American Journal of Nursing and Trinity Healthforce Learning present:

Charting the Course for Nursing: Who Benefits When Documentation Is Complete?

subject matter expert

Deborah Hafernick, RN, LNCC
Owner/Legal Nurse Consultant
Hafernick Legal-Nurse Consulting
League City, Texas
STATEMENT OF NEED

The medical record serves as an indispensable method of communication among healthcare providers. A well-kept record supports your claim to a high standard of care, while a poorly kept record can make an otherwise excellent healthcare provider’s care look deficient.

Content level: Intermediate

TARGET AUDIENCE

The target audience for this activity is nurses.

LEARNING OBJECTIVES

After completing this activity, the participant should be able to:

1. describe current methods of charting.
2. list the stakeholders in thorough documentation.
3. explain the benefits of thorough documentation.
4. outline best practices in charting for registered nurses.

Release date: 1/07

For questions or general information, please contact:

Customer Care
Trinity Healthforce Learning
4101 International Parkway
Carrollton, TX 75007
(800) 688-4999
INTRODUCTION

The importance of a clear, concise, accurate medical record cannot be overemphasized. As a permanent record, it provides an ongoing method of communication among healthcare providers. When either good or bad things happen to a patient, the medical record communicates them to all caregivers. As a result, the medical record provides the best evidence of the patient’s status and of the care provided to the patient.

Learning Objective: Common Charting Methods

WHY CHART?

The medical record is a permanent legal document that serves a variety of purposes. In the legal sense, it is an indispensable part of a defense against any eventual litigation alleging negligence or malpractice.

The medical record is the only permanent record of the care provided the patient from admission to discharge. A well-kept record helps healthcare providers manage patient care more effectively, while a poorly kept record increases the chances of medical error. For example, consider the medication errors that occur as a result of illegible handwriting or failure to document that a medication was given.

While the medical record fulfills many purposes, its primary purpose is to support continuity of patient care. Never forget that the patient is the focus of all of your documentation. All other uses of the medical record derive from this main concept. As a result, the record supports other purposes, such as:

- **Quality assurance.** An example is trending time for C-sections.

- **Risk management.** In the event of litigation, the record remains completely intact and is often the only available evidence years after the event in question occurred. As memories fade, the record remains as documentation of care provided to the patient. As such, it should provide a factual picture of past events.

- **Reimbursement.** The record provides evidence that care and supplies were provided and are, therefore, reimbursable.

WHO CHARTS?

The person rendering the care should be the person who charts (or dictates) the care. This person can change in the event of specific occurrences, such as a code or surgical procedure that requires a designated recorder. Your facility’s policies and procedures should provide guidance.

WHEN SHOULD YOU CHART?

Chart as soon as possible after rendering care. This promptness not only allows the provider to document while the patient assessment is still clear but also allows the provider the opportunity to compare his or her assessment with previous assessments. This plan supports continuity of care by enabling providers to identify potential problems (which may or may not have been reported to them verbally) early enough in the shift that those problems can be monitored and managed as well as possible.

Chart late only when the information documented will impact the care provided to the patient at a later time.

COMMON METHODS OF CHARTING

Many charting methodologies exist, and each has its advantages and disadvantages. You, as an individual caregiver, may not have control over the
methodology chosen at your facility, but you do have control over how you document within that methodology or process.

The six basic charting methods used at most facilities are as follows:

- Flowsheets
- Narrative
- Problem-oriented
- Charting by exception
- Computerized
- Case management

Each of these documentation methods has advantages and disadvantages. Any method can be altered to enhance its advantages and decrease its disadvantages. The primary goals of supporting patient continuity and information management are important regardless of the documentation methodology utilized.

**Flowsheet Charting**

A flowsheet is a pre-printed form on which specific data or repeated observations and/or interventions are documented. This method is usually used to supplement another charting method.

Advantages of the flowsheet include:

- consolidating detailed patient information.
- providing a format for comparisons.
- prompting documentation.
- allowing easy reference to data.

Disadvantages of flowsheets include the following:

- They can be bulky if used extensively.
- They can look blank if observations are infrequent.
- They are not conducive to documenting isolated events or observations.

The use of well-designed flowsheets for critical or routine assessments enhances their advantages and helps minimize their disadvantages, leading to better information management and enhanced continuity of care.

