CHAPTER 1

PURPOSE OF DOCUMENTATION

CHAPTER OBJECTIVE
After completing this chapter, the reader will be able to identify the importance and purpose of complete documentation in the medical record.

LEARNING OBJECTIVES
After studying this chapter, the reader will be able to
1. explain the beginning of documentation and its evolution.
2. identify purposes of a health care record.
3. specify ten records one might find in a patient’s medical chart.
4. indicate forms specifically used by nurses in documenting patient care.
5. identify trends in nursing documentation.

INTRODUCTION
Accurate documentation of patient symptoms and observations is critical to proper treatment and recovery. Starting on the first day of nursing school, students are advised about the requirements for complete and proper documentation. However, documentation still becomes somewhat burdensome and time-consuming. Nurses commonly experience conflict between time spent caring for patients and time needed to accurately record what care was provided and patient responses to treatment. When time is limited, nursing care may take priority and what is documented may not tell the whole story.

EVOLUTION OF DOCUMENTATION
Documentation is a vital part of nursing practice. It has been defined as “anything written or printed that is relied on as a record of proof for authorized persons” (Daniels, 1997, p. 181). It is the recording of pertinent patient data in a clinical record. Good documentation reflects quality of care and evidence of each health care team member’s accountability in providing care. Written communication must contain (a) appropriate language and terminology; (b) correct grammar, spelling, and punctuation; and (c) logical organization. Nursing documentation is not a new requirement; however, it has become increasingly important in determining the quality and cost of patient care.

Documentation has been considered important since the days of Florence Nightingale. In her Notes on Nursing, Nightingale indicated nurses need to record the care provided to patients. Most of the documentation during Nightingale’s time was used for communication of medical orders and not to observe, assess, or evaluate patient status. Today, documentation is one of the most critical skills nurses perform. Many nurses approach documentation as a chore; however, one’s entire nursing career...
could depend on the accuracy and completeness of the charting that has or has not been done.

Nursing documentation was not always thought of as a critical part of patient care. In 1951, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) was established and promoted formalization of nursing standards, which provided a method by which nursing care could be evaluated. Prior to that time, nursing notes were removed from a patient’s chart and destroyed when a patient was discharged. Hospitals are now required by JCAHO to establish quality improvement programs to conduct objective, ongoing reviews of patient care. JCAHO has standards in regard to patient records, including information that must be present in the record. JCAHO requires institutions to establish quality care and methods to monitor policies and practice. Nurses must be aware that JCAHO regulations require completion of the patient’s records within 30 days following discharge. The medical records department may ask nurses to remind physicians to complete their records.

In the early 1970s, nursing documentation was finally considered an important and legal part of a patient’s chart. With the development of diagnosis related groups (DRGs), nursing documentation became an important component in determining monetary reimbursement for care. DRGs provide a method for classifying patients into categories based on age, diagnosis, and treatment requirements. It is the basis for the U.S. Department of Health and Human Services’ prospective payment system. The federal Centers for Medicare & Medicaid Services (CMS) (previously Health Care Financing Administration [HCFA]) requires every patient be classified into one or more of about 500 DRGs. This is necessary for reimbursement for services provided. The CMS also sets a length of stay for each DRG, and documentation must be provided if a patient remains hospitalized beyond the established time. The key source of information for determining the patient’s course of treatment and the correct DRG assignment is the medical record. Because of this reimbursement method, poor documentation may create financial disaster for a hospital. If quality care is provided for fewer expenses than allotted by the DRG, the hospital is allowed to keep the difference, thus realizing a profit.

The North American Nursing Diagnosis Association (NANDA) is an organization involved in developing and promoting the use of nursing diagnoses. The organization formed in 1973 and since 1975 has continued to develop and refine nursing diagnoses. The diagnoses define problems nurses are able to treat because they are qualified to do so. They assist nurses with assessing patients’ biophysical, psychosocial, psychological, environmental, learning, and discharge planning needs. Newly developed components of NANDA address patient strengths as well as problems and also address the move toward wellness.

Even though NANDA is not a regulating body, many admission assessment forms are based on nursing diagnoses. After completing an admission assessment, the nurse selects the appropriate choice from the list of accepted nursing diagnoses to identify actual and potential problems. The identified problems can assist the nurse to develop nursing diagnoses and a plan of care.

The plan of care should guide patient care and documentation in the medical record. Once the plan of care is established, it needs to be regularly reviewed and updated. When a patient’s record is reviewed, the identified nursing diagnoses, interventions, and outcomes should be compared to the documentation in the nursing notes. This comparison can be used to determine whether the patient’s highest priority problems were identified and whether the nursing interventions were effective. Other parts of the patient’s record may also be reviewed to verify that the nurse carried out the plan of care.
Chapter 1—
Purpose of Documentation

Documentation is the very core of nursing. Nurse practice acts and professional standards require nursing documentation and specify the patient’s needs that guide the documentation. Through documentation, changes in a patient’s condition can be tracked, decisions about the patient’s needs can be made and recorded, and continuity of care can be ensured. Good charting saves time, effort, and money. Effective documentation is a systematic, timely, accurate, well-written account of nursing care provided for patients. It must comply with standards established by regulatory and accrediting organizations, insurance companies, and the institution. What is charted may be examined by many reviewers, including accrediting, certifying, and licensing organizations; quality improvement professionals; Medicare and insurance company reviewers; researchers; and, in some cases, attorneys and judges. Therefore, nursing documentation is a critical part of the complete medical record.

