, 10, 12PM, 2, 4, 6, 8, round the clock

Q3hrs - 9, 12, 3, 6, 9, 12, (or depending upon the initial dose time)

Q4hrs - 8, 12, 4, 8, 12, round the clock

Q6hrs - 12, 6, 12, 6

Q8hrs - 8, 4, 12, - 8PM – 4AM

PRN - if necessary (no exact time, only indication)

Q12 - 12-12, 6-6, 8-8

ASAP - as soon as possible

NPO - nothing per orem

PROCEDURES:

App - appendectomy

D&C - dilatation and curettage

CS - caesarean section

BTL - bilateral tubal ligation

ORIF - open reduction internal fixation

Amp B/K - amputation below knee

Amp A/K - amputation above knee

Ex lap - exploratory laparotomy

DISEASES:

AF - atrial fibrillation

AGE - acute gastroenteritis

AIDS - acquired immunodeficiency syndrome

MI - myocardial infarction

ARF - acute respiratory failure

ARDS - acute respiratory distress syndrome

Ca - carcinoma

CAD -coronary artery disease

CAP -community acquired pneumonia

DIAGNOSTICS:

CXR - chest xray

AP/L - antero-posterio / lateral view

UTZ - ultrasound

CT/CAT SCAN- computer (axial) tomography scan

MRI - magnetic resonance imaging

ECG/EKG - electro cardiography

CBC - complete blood count

Hg - hemoglobin

Hct - hematocrit

WBC - white blood cell

BldChem - blood chemistry

BUN - blood urea nitrogen

Crea - creatinine

PT - Prothrombin time

PTT - partial thromboplastine time

CT/BT - clotting time/bleeding time

SGOT - serum glutamicoxalo-acetic acid

SGPT - serum glutamic pyruvic transaminase

TC - total cholesterol

TG - triglyceride

TPAG - total protein – albumin globulin ratio

C/S - culture and sensitivity

ABG - arterial blood gas

FWB - fresh whole blood

PRBC - packed red blood cell

HGT -hemogluco test

CBG - capillary blood glucose

UA - urinalysis

COLOR OF MEDICINE CARDS:

OD - white

BID - green

TID - yellow

QID - pink

PRN - red

Q6 - blue

Q12 - green

Q8 - orange

HS - yellow

STAT - red

Q4 - pink

ROUTE FOR ADMINISTRATION:

SL - sublingual

TIV - through intravenous

IM - intramuscular

SQ - subcutaneous

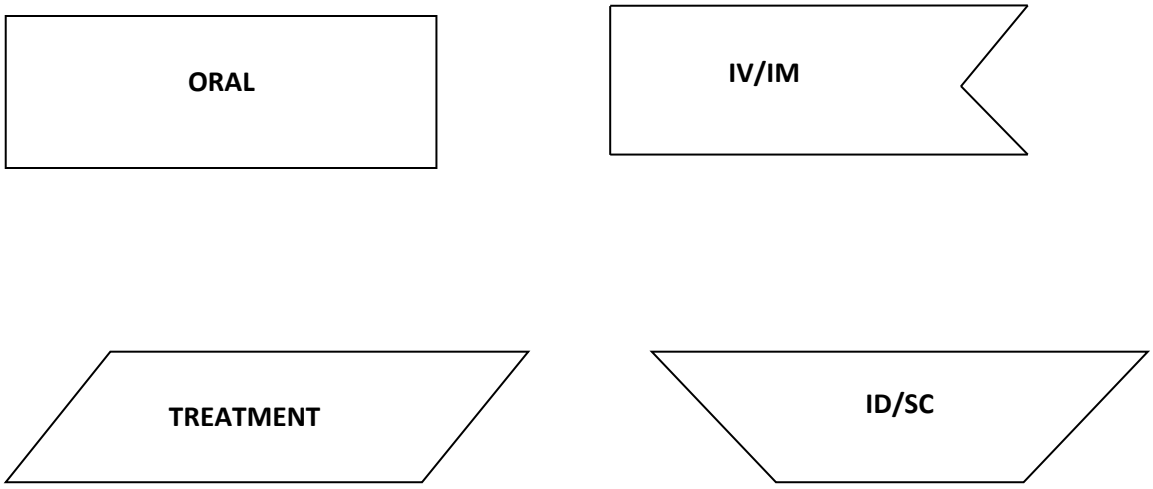
ID - intradermal

NGT - nasogastric tube

CATH - catheter

"U"/IU – international unit

SHAPES OF MEDICINE CARDS:



