**Documenting and Reporting Outline**

**February 20,2018**

**Objectives**

1. Define and identify the significant difference between documenting, reporting and recording.
2. Discuss the purpose of client records.
3. Know the importance of ethical and legal considerations of documentation and reporting.
4. Elucidate ways for ensuring confidentiality and security of computerized records.
5. Compare and contrast various documentations systems.
6. Explain reporting and it’s importance.

**Introduction**

Health personnel communicate through *discussion*, *reports* and *records.*

* **Discussion**: a form of informal oral consideration of a subject by two or more health care personnel. This is to identify a problem or establish strategies to resolve a problem.
* **Report**: oral, written, or computer-based communication to convey information to others.
* **Record**: also called a chart or client record. This is a formal, legal document that provides evidence of a client’s care and can be written or computer based.

**Documenting, Reporting and Recording**

* The process of making an entry on a client record.
* It is a written evidence:
  + The interactions between and among health professionals, clients, their families, and health care organizations.
  + The administration of tests, procedures, treatments, and client education.
  + The results or client’s response to these diagnostic tests and interventions.
  + Each nurse is accountable for practicing recording and reporting client data according to each health organization’s policies.
  + Client record documentation should be timely, complete, accurate, confidential and specific to the client.
  + Electronic Health Record(EHR) was utilized increasingly through the health care reform.

**Purpose of Client Records**

**Communication**

* + Interaction by different health professionals.
  + Prevents fragmentation, repetition and delays in client care.

**Planning Client Care**

* + Data used by health professionals are from the client’s record.
  + Example: an order of an antibiotic after establishing temperature is rising steadily and lab test reveals presence of microorganisms.

**Auditing Health Agencies**

* + An audit is a review of client records for quality assurance purposes.
  + Review of records through auditing determine if a particular health agency is meeting its stated standards

**Research**

* + The information in the record are valuable sources of data for research.

**Education**

* + The record can provide a comprehensive view of the client, the illness, effective strategies and factors that affect the outcome of the illness.
  + Students in health disciplines often use client records as educational tools.

**Reimbursement**

* + Documentation also helps a facility receive reimbursement from the federal government.
  + A correct diagnosis related group ( DRG) and appropriate care has been given is needed

**Legal Documentation**

* + Data in the client’s record is acceptable in court as evidence.
  + It becomes unacceptable in court if the client objects because the information is confidential.

**Health Care Analysis**

* + Records assist health care planners to identify agency needs.
  + It can be used to establish the costs of various services.

**Ethical and Legal Considerations**

The nurse has a duty to maintain confidentiality of all patient information ( ANA-Code of Ethics, 2001).

**Confidentiality is maintained by:**

* + Protecting the clients’ record legally
  + Access to the record is restricted to health professionals involved in giving care to the client.
  + The institution or agency is the rightful owner of the client’s record/ but does not exclude the client’s rights to the same records.
* **Informed consent:** means that the client understands the reasons and risks of the proposed intervention.
* Witnessing confirms that the person who signs the consent is competent.

**Ensuring the Confidentiality**

1. A personal password is required to enter and sign off computer files. **Do not share password with anyone**.
2. **Do not** leave client information displayed on the monitor where others may see it.
3. **Shred** all unneeded computer generated worksheets.
4. Know the facility’s policy and procedure for **correcting an entry error.**
5. Follow agency procedures for documenting **sensitive material**, such as diagnosis of AIDS.

**General Guidelines for Recording**

**Date and Time**

* Document the date and time of each recording for legal reasons and for client safety

**Timing**

* Follow agency’s policy about the frequency of documenting and adjust the frequency as a client’s condition indicates.

**Legibility**

* All entries must be legible and easy to read to prevent interpretation errors.
* Hand printing or easily understood handwriting is usually allowed.
* Follow agency policies about handwritten recording.

**Permanence**

* All entries on the client’s record are made in dark ink so that the record is permanent and changes can be identified/ Follow agency policies.

**Accepted Terminology**

* Use commonly accepted abbreviations, symbols and terms that are specified by the agency.

**Correct Spelling**

* This is essential for accuracy.

**Signature**

* Each recording on the nursing notes is signed by the nurse making the recording.
  + It includes the name and title. Ex. “Almater, Latifah. RN”
* Some agency have signature sheet and after signing this signature sheet, nurses use their initials ( LA).
* For computerized recording, each nurse has a code ( La1131).