**Narrative Charting**

Narrative charting is the most familiar method of documentation for most caregivers. It is in simple paragraph form that allows caregivers to document:

- patient status.
- assessments.
- interventions.
- responses to interventions.
- evaluation of the effectiveness of the care provided.

Advantages:

- It is familiar and easy to integrate with other charting methods.
- It is quick and easy to use in emergency situations.
- The end result is factual, unprompted data.

Disadvantages:

- It lacks structure and focus.
- It is time consuming.
- It is not streamlined (caregivers must re-think and personally format each note).
- There are no prompts for documentation.
- Documentation is inconsistent from one caregiver to another.
- Information is difficult to retrieve, track, and trend.

In general, the disadvantages outweigh the advantages. Narrative notes are cumbersome and difficult to “wade through” when reviewing a patient’s past assessments and history. Occurrences and assessment changes can be easily missed because this documentation methodology lacks the structure of other methodologies.

**Problem-Oriented Documentation**

While problem-oriented documentation methodologies differ in structure, they have some commonalities. They were designed to enhance a structured and logical process. The data are organized to focus on patient problems and/or concerns.
In general, their advantages include that these methodologies:
• follow a structure and/or predetermined format.
• are reflective of the nursing process.
• aid in tracking problems.
• emphasize the patient and his or her problems.
• promote analytical thinking.

For the most part, problem-oriented charting methodologies are more structured and streamlined than narrative charting methodologies.

Disadvantages:
• If the documentation style is not monitored, caregivers can easily revert to narrative documentation.
• They require a change in thinking.
• Caregivers must approach the documentation process differently to construct structured logical and analytical notes.

Charting by Exception
Charting by exception allows caregivers to plan, deliver, evaluate, and prioritize care with the help of standards of care and protocols. Providers record, on a flowsheet, when standards of care were met and, in narrative form, any abnormal or exceptional facts.

Advantages:
• Documentation is streamlined through the use of pre-printed flowsheets.
• Normal and abnormal assessments and/or findings can be easily identified.
• Trends can be easily discerned.
• Repetitive and routine charting is eliminated.

Disadvantages:
• There is a significant change in the documentation format, and caregivers may have difficulty learning to document only negative findings.
• All elements of the physical assessment standard may not be necessary for the entire patient population but must still be completed.

For patients with normal assessments, a “blank” record could be produced.
• The use of minimal standards could obscure the need for a more in-depth assessment.

Computerization
Computerized documentation is the result of entering data into a computer. The data can be entered in a number of ways, including with:
• light pen and screen system.
• touch-sensitive screen.
• keyboard.
• handheld terminal.
• barcode reader.

The output varies with the computer program.

Advantages of computerization include:
• 100 percent legibility.
• easy tracking of patient outcomes.
• reinforcement of standards of care (they can be entered into the computer and can be automatically accessed).
• enhanced facility-wide communication as well as communication with satellite facilities.
• time saved in searching for, retrieving, and filing information.
• readily available test results.
• charting done at bedside.

Disadvantages include:
• possibility of lack of terminals when the caregiver wants to chart.
• computer may be slow at peak times.
• critical information may be lost in the event of a “crash.”
• caregivers may have difficulty learning to work with computers.
• possibility exists for loss of patient’s privacy.
• inaccurate information can be perpetuated.

Case Management
The case management documentation process focuses on providing quality patient care in a cost-effective manner. This documentation utilizes standards of care to monitor patient outcomes on a daily
Documentation is performed via a daily predetermined pathway, flowsheet, and documentation system. The goal is to achieve realistic, desirable patient and family outcomes with appropriate length of stay and utilization of resources via multidisciplinary collaboration.

Advantages:
• The establishment of a collaborative process among nurses, ancillary services, physicians, and patients, through which variances (exceptions to care) are recognized for a quick response.
• Quality outcomes and processes are clearly defined.
• Daily outcomes are established.
• Potential problems are anticipated.
• Standards are clearly delineated.
• Patients know what to expect.

Disadvantages:
• The process requires a change in thinking.
• Physicians must not only accept the process but also actively participate in it.
• The process requires significant resources to develop the pathways and then requires significant training before implementation.
• If there is no variance, there will be no narrative charting. This can make caregivers uncomfortable and lead to a “blank” chart.