PURPOSE OF MEDICAL RECORDS

A medical record is a valuable source of data used by all members of a health care team. Its purposes are to serve as a planning tool for patient care; to record the course of a patient’s treatment and changes in medical condition; to document communication between all health care team members; to protect the legal interests of the patient, the organization, and health care providers; to provide a database for use in statistical reporting, continuing education, and research; and to provide information necessary for third-party billing and regulatory agencies. The medical record must be accurate, complete, current, readily accessible, and systematically organized.

Nursing documentation communicates a patient’s assessment to other health care providers and team members. Professional responsibility and accountability are the most important reasons for accurate documentation. Nurses are managing patients with increased complex problems that require increased technology and equipment for care. Documentation is part of a nurse’s overall responsibility for patient care because it facilitates care, enhances continuity of care, and helps coordinate treatment and evaluation of the patient. Documentation allows a nurse to take credit for care provided, the patient’s response, and actions taken. Documentation must clearly communicate the nurse’s judgment and evaluation of a patient’s status. The patient’s medical record should provide information about a specific situation or illness and the events that occurred during the situation.

Another reason for accurate and complete nursing documentation is that it may be used in malpractice cases. The patient’s record is considered a legal document that can be used as evidence in a legal action. When a patient makes an accusation of negligence or malpractice against a health care provider, the record becomes a major source of information about the care that the patient received. Many lawsuits are won or lost by the amount of or lack of nursing documentation. Nursing documentation provides critical evidence about whether a standard of care was met. The patient’s chart is the best evidence of what happened to the patient; it becomes the witness that never lies and never dies. Accurate, timely, and complete charting helps track quality patient care and protects nurses, physicians, and the hospital from litigation.

The patient’s chart is used for auditing and for quality assurance. It helps organizations review and evaluate the quality of care given in an institution. Hospital accreditation is partially based on nursing documentation. The documentation must meet current requirements and demonstrate compliance with standards. Current JCAHO standards direct all health care facilities to establish policies about the frequency of documentation and necessary types of documentation. Professional organizations and reg-
ulatory agencies require that documentation include initial and ongoing assessments, any variations from the assessment, patient teaching, response to treatment or therapy, and relevant statements made by the patient and the family.

Managed care has evolved and necessitated the need to document accurate care for cost containment. Documentation of care helps organizations receive reimbursement from third-party payers, including private insurance companies and government sources of reimbursement, such as Medicare and Medicaid. The complexity of patient problems and the intensity of patient needs must be documented to ensure complete reimbursement. Each patient’s record must provide the DRG code and documentation of appropriate care to facilitate the receipt of appropriate payment.

A patient’s chart may also be used for education and research. Data gathered from medical records of patients may yield a variety of research studies. Students use medical records as educational tools. Patient records provide a comprehensive view of specific patients, their health problems, their medical treatments, nursing interventions, and the response to treatment interventions. Medical records help students understand patients’ individual experiences with specific health problems.

**COMMON NURSING FORMS**

Each patient’s medical record may include a number of specific forms, some of which are listed in Table 1-1. Although this table is not all-inclusive, it does provide a good representation of forms commonly found in medical records. Forms allow for quick, easy, and comprehensive documentation, and they are more accessible than long, detailed progress notes. Nurses are the primary people documenting on these forms. Discussion of some common nursing forms follows.

**TABLE 1-1: COMMON FORMS THAT MAY BE FOUND IN A PATIENT’S CHART**

Medical records vary by institution and the services provided. All records should contain some or all of the following basic information, if applicable to the patient:

- Patient identification and demographic data
- Informed consent for treatment and procedures
- Medical history, physical, and diagnosis
- Initial nursing admission assessment
- Anesthesia assessment
- Nursing diagnosis or problems
- Nursing or multidisciplinary care plan
- Record of nursing treatments and evaluations
- Diagnostic and therapeutic orders
- Health care providers’ progress notes
- Medication and treatment records
- Results of diagnostic studies
- Operative reports
- Delivery records
- Nurses’ notes of nursing observations
- Vital sign graphs or records
- Consultation notes and reports
- Reports from other disciplines (social services and recreational, occupational, and activity therapy)
- Physical therapy reports
- Nutritional notes and reports
- Fluid intake and output charts
- Patient education
- Discharge plan and summary

(Daniels, 1997; Pozgar, 2002)

**Nursing History Forms**

The nursing history form, or admission assessment form, must be completed by a registered nurse within a specified time frame from the time of a patient’s admission, usually within 24 hours. The form contains basic biographical data such as the patient’s age; method of admission; physician; the
admitting medical diagnosis or chief complaint; a brief medical-surgical history, including medication and drug allergies; the patient’s perceptions about illness or hospitalization; and a review of health risk factors. A nursing physical assessment of all body systems may also be included on the form or on a different form.

The data collected serves as a baseline with which changes in the patient’s status may be compared. Baseline data is very important. The exact form may differ by institution and is dependent upon standards of practice and the institution’s nursing care philosophy. A sample nursing history form is found in Figure 1-1 on pages 6 to 8.

**Graphic Sheets and Flow Sheets**

Graphic sheets and flow sheets allow nurses to readily see and assess changes in patient status. They provide a quick, efficient method to record information about vital signs and routine patient care. When a significant change is observed, the nurse may further document the assessment, intervention, and evaluation of that change in a narrative or progress note. The graphic sheet or flow sheet provides a quick, easy reference that all health care team members can use in assessing a patient’s status. A sample graphic flow sheet is found in Figure 1-2 on page 9.

**Nursing Kardex**

Daily patient care is commonly recorded on a flip-over card that is kept in a portable index file or notebook at the nurses’ station. Most Kardex forms have an activity and treatment section with a nursing care plan section. Referral to the Kardex throughout the shift helps a nurse organize information and plan care. The up-to-date Kardex reduces the need for continual referral to the patient’s chart for routine information. Depending on the institution’s requirements, the Kardex may become part of the patient’s permanent record. The Kardex provides the nurse an opportunity to communicate useful information to the nursing team about a patient’s unique needs. A sample Kardex form appears in Figure 1-3 on pages 10 and 11.

