Documentation That Matters

Objectives

- Define nursing documentation.
- Discuss the importance of documentation in health care.
- Summarize key elements to be included for accurate documentation.
- Review two documentation methods that produce quality results.

Definition

Any written or electronically produced information that describes the care discussed, planned, recommended, and/or provided to the patient and the subsequent outcomes.

Purpose

- To record all patient care activities and demonstrate professional practice and accountability.
- For reimbursement.
- To provide data for Research and Quality Management.

Documentation Tools

- Electronic
- Flowsheets
- Progress Record
- Checklists
- Care Plans
- Care Maps
- Monitor Strips
- Kardex

Factors that Improve the Quality of Documentation

- Accuracy
- Relevance
- Completeness
- Timeliness
- Confidentiality

What to document

Patient's physical and mental status

All care & education provided by nursing and the interdisciplinary team

The patient's response to treatment

Any issues involving the patient and/or family

(documentation that matters cont'd)

When to document

- On admission/transfer/discharge
- Every time care is provided
- Assessment/reassessment
- If there are issues/occurrences

Incident Report

A document that records an occurrence involving patients, visitors, and/or employees.

DO's for quality documentation

- Document often to tell the whole story
- Write professionally - terminology, content, syntax
- Sign, date, time all entries

DON'T's for quality documentation

- Document before care is provided
- Alter the medical record
- Block chart
- Write imprecise descriptions
- Leave large spaces and blank lines

Documentation Methods

SOAPIER - Problem Oriented Charting

S	**subjective**	What the patient says
O	**objective**	Factual data – observed/measured
A	**assessment**	Conclusions based on objective & subjective data
P	**plan**	Management plan of care
I	**interventions**	Care given
E	**evaluation**	Outcome/responses to care
R	**revision**	Changes in the management plan

DAR - Focus Charting

D **assessment phase of the nursing process** – subjective & objective data

A **action** – planning & implementation

R **response** – evaluation of care