Learning Objective: Stakeholders

NURSES NAMED IN LAWSUITS: A GROWING TREND

Historically, nurses working for an organization (e.g., a hospital) generally were not named in malpractice or other liability lawsuits. The organization was named in place of the nurse(s) involved in the suit. Under the legal doctrine respondeat superior, an employer can be held legally responsible for its employees' actions. The only qualifiers are that there must have been an employer/employee relationship and that the employee must have been working within the scope of his or her employment.

However, there is a slowly growing trend of naming nurses individually in lawsuits. While this is not happening with great frequency, the legal profession sees it happening more often than before. Note that under an employer/employee relationship, the employer should still provide a defense and indemnification (payment of settlements or judgments) on behalf of its employed nurses, regardless of whether the nurses are individually named.

ADDITIONAL STAKEHOLDERS

More is at stake than the liability of those in nursing. Other stakeholders include:
• other members of the patient’s healthcare team.
• the patient.
• the patient’s family members.
• the healthcare organization.
• insurers.

General documentation goals were developed to objectively evaluate how each method supports the above global goals. You are encouraged to evaluate your facility’s charting methodology and your individual techniques. For example, while your individual style may be streamlined, narrative charting typically is not.

Knowledge Assessment

1. List three advantages of computerized charting.

Please refer to the end of the course materials for answers.
Learning Objective: Best Practices

A clear chart not only improves patient care but also helps to decrease the chance of malpractice litigation. If a patient’s recollection varies from that of a clearly written medical record, a jury almost always believes the record. In addition to a commitment to continuity of care, you also have a legal obligation to chart. Each state has some statutory scheme that mandates the minimum standards for charting.

More than just avoiding litigation, risk management consists of effective communication and proper documentation. Consider why you are documenting. The primary purpose of the medical record is to provide continuity of patient care. Therefore, chart whatever the next caregiver will need to safely and effectively care for the patient.

A written care plan, standards of care, and/or clinical pathways often help guide patient care. Update or individualize these plans as appropriate. Documentation should follow the plan, standards, or pathway used for each patient. Also, keep in mind that medical records serve other purposes. Therefore, if the patient is involved in a research project and specific documentation is needed to provide research data (e.g., orthostatic blood pressures 30 minutes and 60 minutes after drug administration), make sure those data are obtained and documented.

Additionally, if specific documentation is needed for reimbursement (e.g., documentation of specific equipment or supply use), make sure that information is documented. From a legal perspective, in the event of a lawsuit, documenting according to the above guidelines provides your best defense. Never use the record for complaining, finger-pointing, or commenting on other non-patient care issues. If your statement does not support patient care, it does not belong in the record.

RESULTS

The results should be a clear picture of what happened during your shift. Your documentation should:

• reflect your complete assessment of your patient’s needs and his or her condition.
• serve as a basis for the nursing diagnosis that can be used to update the patient’s care plan.
• reflect your competency in providing care.

CHARTING CONSIDERATIONS

When documenting, consider the following:

• What is the patient’s diagnosis?
• What is a normal assessment for this patient at this time?
• Is the patient’s current assessment different now from previous assessments?
• If the assessment is different, how is it different? Is it better or worse?
• Did you document anticipated and unanticipated changes?
• What will the next caregiver need to know to better understand and care for the patient?

Your documentation should support the patient’s diagnosis, justify the treatment provided, and inform others of anticipated changes that did not occur and unanticipated changes that did occur.

POLICIES AND PROCEDURES

Your facility’s particular policies and procedures play an important role in forming the standards to which you will be held accountable. It is easier to breach policies and procedures if you are not familiar with them. On the other hand, if they are
not commonly used because they are outdated, too rigid, difficult to access, or not supported by management, you are setting yourself up to breach a written standard as set by the hospital. This mistake is a primary component of medical malpractice.

### Unexpected Outcomes

If an outcome was unexpected by you, imagine how the patient and his or her family must feel about it. These patients and their families need additional support. If they perceive that the outcome was related to a caregiver’s acts or omissions or that you had been or are withholding information from them, they will be more likely to contact a plaintiff’s attorney in order to “get answers.” This contact can lead to the subpoena of records and may be the first step toward a lawsuit.