Even though the Kardex is helpful, it does have disadvantages. Access is limited to nurses and does not allow space for writing an extensive plan for multiple complex patient problems. In such instances, the nurse should consult the care plan. Another disadvantage is that the Kardex may not be updated routinely and thus a nurse may miss a current or active order.

**24-Hour Patient Care Records and Acuity Charting System**

Twenty-four hour patient care records eliminate unnecessary record-keeping. Accurate assessment information is documented on a flow sheet in checklist format. The form is the basis for the acuity charting system, which requires nurses to document interventions used to identify patient acuity. The acuity rating compares patients with one another and provides a system for determining staffing patterns. See Figure 1-4 on pages 12 to 14 for an example of a 24-hour patient care record.

**Standardized Care Plans**

Standardized care plans have simplified nursing documentation by providing preprinted, established guidelines to be used for patient care for specific problems. After the initial nursing assessment is completed, the nurse selects the appropriate standardized care plan and individualizes it to meet the patient’s specific needs. Many standardized care plans provide spaces for writing specific outcomes of care and recording the dates by which the outcomes should be achieved. A major advantage is that specific standards of care have been established and can easily be adapted to specific patients. The educational needs of the patient can easily be identified and addressed. Standardized care plans improve continuity of care and decrease documentation time.

A major disadvantage of standardized care plans is the risk of not taking the time to individualize the
FIGURE 1-1: SAMPLE NURSING HISTORY FORM (1 OF 3)

<table>
<thead>
<tr>
<th>WELLSTAR Health System</th>
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<tbody>
<tr>
<td>ADULT ADMISSION DATABASE</td>
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</table>

If patient is 17 or under, use the Pediatric Database  Form initiated by (Unit Name)  Date:  Time:

ADMISSION DATA:  Patient  Family  Other:  Emergency Contact/Phone:

REASON FOR ADMISSION:

VITAL SIGNS:  Ht.  Wt.  Actual  Stated  Temperature  Tymp.  Oral  Axillary  Rectal  Pulse  Respirations  Blood Pressure  Fetal Heart Tones

ALLERGIES:  Y  N  Type Reaction:  Drug  X-ray dye  Food  Latex  Allergy Band applied  Identification Band applied

ADVANCED DIRECTIVES/PATIENT RIGHTS/RELIGIOUS/SPIRITUAL/CULTURAL:

Have you completed a written document, such as a Living Will, that tells us what you would want in terms of your future healthcare?  Yes  No

If no: Provide written information; consult Social Services if further info requested.  

If yes: Copy on chart  Y  N  If copy not on chart: 1. Refer all inpatients to Social Services  

2. “Need copy of advance directive”

Do you have any questions regarding your rights and responsibilities as a patient?  Y  N  (If yes, review with patient/family)

Are there any special considerations/needs related to your religious/cultural/spiritual beliefs (such as blood transfusions, dietary restrictions, etc.)?

Are there any spiritual practices that are important to you?

Would you like for us to contact your church or someone from Pastoral Services for you?  Y  N

If yes, contact name  

Date/time contacted

COMMUNICATIONS:  English  Y  N  If no, language spoken  Interpreter:  Y  N

Speech:  Clear  Slurred  Mute  Aphasic  Other

Vision:  Normal  Blind  Contact(s)  Glasses  Lens Implant  Hearing:  Normal  Deaf  Hard/Hearing  Hearing aid

LEARNING ASSESSMENT:  How do you best learn?  Video  Verbal  Written  Demo  Other

Identified barriers to learning:  None  Emotional  Physical  Cognitive

HABITS/HISTORY:  Tobacco:  Never  Stopped date  packs/day  years

Alcohol:  Never  Stopped date  If yes, when was last drink  Recreational Drugs:  Y  N  Type/amt.

Medications Taken at Home:  (Include prescription drugs, aspirin, eye drops, inhalers, birth control, over the counter, herbal medications, natural therapies, complementary therapies, dietary supplements and vitamins)  Y  N  Type/amt.

<table>
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<th>Home Medications</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Last Dose</th>
<th>Home Medications</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Last Dose</th>
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</tbody>
</table>

Meditations:  None brought  Sent Home  Pharmacy  Insulin Pump  Pain Control Pump  Other  Exceptions

Prior Hospitalizations, Surgeries, Invasive Diagnostic testing, etc.:

Describe:  

Date:  

Describe:  

Date:  

Describe:  

Date:  

SIGNATURE:  

RN/LPN  DATE:  TIME:
## FIGURE 1-1: SAMPLE NURSING HISTORY FORM (2 OF 3)

<table>
<thead>
<tr>
<th>Health System</th>
<th>KENNESTONE</th>
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<td>ADULT ADMISSION</td>
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<td>WINDY HILL</td>
</tr>
<tr>
<td>DATABASE – Page 2</td>
<td>PAULDING</td>
<td></td>
</tr>
</tbody>
</table>

### PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: Check all that apply

- Anesthesia: □ Malignant hyperthermia
- □ Self
- □ Family Member
- □ Complications
- □ Other

- Cardiovascular: □ Abnormal EKG
- □ When?
- □ Heart Attack/When?
- □ Angina/Chest Pain
- □ CVA/TIA/When?
- □ Slow/Rapid/Irregular pulse (which)
- □ Congestive Heart Failure
- □ Mitral Valve Prolapse
- □ High Blood Pressure
- □ Pacemaker
- □ Aneurysm
- □ Heart Murmur
- □ Bleeding or Clotting Problems