OBSOLETE TERM	REASON	SUGGESTED PHRASE
Conscious Coherent	Only for patients whose neurological status is affected and disoriented	Patient oriented to date, time and place
Vital signs taken	Vital signs are already written on the monitoring sheet	Document of you were not able to take vital signs and why
Afebrile	Temperature is included in the monitoring sheet, status can be deducted here	If the patient is febrile support it with subjective and objective cues Evaluate effectiveness of nursing intervention for fever, include element of time
Due meds given	Recording of medications given is on the medication sheet	Document medications that were not given and indicate the reason Document stat medications given, its indications and evaluate effectiveness
Seen at intervals	It is expected that we visit the patient at intervals	Visit patients frequently and assess for any complications
Needs attended	It is expected that we make	Enumerate measures done to make

Kept comfortable Kept undisturbed Kept safe	the patients comfortable during their hospital stay	the patient comfortable Verbalized needs must also be documented and referred to the doctors as necessary
Slept fairly Slept well Asleep the whole shift	Only noted if the patient is having sleeping difficulty	If the patient has difficulty sleeping, document subjective cues, interventions done and evaluation "Slept for approximately 5 hours as verbalized by the patient"
MGH	Not an accepted abbreviation	"Patient seen by DrGueco with discharge order given"
On DFA With fair/good appetite	DFA is not an accepted abbreviation Include a recording of the food intake if the appetite was affected by the illness	"Patient was able to eat half of the food that was served for lunch" Include the instruction given regarding the prescribed diet and the patient's compliance
No complaints made For further management	Do not document something that did not happen	
No pain		Note pain level and characteristics (PQRST) Evaluate patient's response to interventions done "Denies any pain at this time"
S.O.	Not an accepted abbreviation	If abbreviations are used they should be standardized throughout the agency Abbreviations must be consistent so that they mean the same thing to everyone reading the record

Forbidden Abbreviations

DO NOT USE	POTENTIAL PROBLEM	USE INSTEAD
U (Unit)	Mistaken for "0", "4" or "cc"	"unit"
IU (International Unit)	Mistaken for "IV" or "10"	"international unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod, EOD (every other day)	Mistaken for each other. Period after "Q" mistaken for "I" and the "O" mistaken for "I"	"daily" "every other day"
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium	"morphine sulfate" "magnesium sulfate"

	sulfate Mistaken for one another	
> greater than < less than	Misinterpreted as "7" or "L"	"greater than" "less than"
HS (half-strength) Hs (at bedtime, hour of sleep)	Mistaken as "bedtime Mistaken as "half strength"	"half strength" "bedtime"
SC, SO, sub (subcutaneous)	"SC" mistaken as "SL"; mistaken as "every", the "q" in "sub q" has been mistaken as "every"	"subcut" or "subcutaneously"
Abbreviations for drug names	Misinterpreted due to similar abbreviations	Write drug names in full
Trailing zero (X.0 mg)* Lack of leading zero (.Xmg)*	Decimal point is missed	Write X mg Write 0.X mg

Standards on Nursing Documentation

Standard I: Structural Data

The nurse documents structural data of each patient accurately and completely based on applicable laws and regulations, professional standards and institutional requirements.

Measurable Elements

1. There is an accurate and complete documentation of patients' structural data in all nursing and applicable forms which include but are not limited to the following:

    Patient's addressograph – name, age, gender, civil status, date of birth
    Registration number or admission number
    Date and time of admission and discharge
    Mode of admission/transport/discharge
    Admitted via: ambulatory, wheelchair, stretcher
    Admitted from: home, transferring hospital, care facility
    Attending physician and referring physician, if any
    Religion
    Languages spoken
    Advanced directive
    Health care insurance

Standard II: Clinical Data

The nurse documents essential clinical data of each patient accurately and completely based on individualized nursing care plan from admission to discharge in health care facility.

1. There is relevant/essential, accurate and complete nursing documentation of patients' clinical data in all appropriate forms from admission to discharge in health care facility which include but are not limited to the following:

Physical Assessment (head-to-toe)
Health history
Psychological, social, spiritual and economic evaluation
Actual and potential health problems and needs
Diagnostic and therapeutic intervention
Pharmacological management
Nursing interventions
Health teachings – patient and family
Patient's response and outcome
Preferences and idiosyncrasies

NURSING DOCUMENTATION:

FOCUS CHARTING SYSTEM

- It encourages using assessment data to evaluate patient care concerns
- It helps identify necessary revisions to the care plan as you document
- This works well in acute care setting and in areas where the same care and procedures are repeated frequently
-Focus charting is patient-centered rather than problem oriented and addresses the patient's strengths, concerns