### Managing Adverse Events

When managing an adverse event (an unexpected and/or dangerous reaction to a medical therapy, especially a drug), identify the event, and then effect an immediate response:

- Attend to the patient. The patient is your first responsibility.
- Communicate appropriately but carefully. Acknowledge the adverse event, express concern, and show that you are taking action, but do not accept blame or admit a mistake (e.g., “I’m sorry that this happened” versus “How could I have done this. I am so sorry”).

Follow applicable policies, both clinical and administrative:

- Note time and actions in the medical record.
- Meet with the healthcare team (risk manager, physician, nursing, therapy) to devise a coordinated response.
- Decide who will follow up with the patient and his or her family.
- Investigate.
- Manage the billing situation. It may be appropriate to hold or write off specific bills (e.g., associated with a second surgery performed solely to remove an item left in during the prior surgery).
- Provide exceptional follow-up.
- Documentation should show:
  - prompt recognition of the problem.
  - timely and appropriate intervention.
  - the patient’s response.
  - new plan for care.

---

### 10 Commandments of Charting

I. Do not erase, use “white out,” or cross out an error with more than one line.

II. Record only the facts. Chart only observed behavior.

III. Do not write critical comments. Do not chart your opinions.

IV. Begin each entry with time and end each entry with signature and title. For example: 7:50 a.m.—Jane Doe, BCCNS

V. Do not leave blank spaces.

VI. Record all entries legibly and in ink.

VII. Avoid using generalized phrases, such as “The patient had a good day.”

VIII. If order is questioned, record that clarification was sought.

IX. Chart for yourself. Only document on a chart what YOU did, what YOU observed, and the outcomes YOU witnessed. Do not chart patient information for other co-workers or what their experience was. Co-workers need to record data themselves so something is not inadvertently omitted or entered incorrectly on their behalf.

X. Do not allow any visiting relatives access to the chart.
• Documentation should not include:
  – self-serving comments.
  – finger-pointing.
  – alterations.
  – mention of the incident report.
• Complete an incident report according to your facility’s policies and procedures.

  **Knowledge Assessment**

  3. Which of the following is an acceptable statement to record in a patient’s medical chart?
   a. “Mrs. Brown had a good day”
   b. “As usual, the nurse on duty didn’t come when Mrs. Brown pressed the call button”
   c. “Mrs. Brown ate half of the food on her plate for breakfast”
   d. “Mrs. Brown is hard to deal with in the evenings”

   Please refer to the end of the course materials for answers.

  **Conclusion**

  Many charting methodologies exist, and each has its advantages and disadvantages. You, as an individual caregiver, may not have control over the methodology chosen at your facility, but you do have control over how you document within that methodology or process. Ultimately, your responsibility as it relates to charting is to protect the patient. One of the most effective ways to do that is to manage patient information in a manner that results in clear communication and supports continuity of patient care. The result is that you protect the patient, the hospital, and yourself.

  **Answers to Knowledge Assessments**

  1. Possible answers include:
   • 100 percent legibility.
   • easy tracking of patient outcomes.
   • reinforcement of standards of care (they can be entered into the computer and can be automatically accessed by patients).

  2. Possible answers include:
   • nurses.
   • other members of the patient’s healthcare team.
   • the patient.
   • the patient’s family members.
   • healthcare organization.
   • insurers.

  3. c

   “Mrs. Brown ate half of the food on her plate for breakfast” is an acceptable statement to record in a patient’s medical chart. The other statements are generalizations or personal opinions and should not be recorded.

  **Bibliography**


REFLECTION SECTION

What are the key points you have identified from this activity?

_________________________________________________________________________________

How will you incorporate what you have learned into your practice?

______________________________________________________________

PRESENTATION NOTES
POST TEST

CHARTING THE COURSE FOR NURSING: WHO BENEFITS WHEN DOCUMENTATION IS COMPLETE?

1. While the medical record fulfills many purposes, its primary purpose is to:
   a. defend the caregiver in case of allegations of medical malpractice.
   b. provide documentation for the performance improvement processes within the facility.
   c. support continuity of patient care.
   d. develop standards of care within the facility.

2. When documenting, you should avoid writing down:
   a. your patient’s diagnosis.
   b. your patient’s previous assessment and any anticipated or unanticipated changes.
   c. what the next caregiver will need to know better understand and care for the patient.
   d. your complaints about the patient.