- Endocrine: □ Diabetes Mellitus
- □ Cirrhosis
- □ Pancreatitis
- □ Hepatitis
- □ Hyper/Hypo Thyroidism
- □ Other

- Eyes: □ Eye Glasses
- □ Contact Lenses
- □ Glaucoma

- Gastrointestinal: □ Hiatal Hernia
- □ Bleeding Ulcers
- □ Rectal Bleeding
- □ Reflux
- □ Crohn’s/Ulcerative Collitis
- □ Colostomy, etc.
- □ Heart Burn

- Kidney & Bladder: □ Kidney Stones
- □ Kidney Failure
- □ Dialysis
- □ Kidney Transplant
- □ Prostate Problems
- □ Urinary Tract Infection

- Lung: □ Abnormal CXR
- □ Collapsed Lung
- □ Chronic Lung Disease
- □ Lung Cancer
- □ Emphysema
- □ Bronchitis
- □ TB
- □ Chronic Cough
- □ Excessive Sputum
- □ Asthma (last attack)
- □ Wheezing
- □ SOB: □ @/Rest □ after activity

- Neurologic: □ Epilepsy (last attack)
- □ Paralysis
- □ Muscle Weakness
- □ Muscle Disease
- □ Nerve Injury
- □ Parkinson’s
- □ Migraine Headaches
- □ Spinal Meningitis

- OB/Gyn: □ Last Menstrual Period
- □ Female Problems
- □ Currently Pregnant
- □ Problems with Childbirth

- Orthopedic: □ Neck/Back Pain
- □ Arthritis
- □ Other

- Teeth: □ Dentures/Bridges
- □ Loose Teeth
- □ Caps or Crowns
- □ Gum Disease
- □ Bleeding

### ADMISSION PAIN ASSESSMENT

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<tr>
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<th>Back</th>
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</table>

- Is patient able to give self-report of pain? If no, complete assessment with significant other. □ Y □ N
- Does patient have any ongoing pain problems? □ Y □ N
- Does patient have pain now? □ Y □ N
- Did patient take medication for pain prior to admission? (if yes, list under medication history) □ Y □ N
- Does patient use alternative treatments for pain? □ Y □ N

- Mark location(s) of pain body figure with a "P"

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<thead>
<tr>
<th>Current pain intensity: (Circle)</th>
<th>0 1 2 3 4 5 6 7 8 9 10</th>
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<td>Average/usual pain intensity: (Circle)</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
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<table>
<thead>
<tr>
<th>Pain scale used:</th>
<th>□ 0-10 numbers/faces scale</th>
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<tr>
<td>□ 0-10 behavior scale</td>
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<table>
<thead>
<tr>
<th>Pain quality:</th>
<th>Throbbing □ Sharp □ Pressure □ Dull □ Burning</th>
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<tbody>
<tr>
<td>□ Cramping □ Tender □ Aching □ Other</td>
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<thead>
<tr>
<th>Onset/Duration:</th>
<th>Time of onset □ Constant □ Intermittent</th>
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<tbody>
<tr>
<td>□ Day □ Night □ Activity/movement □ Other</td>
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### FALL RISK ASSESSMENT: (Circle points)

- Age > 65: 10
- Unsteady gait: 20
- Disoriented: 10
- Recent falls (past 3 months): 20
- Fall Prevention Protocol: □ Dementia or Psychosis: 10
- □ Incontinence/Urinary: 10
- □ Sedatives or Antipsychotics: 10

### BRADEN CHART

- □ Examined □ Verbal

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<tr>
<th>SKIN:</th>
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<th>Y □ N</th>
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<tr>
<td>□ Warm</td>
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<td>□ Cool</td>
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<td>D</td>
<td>Decubitus</td>
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<td>13-14 Mod</td>
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### SIGNATURE:

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</tbody>
</table>

<table>
<thead>
<tr>
<th>TIME:</th>
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</thead>
<tbody>
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</tbody>
</table>
**FIGURE 1-1: SAMPLE NURSING HISTORY FORM (3 OF 3)**

<table>
<thead>
<tr>
<th>WELLSTAR Health System</th>
<th>□ KENNESTONE □ DOUGLAS</th>
<th>□ COBB □ WINDY HILL</th>
<th>□ PAULDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADULT ADMISSION</td>
<td>DATABASE — Page 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PHYSICAL ASSESSMENT — Complete for: Peri-Op, Behavioral Health, Women's Unit, Invasive, Central Clinical Admissions**

<table>
<thead>
<tr>
<th>Operative/invasive site has been confirmed and verified:</th>
<th>Site location</th>
<th>□ Right □ Left □ Bilateral □ N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATT □ V □ Y □ N</td>
<td>□ Right □ Left □ Bilateral □ N/A</td>
<td></td>
</tr>
<tr>
<td>Day of Procedure □ Y □ N N/R</td>
<td>□ Right □ Left □ Bilateral □ N/A</td>
<td></td>
</tr>
</tbody>
</table>

**COGNITIVE/NEURO:**

<table>
<thead>
<tr>
<th>Oriented to: □ Person □ Place □ Time □ Decreased LOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral: □ Alert □ Anxious □ Angry □ Drowsy □ Cooperative □ Lethargic □ Confused □ Combative</td>
</tr>
</tbody>
</table>

**GASTROINTESTINAL:**

<table>
<thead>
<tr>
<th>Abdomen: □ Soft □ Firm □ Flat □ Distended □ Tender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Sounds: □ Present □ Absent □ Hypo □ Hyper</td>
</tr>
</tbody>
</table>