**Accuracy**

* + Client’s name and identifying information should be stamped or written on each page of the clinical record.

**Sequence**

* + Document events in order in which they occur.
  + Update or delete problems as needed.

**Appropriatenss**

* + Record only information that pertains to the client’s health problems and care.

**Completeness**

* + Information that is recorded needs to be complete and helpful to the client and health care professionals.
  + Nurses needs to reflect the nursing process.
  + Care that is omitted because of the client’s condition or refusal of treatment must be recorded.

**Legal Cautiousness**

* + Accurate, complete documentation should give legal protection to the nurse, the client’s other caregivers, the health care facility, and the client.

**Documentation Systems**

I. Source-oriented Record

II. Problem –oriented Medical

III. Problems Intervention, evaluation (PIE model)

IV. Focus Charting

V. Chartinf by Exception (CBE)

VI. Computerized Decomntation

VI. Case Manegment

**I. Source-oriented Record**

**Traditional client record**

* + Each person or department makes notation in a separate section or sections of the client’s chart.( Admission sheet – admissions department, physician’s forms – primary care provider, nurses notes- nurses)

**Narrative charting**

* Consists of written notes that include routine care, normal findings and client problems.

**II. Problem –oriented Medical Record**

**Data arranged according to client’s problems.**

1-**Database:** All information known about the client when the client first enters the health care agency.

**2. Problem List:** Derived from the database/ Problems are listed in the order they are identified.

**3.Plan of Care:** Generated by the individual who lists the problems. Primary care providers write physician’s orders /nurses write nursing orders or nursing care plans.

**4. Progress Notes:** The chart entry made by all health professionals involved in a client’s care.

**III. Problems Intervention, evaluation (PIE)**

Groups the information into three categories:

* + - * P. Problem statement
      * I: Intervention
      * E: Evaluation

**IV. Focus Charting**

* + Intended to focus on the client concerns and strengths the focus of care.
  + Three columns for charting are usually used to distinguish the entry from other recordings in the narrative notes: Date/Hour, Focus, Progress Notes
  + The progress notes are organized into;
    - Data (D)
    - Action (A)
    - Response (R)

**V. Chartinf by Exception (CBE)**

* + Documentation system in which only abnormal or significant findings or exceptions to norms are recorded.
  + 3 key elements of CBE:
    - Flow sheets
    - Standards of nursing care
    - Bedside access to chart forms
  + Avoids lengthy, repetitive notes.

**VI. Computerized Decomntation**

* + Used to manage the huge volume of information required in contemporary health care.
  + Increases the quality of documentation and save time.
  + Increases legibility and accuracy.
  + Facilitates statistical analysis of data.

**VI. Case Manegment**

* + Emphasizes quality, cost effective care delivered within an established length of stay.
  + Uses a multidisciplinary approach to planning and documenting client care, using critical pathways.
  + Identifies the outcomes that certain groups of clients are expected to achieve on each day of care along with the interventions.
  + A critical pathway is a multidisciplinary plan or tool that specifies assessments, interventions, treatments and outcomes of health related problems a cross a time line.

**Documenting Nursing Activities**

* Admission Nursing Assessment
* Nursing Care Plans
* Kardexes
* Flow Sheets
* Progress Notes
* Nursing Discharge/Referral Summaries

**Reporting**

* It is an oral or written communication of specific information to a person or group of people.
* It should be concise, including pertinent information but no irrelevant detail.
* Reporting is based on the nursing process

**Change-Of-Shift Report**

* + given to all nurses on the next shift;
    - Two way, face to face communication
    - Written support tools
    - Content in hand over

**Telephone reports and orders**

* + Report transfers, communicate referrals, obtain client data, solve problems, inform a physician and/or client’s family members regarding a change in the client’s condition.
  + Telephone orders MUST be documented

**Care Plan Conference**

* + Is a meeting of a group of nurses to discuss possible solutions to certain problems of a client.

**Nursing Rounds**

* + Procedures in which two or more nurses visit selected clients at each client’s bedside to:
    - Obtain information that will help plan nursing care
    - Provide clients the opportunity to discuss their care
    - Evaluate the nursing care the client has received.