A focus will identify a change in a patient's condition or behavior, such as disorientation to time, place and person.
A significant event in the patient's treatment/therapy, such as safety concerns, or initiation in focus charting you may write each focus as a nursing diagnosis, such as risk for infection or fluid volume deficit. However, the focus may also refer to:

Sign or symptom – chest pain, nape pain, etc
Patient behavior – inability to ambulate, altered ADLs
Acute changes in patient's condition – loss of consciousness, increased BP, pain
Significant event – surgery, transfer, etc
Blood transfusion

FOCUS PROBLEM

Abnormal lab results	Aspiration
Activity	Cardiovascular
Admission	Central line therapy
Airway impairment	Chest tubes

Allergic reaction

Anxiety

Confusion

Comfort

Constipation

Coping

CNS status

Dehydration

DNR/Therapeutic choices

Dialysis

Discharge

Enema

Elimination

Falls

Fatigue

Family dynamics/concerns

Fluid balance

Fever

GI/GU status

Health teaching

Hemorrhage/Bleeding

High risk/Suicidal

Hypotension

Hypertension

Hypothermia

Code

Cognitive impairment

Hyperthermia

Incontinence

Infection

Isolation

Mental/emotional status

Nausea/vomiting

Neurovascular

Musculoskeletal

Pain control

Physician/Visit/Assist/Notified

Physical status

Respiratory status

Restraints

Skin integrity/wound care

Spiritual interventions

Swallowing

Substance abuse

Teaching

Telemetry

Transfer

Vital signs

Wound care

ADVANTAGES

- Flexible, can be adapted to fit any clinical setting
- Centers on the nursing process
- Easy to find data on a particular problem
- Encourages regular documentation of patient's response to nursing and medical care
- Helps organize thoughts
- Helps identify areas in the care plan that needs revising

DISADVANTAGES

- Staff members who are familiar with other systems may need in-depth training
- Requires you to use many flow sheets and checklists
- Can be a narrative note if you neglect to include patient's response to interventions

FOCUS CHARTING SYSTEM

DATE/TIME	FOCUS	DATE, ACTION, RESPONSE
08-31-10 6AM	Ineffective airway clearance	D – "Hirap pa din akoilabasang phlegm ko", with severe cough, RR – 25 with rales upon auscultation on the left lung A – nebulization done, chest – physio therapy facilitated, deep breathing exercises advised, and increase in oral fluid intake advised
8AM	Fever	D – "Mainit pakiramdam ko" patient is warm to touch with a temperature of 39.6C A – PRN meds given Aeknil 2 amps IV, TSB facilitated and increase in oral fluid intake instructed
12PM	Hypertension	D – "Medyo nahihilo ako, mataas daw BP ko" patient is weak looking with a BP of 160/100 A – bed rest instructed, referred to Dr. Quijano with orders made, Catapres 75 mcg 1 tab SL given as stat meds, O2 inhalation maintained @2-3L/min
1PM	Fever	R – patient is no longer warm to touch, Temp 37
3PM	Hypertension	R – patient can now sit up on bed, BP 130/90
5PM	Ineffective airway clearance	R – patient verbalized that he can now easily spit out phlegm. Still with minimal rales on left lung RR 20.

DATE/TIME	FOCUS	DATA, ACTION, RESPONSE
08-31-10 9AM 10AM	Altered body temp/fever Fever	D – "4 days na ako may lagnat" came in to ER ambulatory, weak looking and warm to touch, with a temp of 38.5C A – sponge bath facilitated, referred to Dr, Quijano with admitting orders made and carried out, Aeknil 1cc IM given as stat meds, hooked to IVF with a gauge of 20, CBC w/ PC and BT done, soft diet and no dark colored food advised. R – patient is no longer warm to touch with a temp of 37.6C
DATE/TIME	FOCUS	DATA, ACTION, RESPONSE
Aug 16, 06 11AM	Discharge Planning	D – may go home as previously ordered by Dr. Quijano. Patient verbalized desire to go home, but still in due to financial constraints. A – availability of meds reinforced, and frequency advised, referred to social worker on duty for assistance R – discharged, with home meds instructions, follow up check up advised.