**GENITOURINARY:**

<table>
<thead>
<tr>
<th>Voiding without difficulty: □ Y □ N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolieting: □ Self □ Min □ Max</td>
</tr>
<tr>
<td>Cloudy □ Concentrated □ Incontinence □ Distended Bladder □ Catheter</td>
</tr>
<tr>
<td>Frequency □ Other</td>
</tr>
</tbody>
</table>

**NUTRITION:**

<table>
<thead>
<tr>
<th>I do not always have enough money to buy the food I need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without wanting to, I have lost or gained ten pounds in the past six months</td>
</tr>
<tr>
<td>I am on a special diet and do not understand the diet</td>
</tr>
<tr>
<td>I eat fewer than two meals per day</td>
</tr>
<tr>
<td>Nutrition Resource Sheet given: Initials</td>
</tr>
</tbody>
</table>

**RESPIRATORY:**

<table>
<thead>
<tr>
<th>Breath Sounds (RT): □ Normal □ Laboried □ Shallow □ Wheezing □ Productive Cough □ 0₂ at home □ L/min □ Trach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Procedural Plan of Care: □ To provide pre/post op teaching</td>
</tr>
<tr>
<td>□ Keep side rails up □ Provide aseptic environment □ Provide privacy during prep □ Limit traffic □ Limit physical exposure except as required</td>
</tr>
<tr>
<td>□ Provide warm blankets □ Confirm patient identity and allergy □ Keep family informed of progress □ N/A □ Other</td>
</tr>
</tbody>
</table>

**PRE-PROCEDURE PLAN OF CARE:**

<table>
<thead>
<tr>
<th>RNL/PN</th>
<th>DATE:</th>
<th>TIME:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADMITTED FROM: □ EC □ Home □ Admissions □ MD Office □ PACU □ OR □ V/A □ WC □ Stretcher □ Bed □ Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNIT ORIENTATION: □ Patient □ SO □ N/A □ Chaplain Service □ Visitation Policy □ Intercom □ Bathroom</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Bed/Door Labeled □ Bed Rails □ Shower □ Smoking Policy □ TV/Phone □ Valuables: □ Yes □ No Given to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent change in activity status: □ Yes □ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NUTRITION STATUS:**

<table>
<thead>
<tr>
<th>Diet at home □ New Diagnosed Diabetic □ Limited Diabetic Education □ No Home Glucose Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alterations: □ Difficulty Swallowing □ Tube Feeding □ Nausea &amp; Vomiting □ Eating Disorder □ Uloer</td>
</tr>
<tr>
<td>□ High Hematoma □ Unable to eat for &gt; 3 days □ Recent Weight Loss &gt; 10% 3 mos. □ Recent Weight Gain &gt; 10% 3 mos.</td>
</tr>
<tr>
<td>□ Nutrition Resource Sheet given: 23rd patient □ Initials</td>
</tr>
</tbody>
</table>

**IMMUNIZATIONS:**

<table>
<thead>
<tr>
<th>□ Flu □ TB □ Hepatitis □ Pneumonia</th>
</tr>
</thead>
</table>

**Home medical equipment will be used during hospital stay. Notify Biomed prior to use of home equipment.**

**Notify:** By computer or phone within 24 hours of admission to unit

<table>
<thead>
<tr>
<th>Wind Ostomy Continuity Nurse (w)</th>
<th>/</th>
<th>Pastoral Care (C)</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Nutrition (N)</td>
<td>/</td>
<td>Social Services (S)</td>
<td>/</td>
</tr>
<tr>
<td>Diabetic Education (D)</td>
<td>/</td>
<td>Pharmacy (P)</td>
<td>/</td>
</tr>
<tr>
<td>Respiratory Therapy (R)</td>
<td>/</td>
<td>Biomed (B)</td>
<td>/</td>
</tr>
<tr>
<td>Discharge Planning (DP)</td>
<td>/</td>
<td>*Rehab Services (RS)</td>
<td>/</td>
</tr>
<tr>
<td>Outpatient Care Management Patient: □ NA □ Unknown □ CHF □ Asthma □ COPD □ Diabetes □ Other</td>
<td></td>
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</table>

**DISCHARGE PLAN:**

<table>
<thead>
<tr>
<th>Probable Disposition</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Home Health Service: □ Y □ N Agency □ Hospice</td>
<td>Phone:</td>
</tr>
<tr>
<td>Equipment:</td>
<td></td>
</tr>
<tr>
<td>Discharge to: □ Home □ Nursing Home □ Personal Care Home □ Other</td>
<td></td>
</tr>
<tr>
<td>Rehab □ LTAC □ Subacute □ IRU □ Other</td>
<td></td>
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<tr>
<td>Primary Care Giver/Emergency Contact: Relationship: Phone:</td>
<td></td>
</tr>
</tbody>
</table>

**SIGNATURE:**

<table>
<thead>
<tr>
<th>RN/LPN</th>
<th>DATE:</th>
<th>TIME:</th>
</tr>
</thead>
</table>

**Nursing Notes:**

---

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### FIGURE 1-2: SAMPLE GRAPHIC FLOW SHEET

#### St. Joseph Hospital
Augusta, Georgia

**INTAKE/OUTPUT and GRAPHIC RECORD**

<table>
<thead>
<tr>
<th>Date</th>
<th>Weight</th>
<th>08</th>
<th>12</th>
<th>16</th>
<th>20</th>
<th>24</th>
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<th>12</th>
<th>16</th>
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<th>04</th>
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<tr>
<td>SHIFT OUTPUT</td>
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<tr>
<td>24 HR. OUTPUT</td>
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</tr>
</tbody>
</table>

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plan of care. In addition, plans must be formally updated and kept current and the costs of printing and storing the forms may become problematic. Standardized care plans are not designed to replace the nurse’s professional judgment and decision-making process. See Figure 1-5 on pages 15 and 16 for an example of a standardized care plan.