3. Which statement is TRUE?
   a. Oral reports are more accurate than written reports because they give a more complete picture of the patient’s health.
   b. The healthcare provider should avoid reading previous patient assessments to prevent forming preconceived judgments about care.
   c. The healthcare provider should document as soon as possible after providing patient care.
   d. A nurse cannot be held individually responsible for a breach of his or her duty that results in patient injury.

4. In general, problem-oriented charting methodologies:
   a. are more structured and streamlined than narrative charting methodologies.
   b. allow easier reference to data than computerized methodologies.
   c. have more structured prompts than case management methodologies.
   d. were designed to enhance a structured, but not logical, process.

5. Which statement is FALSE?
   a. The charting by exception method requires a significant change in the documentation format, and caregivers may have difficulty learning to document only negative findings.
   b. Trends are not easily discerned with the charting by exception method.
   c. The use of minimal standards in the charting by exception method could obscure the need for a more in-depth assessment.
   d. With the charting by exception method, patients with a normal assessment may have an essentially “blank” record.

6. For the respondeat superior doctrine to apply:
   a. an employer/employee relationship must exist.
   b. an “intentional act” on the part of the employee must be present.
   c. the employee must have been acting within the scope of his or her employment.
   d. a and c
7. When managing an adverse event, the nurse should:
   a. quickly admit the mistake.
   b. mention the incident report.
   c. avoid communicating with the patient.
   d. document the new plan of care.

8. Which of the following is NOT necessary to support charting by exception?
   a. Guidelines, protocols, and procedures that identify and document standards of care.
   b. Examples of required documentation elements.
   c. Format for narrative charting when appropriate.
   d. Copies of Taber’s medical dictionary and a current Physicians’ Desk Reference (PDR).

9. A secondary benefit of thorough documentation is that information gathered from the patient record can be used to:
   a. protect the nurse in legal cases.
   b. show that the patient was unpleasant to staff.
   c. document the author’s assessment of other healthcare providers.
   d. document opinions about the patient’s family.

10. Which of the following is among the 10 commandments of charting?
    a. Erase all erroneous entries
    b. Chart your opinions
    c. Leave blank spaces if they are not needed
    d. Avoid using generalizations
ANSWER KEY

CHARTING THE COURSE FOR NURSING:
WHO BENEFITS WHEN DOCUMENTATION IS COMPLETE?

1. c
   While the medical record fulfills many purposes, its primary purpose is to support continuity of patient care. (Course materials, Obj. 1)

2. d
   When documenting, you should consider the patient’s diagnosis, previous patient assessments and any anticipated or unanticipated changes, and what the next caregiver needs to know. You should NOT document your complaints about the patient. (Course materials, Obj. 4)

3. c
   Documentation should occur while the care is still fresh in the nurse’s mind. (Course materials, Obj. 4)

4. a
   In general, problem-oriented charting methodologies are more structured and streamlined than narrative charting methodologies. (Course materials, Obj. 1)

5. b
   Trends are more easily discerned with the charting by exception method. (Course materials, Obj. 1)

6. d
   For the respondeat superior doctrine to apply, an employer/employee relationship must exist and the employee must have been acting within the scope of his or her employment. (Course materials, Obj. 2)

7. d
   When managing an adverse event, the nurse should communicate appropriately but carefully. Acknowledge the adverse event, express concern, and show that he or she is taking action, but do not accept blame or admit a mistake. The nurse should document the new plan of care, and avoid mentioning the incident report. (Course materials, Obj. 4)

8. d
   While a medical dictionary and PDR are important and useful references to inform care, they do not specifically support charting by exception. Standards, guidelines, and references for what is “normal” practice; guidelines for what is considered a deviation from the norm and requires documentation; and guidelines for charting the exceptions are some of the resources that support this charting method. (Presentation, Obj. 4)

9. a
   The patient record provides a wealth of information for research, for communication among healthcare providers, and for malpractice and liability cases. However, subjective comments about the patient or other healthcare providers as a means of “protecting” the nurse should not be included in any documentation. (Presentation, Obj. 4)
10. d

The 10 commandments of charting state that you should avoid using generalized phrases, such as “The patient had a good day.” In addition, never erase an entry in the patient record or obscure what was written with “white out” or multiple lines. Use a single line to cross out the erroneous statement and add your initials. This allows others to see what was written by mistake, rather than wonder what has been erased or obscured. (Presentation, Obj. 4)