DOCTOR'S DOCUMENTATION:

PART OF THE MEDICATION ORDER (Doctor's Order)

1. Name of the client
2. Date and time when the order is written
3. Name of the drug to be administered
4. Dosage/frequency
5. Route by which the medication is o be administered and special derivatives about its administration
6. Time of administration
7. Signature of the person writing the order

DOCTOR'S PROGRESS NOTES:

I. S – subjective signs
II. O – objective signs
III. A – action
IV. P –plan

PATIENT CARE AUDIT

A. **Concurrent Audit –**is one in which patient care is observed and evaluated. It is given through:
    a. Review of patient's chart while patient is still in the hospital
    b. Observation of the staff as patient care is given
    c. Inspection of patient's and/or observation of effects of patient care where the focus is on the patient

B. **Retrospective Audit –**is one in which patient care is evaluated through:
    a. A review of discharged patients' charts
    b. Interviews conducted on discharged patients

USES OF IV THERAPY

- Restore and maintain fluid and electrolyte balance
- Provide medication and chemotherapeutic agents
- Transfuse blood and blood products
- Deliver parenteral nutrients and nutritional supplements

RISKS OF IV THERAPY

- Blood vessel damage
- Bleeding
- Infiltration (infusion of the IV solution into the surrounding tissue)
- Infection
- Overdose (response to IV drugs is more rapid)
- Incompatibility when drugs and IV solutions are mixed
- Allergic responses to infused substances

PURPOSES OF DOCUMENTATION

- Provides accurate description of care that can serve as legal protection
- Mechanism for recording and retrieving information
- Record for health care insurers of equipment and supplies used

FORMS USED IN THE DOCUMENTATION OF IV THERAPY

- Nurse's progress notes
- IV fluid sheet
- Medication sheet
- Blood transfusion sheet

DOCUMENTING INITIATION OF IV THERAPY:

- Size, length and type of device
- Name of the person who inserted the device

- Date and time
- Site location
- Type of solution
- Any additives
- Flow rate
- Use of an electronic infusion device/flow controller
- Patient teaching and evidence of patient understanding
- Number of attempts (both successful and unsuccessful)

LABEL THE DRESSING

- Date of insertion
- Gauge and length of venipuncture device
- Your initials

DOCUMENTING IV THERAPY MAINTENANCE

- Condition of the site
- Site care provided
- Dressing changes
- Tubing and solution changes
- Patient teaching and evidence of patient understanding

INFORMATION REQUIRED BEFORE IV DRUG ADMINISTRATION

- PATIENT – name, id tag, allergies, treatment chart
- DRUGS – name, dosage, frequency, side effects and expiration date

BLOOD TRANSFUSION

The introduction of whole blood or blood components into the bloodstream

PURPOSE OF BLOOD TRANSFUSION

- Restore and maintain blood volume
- Improve the oxygen-carrying capacity of the blood
- Replace deficient blood components and improve coagulation

CHECK, VERIFY AND INSPECT

- Check to make sure that an informed consent form was signed
- Double check patient's name, medical record number, ABO and Rh status, and the blood bank identification number against the label on the blood bag
- Check the date of extraction and expiration date

MONITORING A BLOOD TRANSFUSION

- Record the patient's vital signs before the transfusion, and every 15 minutes after
- Always have a sterile saline solution, an isotonic solution as a primary line along with the transfusion
- Act promptly if the patient develops wheezing and bronchospasm
- Stop the transfusion immediately, start the normal saline solution
- Check and document the patient's vital signs
- Call the doctor and initiate anaphylactic procedure
- If the patient develops a transfusion reaction, return the remaining blood with the blood transfusion form to the lab

TERMINATING THE TRANSFUSION

- Record the date and time of the transfusion
- Identification of the blood bag
- Type and amount of blood transfused
- Volume of normal saline transfused, status of the venous access device
- Patient's vital signs
- Signs and symptoms of a reaction (or the absence of signs and symptoms)
- How well the patient tolerated the procedure

SPECIMEN CARE

The term 'specimen handling' is meant to include identifying, collecting, labeling, preserving, storing, preparing for transport, documenting and communicating.

Specimen refers to blood, body fluids, tissue or other specimen type removed from the patient, implanted, or reinfused, including those sent for pathological or gross examination, culture and sensitivity, or other studies. Delivering a specimen to the pathology department involves many steps including:

- Correctly identifying the patient
- Correctly identifying and confirming the specimen by the surgical team
- Placing the specimen in an appropriate container and preservative
- Correctly labeling the specimen
- Completing the pathology requisition slip
- Transporting the specimen to the pathology department

Proper identification of the patient and item or tissue removed, the correct preservative, and specimen documentation are of primary importance in the care of the specimen.

IMPLEMENTATION DATE: This policy has been implemented since September 1, 2010 with minor revision 2011, 2016. This policy will continue to be implemented as rewritten.

SCHEDULE FOR POLICY REVIEW: The policy shall be reviewed every 3 years or as deemed necessary.