**Medication Administration Record**

The medication administration record (MAR) provides a list of the patient’s medications, dosages, routes, and times for administration, and it includes spaces for indications by the nurse if the medication has been given. Accurate documentation is crucial so that patients receive the appropriate drug, dose, and route of administration. If a patient refuses a drug or is off the unit for a specific diagnostic reason, the nurse should document in the nurses’ notes the reason the medication was not given. Some notation (such as an asterisk or the space circled) is made on the MAR to indicate that the medication was not given. See Figure 1-6 on pages 17 and 18 for a sample MAR.

**Discharge Summary Form**

To insure that the patient’s discharge results in desirable outcomes, discharge planning begins at admission. These outcomes may be documented on the discharge summary form. Revisions to the care plan provide evidence of patient and family involvement in the discharge-planning process. Discharge summary forms make the summary concise and informative. A copy of the form is usually sent home with the patient. The form may include information about the patient; identification of possible problems; names and phone numbers of people to contact if problems or questions arise; teaching, activity, diet, medication, wound care, and special instructions; and the date and time of the next physician’s visit. The information provides for continuity of self-care upon discharge. See Figure 1-7 on page 19 for an example of a discharge summary form.
### FIGURE 1-3: SAMPLE KARDEX FORM (2 OF 2)

#### ANCILLARY REFERRALS NEEDED
- Social Work
- Home Health Care
- Pastoral Care
- Dietary
- Speech Therapy
- Physical Therapy
- O/T
- Diabetic Educator
- Other: 

#### PATIENT/FAMILY TEACHING NEEDS

#### CIRCUMCISION:
- Date: 
- Gomco
- Plastibell
- Mogen
- Vaseline
- H2O2
- Other 

#### HIGH RISK FALL LABEL:

#### DISCHARGE NEEDS:
- Home Health Care
- New Arrival Program Member
- Short Stay / 24 hr. stay
- 23 Hr. Observation
- Dressing Supplies
- Diabetic Supplies
- Personal Care Assistance
- Assistance with Household Tasks
- Other: 

#### IF EMERGENCY NOTIFY:
- Name: 
- Relation: 
- Phone: 

#### VALUABLES:
- To Home
- To Safe

#### EPIDURAL CATH LABEL:

#### MEDICATION:
- To Home
- To Pharmacy

<table>
<thead>
<tr>
<th>LABORATORY</th>
<th>DAILY LABS</th>
<th>RADIOLOGY</th>
<th>TREATMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Due</td>
<td>Date Due</td>
<td>Date Due</td>
<td>Freq Times</td>
</tr>
<tr>
<td>Met Screen</td>
<td>Blood Glucose</td>
<td></td>
<td>Dressing Chg.</td>
</tr>
<tr>
<td>Chemstrip:</td>
<td></td>
<td></td>
<td>Sitz Bath/Hygiene</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date Due</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EKG/ECHO</td>
</tr>
</tbody>
</table>

| Date Due | MISC | CONULTING PHYS: |

<table>
<thead>
<tr>
<th>Room #</th>
<th>Adm. Date</th>
<th>Age</th>
<th>DOB</th>
<th>MR#</th>
<th>ACCT #</th>
<th>OLD RECORD</th>
<th>C/Section</th>
<th>NSVD</th>
<th>Date</th>
<th>Time</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Diagnosis</td>
<td>Physician</td>
<td>Pediatric</td>
<td>Blood Type</td>
<td>Mother:</td>
<td>Rh</td>
<td>Coombs</td>
<td></td>
<td></td>
<td></td>
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<td>Wt:</td>
</tr>
</tbody>
</table>
### FIGURE 1-4: SAMPLE 24-HOUR PATIENT CARE RECORD (1 OF 3)

#### PIEDMONT HOSPITAL

**MED-SURG 24 HOUR RECORD**

**DATE**

<table>
<thead>
<tr>
<th>Normal Parameters</th>
<th>Time:</th>
<th>Time:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nervous System</strong></td>
<td><strong>WITHIN NORMAL</strong></td>
<td><strong>WITHIN NORMAL</strong></td>
<td><strong>WITHIN NORMAL</strong></td>
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See nursing notes.
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<td>WNL  ( \square ) Condition</td>
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<td>#2 Site</td>
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<td><strong>Activity</strong></td>
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<td>BRP self  ( \square ) Assist  ( # )</td>
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<td>Dangle Self  ( \square ) Assist</td>
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<td>Hall  ( \square ) Tolerance</td>
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<td>TCDB q  ____ H Self  ( \square ) Assist</td>
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<td><strong>Hygiene</strong></td>
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<td>Bath Complete  ( \square ) Partial  ( \square )</td>
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<td>Shower  ( \square ) Refused  ( \square ) Self  ( \square ) Assist  ( \square )</td>
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<td><strong>Nutrition</strong></td>
<td>Tube feeding  ( \square ) Residual  ( \square )</td>
<td>Tube feeding  ( \square ) Residual  ( \square )</td>
<td>Tube feeding  ( \square ) Residual  ( \square )</td>
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<td>NPO  ( \square ) Self  ( \square ) Assist  ( \square ) Feed Pt.  ( \square )</td>
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<td>B’fast All  ( \square ) &lt;1/2  ( \square ) &gt;1/2  ( \square )</td>
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<td>Lunch All  ( \square ) &lt;1/2  ( \square ) &gt;1/2  ( \square )</td>
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<td>ID Band on  ( \square ) Siderails  ( \square )</td>
<td>ID Band on  ( \square ) Siderails  ( \square )</td>
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<td>Rounds Q  ____ H and PRN  ( \square )</td>
<td>Rounds Q  ____ H and PRN  ( \square )</td>
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<td>Restraint/protective device  ( \square )</td>
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<td>Type  ( \square )</td>
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<td><strong>Equipment, treatments, physician</strong></td>
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<td>notification, etc.</td>
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# FIGURE 1-5: SAMPLE STANDARDIZED CARE PLAN (1 OF 2)

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<tr>
<th>Interdisciplinary Plan of Care</th>
<th>Desired Outcome</th>
<th>Patient Specific Problem</th>
<th>Plan (Date each entry)</th>
<th>Outcome Status</th>
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</thead>
<tbody>
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<td>** Desired Outcome**</td>
<td><strong>Patient Specific Problem</strong></td>
<td><strong>Plan (Date each entry)</strong></td>
<td><strong>Outcome Status</strong></td>
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<td><strong>Pain</strong></td>
<td>1. Pain is controlled with medication and/or comfort measures</td>
<td>2. Pain free with medication and/or comfort measures</td>
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<td><strong>Nutrition</strong></td>
<td>1. Adequate nutrition status</td>
<td>2. Intake meets nutrition needs</td>
<td>3. Adequate elimination status</td>
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<td><strong>Hydration Elimination</strong></td>
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<td>2.</td>
<td>3.</td>
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<td><strong>Mobility, Safety and Self Care</strong></td>
<td>1. Dependent, does not participate</td>
<td>2. Requires assistive person and device</td>
<td>3. Requires assistive person and device</td>
<td>4. Independent</td>
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</table>
## FIGURE 1-5: SAMPLE STANDARDIZED CARE PLAN (2 OF 2)

<table>
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<th>Problem</th>
<th>Desired Outcome</th>
<th>Plan (date each entry)</th>
<th>Outcome</th>
<th>Status</th>
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<td>1. Patient and family are coping appropriately.</td>
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<td></td>
<td>2. Spiritual needs addressed</td>
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<td></td>
<td>3. Issues of crisis and loss addressed</td>
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<td>Tissue</td>
<td>1. Vital signs within normal limits and/or at baseline</td>
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</tr>
<tr>
<td>Perfusion</td>
<td>2. Pulse improved or at baseline</td>
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<td>Oxygenation</td>
<td>3. Patterns warm and normal color</td>
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<td></td>
<td>4. Adequate ventilation</td>
<td></td>
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<td>5. Level of consciousness within normal limits for patient</td>
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<td>6. Skin integrity maintained</td>
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<td>Infection</td>
<td>1. Abscess clean, warm, dry and no signs of redness</td>
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<td></td>
<td>2. Infection control measures initiated</td>
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<td></td>
<td>3. No purulent secretions</td>
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<td></td>
<td>4. WBC's normalizing</td>
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<tr>
<td>Communication</td>
<td>1. Oriented to environment and condition</td>
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<td></td>
<td>2. Hears spoken language</td>
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<td></td>
<td>3. Understands instructions</td>
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<td></td>
<td>4. Expresses needs and emotions</td>
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<tr>
<td>Discharge Planning</td>
<td>1. Identify discharge needs and support</td>
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<td></td>
<td>2. Systems collaborate with team</td>
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<td></td>
<td>3. Patient and family agree to plan of care</td>
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FIGURE 1-6: SAMPLE MEDICATION ADMINISTRATION RECORD (1 OF 2)

Department of Nursing
MEDICATION RECORD FORM

REGULARLY SCHEDULED DOSES

INSTRUCTIONS: Make first entry on Day of Week that medication is started. Identify all initials on reverse side.

ALLERGIES: __________________________

<table>
<thead>
<tr>
<th>START Dose, Route</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>SUN.</td>
<td>MON.</td>
<td>TUES.</td>
<td>WED.</td>
<td>THURS.</td>
<td>FRI.</td>
<td>SAT.</td>
</tr>
</tbody>
</table>

MEDICAT
FIGURE 1-6: SAMPLE MEDICATION ADMINISTRATION RECORD (2 OF 2)

Identify Injection Site with circled Code Number

e.g. 4 = Anterior Left Thigh

NOTE: 7, 8, 9, 10 are for subcutaneous injections only.

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>2. Left Deltoid</td>
<td>5. Ant. Right Thigh</td>
<td>8. Left Upper Quadrant</td>
</tr>
<tr>
<td>10. Left Lower Quadrant</td>
<td>11. Left Gluteal Area</td>
<td>12. Right Gluteal Area</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FULL NAME OF NURSE</th>
<th>INITIALS</th>
<th>TITLE</th>
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ST. JOSEPH HOSPITAL
Augusta, Georgia

**Patient Discharge Instruction**

<table>
<thead>
<tr>
<th>Room #</th>
<th>Date:</th>
<th>Time Discharged:</th>
<th>Ambulatory</th>
<th>W/C</th>
<th>Stretcher</th>
<th>Accompanied By:</th>
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</tbody>
</table>

Discharged/Transferred to: Home Other Name of Facility:

Transportation: Car Ambulance Left AMA: Yes No Expired: Yes No Funeral Home:

Pronounced Dead: Time: By Dr. Autopsy: Yes No Autopsy Forms/Permits Signed: Yes No

**LEVEL OF INDEPENDENCE:**

- [ ] Self Care
- [ ] Partial Assistance
- [ ] Maximum Assistance

Care Needs after D/C: Support services at home:

Discharged with:

- [ ] Glasses/contacts
- [ ] Dentures
- [ ] Meds from pharmacy
- [ ] Valuables
- [ ] Hearing/speech aid
- [ ] Other:

---

**PATIENT/RESPONSIBLE PERSON INSTRUCTED ON FOLLOWING WITH RETURN DEMONSTRATION AS NECESSARY**

1. **Medications/Prescriptions:**
   - **Name**
   - **Dose**
   - **Freq.**
   - **Name**
   - **Dose**
   - **Freq.**
   - **PMI Sheet Given**

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Freq.</th>
<th>Name</th>
<th>Dose</th>
<th>Freq.</th>
<th>PMI Sheet Given</th>
</tr>
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<td>Yes</td>
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<td>No</td>
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</tbody>
</table>

2. **Diet:**
   - Type: Instructions:

3. **Printed Instructions Given:** Yes No Type:

4. **Activity:**
   - [ ] Up as Desired
   - [ ] Walking
   - [ ] Do Not Lift
   - [ ] Bathtub/Shower
   - [ ] Use Walker
   - [ ] Driver
   - [ ] Do Not Climb Stairs
   - [ ] Other:
   - [ ] Use Crutches
   - [ ] Do Not Bend
   - [ ] Sexual Activity

5. **Treatments:**
   - [ ] Cold/Heat
   - [ ] Sitz Bath
   - [ ] Foley Care
   - [ ] Ostomy Care
   - [ ] Dressing Change
   - [ ] Pericare/Light
   - [ ] Bladder Instr.
   - [ ] T.E.D. Hose
   - [ ] Cast Care
   - [ ] Bowel Instr.
   - [ ] J-Vac
   - [ ] Circ. Check

6. **Equipment/Supplies:**

**Problems to Report to Physician:**

- [ ] Bleeding
- [ ] Fever
- [ ] Difficulty Breathing
- [ ] Unrelieved Pain
- [ ] Nausea/Vomiting
- [ ] Redness at Operative Site

Comments:

Agency to provide services at home:

Phone:

Your hospital Social Worker is:

Phone:

Appointment with Dr.:

Date: Time:

**These instructions have been reviewed/read to me and I understand them.**

Signature ________________________________ Relationship ________________________________

Nurse Signature: ___________________________ Hospital Phone Number and Unit Extension ___________________________
TRENDS IN CHARTING

In the past, documentation was process-oriented and emphasized tasks performed by health care providers. Today, increased consumer awareness, increased acuity of the patient, and increased emphasis on health care outcomes has created the need for changes in nursing documentation. Consumers expect nurses to be knowledgeable, competent, and caring while providing high-quality, highly technical care. This care must be recorded in the patient’s chart. Complex health problems, decreased lengths of stay, and increased patient acuity require documentation systems that reflect safe, efficient, and effective care.

Significant trends in documenting patient care have been observed. Trends include changes in traditional care planning and efforts to meet the need for increased documentation and improved communication while making charting less time consuming. Beginning in the 1990s, handwritten care plans were replaced with standardized care plans that require individualization to meet specific patient needs. Another trend at that time was the use of critical pathways, or care maps.

Increasing documentation efficiency is another trend. Methods have been developed to reduce the amount of time required for nursing documentation. Emphasis is being placed on documenting patient care outcomes, especially those that influence discharge planning. Trends aimed at improving communication through documentation involve using nursing diagnoses. A shift is also occurring from narrative and problem-oriented documentation to Focus charting and charting by exception. Furthermore, computerized documentation is becoming the primary means of documenting care in the 21st century. Some of these trends will be discussed in more detail throughout this course.

CONCLUSION

Nursing documentation is a critical component of nursing practice. It allows nurses to protect their careers by bringing together the best available evidence about nursing diagnoses, interventions, and outcomes about the care provided. It also protects nurses from inaccurate claims of malpractice and negligence.

The purpose of this course is to provide information to help nurses explore the professional and regulatory requirements for the documentation process; review documentation processes and systems; be aware of the impact of nursing documentation on patient care, the nursing career, and reimbursement; and learn steps to avoid litigation.

Nursing documentation methods must change to keep pace with rapid changes in the health care system. Patient outcomes are the latest trend for documenting patient care. The transition to outcome charting is not easy. It is now critical for nurses to document nursing judgments rather than tasks. Different forms used for nursing documentation vary from institution to institution. Representative forms a nurse may encounter were presented in this chapter. There are numerous charting methods that help nurses document outcomes and communicate complete, accurate, and clearly understood health care interventions and will be discussed further in the course.
EXAM QUESTIONS

CHAPTER 1
Questions 1-6

1. Documentation is a critical factor in patient care because it
   a. encourages lawsuits and disciplinary actions.
   b. provides the patient with a method to record his or her care.
   c. provides proof of the type of care rendered.
   d. underwrites the cost of patient care.

2. Nursing documentation is thought to have begun with the need for nurses to record their actions initiated by
   b. JCAHO.
   c. Florence Nightingale.
   d. DRGs.

3. The purpose of a medical record is to
   a. serve as a planning tool for patient care.
   b. serve as a method to blame others for not providing appropriate care.
   c. collect data against insurance claims.
   d. increase nurses’ work by requiring nonsense notes.

4. When reviewing Mr. Jim Jones medical record, a nurse would probably find which of the following forms?
   a. Medical history, operative report, and delivery record
   b. Physical therapy report, PAP smear report, and graphic record
   c. Medication record, nurses notes, and patient education
   d. Consultation notes, progress notes, and birth weight record

5. Effective documentation encompasses
   a. entries into patient records to show lack of the need for care.
   b. entries of nursing activities performed on behalf of the patient.
   c. oral communication of nonessential facts given during the shift report.
   d. scratch notes that can be discarded once the patient is discharged.

6. Increased consumer awareness, increased acuity of the patient, and increased emphasis on health care outcomes has created the need for such changes in nursing documentation as
   a. increased length of stay.
   b. continued use of handwritten care plans.
   c. reintroduction of the exclusive use of narrative notes.
   d. increased documentation efficiency.
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