Student Resource 10.6

Reading: Nurse Charting

One of a nurse’s most important responsibilities is to thoroughly chart, or document and record, every interaction a nurse has with a patient. Hospitals, long-term care facilities, and medical offices have different policies and procedures that nurses follow when charting. However, all charting done by nurses must be an accurate account of a nurse’s observations, decisions, actions, and the results of the actions. Charting is a complex subject that nurses receive training in, both in college and at the facility where they work. Nurses use different tools when they chart. These tools include worksheets, checklists, and care plans, which may be paper or electronic.

More and more health care facilities are using electronic medical records, or EMRs. Experts believe that having a patient’s medical information in one centralized digital location that is accessible by the patient’s interdisciplinary team improves both the quality of care the patient receives and the convenience for the nurses and other health care providers. They think EMRs decrease the likelihood for error caused by ineligible handwritten charting and other human mistakes. This image shows one screen from a patient’s EMR.

|  |
| --- |
| ::::Untitled.png |

The Importance of Charting

Charting is important because it helps nurses meet legal standards. It is also important because it allows nurses to communicate with each other and with doctors. It ensures that patients receive continuous care, or uninterrupted care.

Imagine this scenario: a nurse administers a dose of a strong pain medication to a patient but she fails to document it on the patient’s paper chart. Her shift ends and she goes home. The next nurse on duty reviews the patient’s chart. This new nurse sees that the physician ordered that the patient be given the pain medication. But there is no note that the patient ever received the medication. So the new nurse administers the medication again. The consequences of a patient receiving an unnecessary dose of medication are serious. It could harm the patient, and the hospital and nurse responsible could face legal action or penalty.

The Patient’s Record

The information that a nurse charts is usually part of the patient’s record. The hospital, clinic, or doctor’s office owns the record. But patients have the right to access any information in their records.

The information in patient records is confidential, or private. Legally paper records must be maintained and kept for a required amount of time, which is usually between 6 and 10 years. When that time has expired, the records must be destroyed completely so that no one can access them. Paper records should be shredded, not deposited into a recycling bin.

Information to Chart

The information that nurses chart is varied and depends on the patient’s condition, the facility, and the type of interaction the nurse has with the patient. For example, when a patient is first admitted to a hospital, the nurse will likely document information that includes the following:

* A history of the patient’s problem
* All injuries and illnesses the patient has
* The patient’s allergies, including allergies to medications
* Current medications that the patient takes
* The last time the patient ate food or drank fluids
* Details about the patient’s emergency contact
* The patient’s vital signs

A nurse who is providing care to a patient who has been hospitalized for several days will likely document the following:

* The patient’s current symptoms, often using the patient’s own words
* Any new symptoms or conditions, such as if the patient has an elevated temperature or is refusing to eat
* The patient’s vital signs
* Actions the nurse takes to respond to one of the patient’s problems, such as readjusting the patient so that he or she is more comfortable
* What the patient has eaten
* When the doctor examined the patient and what happened
* The nurse’s observations

Subjective and Objective Observations

The nurse will record both subjective and objective observations. A subjective observation cannot be seen or measured by a nurse. It is often a statement that the patient makes about the way that she feels. For example, if a patient says, “I feel warm and my eyes are burning,” the nurse will record that subjective information.

Objective observations can be seen or measured by the nurse. For example, temperature can be measured. Swelling, rashes, bruises, or wounds can be seen.

Imagine that a patient tells a nurse that he feels itchy and uncomfortable. The nurse then examines the patient and observes rashes on his stomach. The rash is an objective observation. An appropriate note in his record might say, “Mr. L is complaining of ‘feeling itchy and uncomfortable.’ The skin on his abdomen is red and swollen.”

Narrative Documentation

Nurses use different methods for charting information. One method is called narrative documentation. Using this method, nurses record events relating to a patient in chronological order over a period of time. Nurses create a narrative, or the whole story, of the care given to a patient. Narrative documentation can be used to assess a client before and after medication, to report information given to a physician, or to indicate instructions given to a patient’s family. Narrative documentation can stand alone or it can accompany another tool like a flow sheet or checklist.

Below is an example of narrative documentation. Notice that the date is given. The time for each entry is also given, and the entries are written in chronological order. Also notice that each entry gives a brief summary of what occurred with the patient at that time and that the nurse signed his or her name after each entry.

**Nurse’s Progress Record**

|  |  |  |
| --- | --- | --- |
| **Date** | **Hour** | **Progress Notes** |
| 3/5/12 | 1230 | Physical Therapist at bedside with Mrs. K. for ordered PT. Mrs. K. says she feels “comfortable” at this time. –P. Smith, RN- |
|  | 1245 | After PT session, Mrs. K denies pain. Rates pain 0/10. –P. Smith, RN- |

Abbreviations

In the first entry above, the nurse uses the abbreviation PT, which stands for physical therapy. Nurses are required to use abbreviations when they chart. Each medical facility uses different abbreviations, but here are some common ones.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Abbreviation** | **Meaning** |  | **Abbreviation** | **Meaning** |
| BID | twice a day |  | MN | midnight |
| CBR | complete bed rest |  | oint | ointment |
| DOB | date of birth |  | P | pulse |
| DX | diagnosis |  | QD | every day |
| Ex | examination |  | q3h | every 3 hours("q" for *quaque*, which means "every" in Latin) |
| FBW | fasting blood work |  | R/O | rule out |
| FH | family history |  | tab | tablet |
| HOH | hard of hearing |  | TID | three times a day |
| HS | at bedtime  |  | VS | vital signs |
| inj | injection |  | w/c | wheelchair |

Charting Checklist

Here is a list of general guidelines that nurses follow when they chart using paper records. (A different set of guidelines applies for electronic charting.)

* Write the date and time for each entry. The time should be given in military time. For example, 9:23 a.m. should be written as 0923, and 2:04 p.m. should be written as 1404.
* Entries should be legible.
* The nurse should sign each entry with his or her first initial, last name, and title. The signature should be on its own line at the end of each entry.
* Entries should always be in black ink because this is best for copying.
* A single line should be drawn through errors. The reason for the deletion must be noted, and deletions must always be initialed and dated. White out should never be used.
* Only abbreviations and symbols that have been approved by the facility should be used.
* No slang should be used, unless it is part of a patient’s quote.
* Information in entries should be clear and concise.
* Vague terms, like “good” or “normal,” should not be used.
* There should be no spelling or grammar errors.
* Something that has not happened yet should not be documented. For example, a nurse who is going to administer Tylenol, should not document it until the patient is given the medication.

Student Resource 10.7

Practice: Nurse Charting

Student Names:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_

Directions: After you have completed reading Student Resource 10.6, Reading: Nurse Charting, complete this resource based on the information in the reading. You may look back to the reading while you work.

Explain one reason why charting is important.

Who owns a patient's health records? What rights do patients have regarding their records?

Read the following scenario. Then, take on the role of the nurse. Fill in the line of the patient’s chart below with the pieces of information from the scenario that are necessary to chart. When possible, use the correct abbreviations.

On March 6, 2010 at 3:45 p.m. a mother and her child interacted with a nurse. The mother told the nurse, “My son is refusing milk and food.” The nurse asked the mother if the child had any allergies that she knew about. The mother said no. The nurse saw that the child’s face looked flushed. She took his temperature. It was 102°.

|  |  |  |
| --- | --- | --- |
| **Date** | **Hour** | **Progress Notes** |
|  |  |  |

Decide if each observation given in the chart is subjective or objective.

|  |  |
| --- | --- |
|  | Subjective or Objective |
| There is a blue bruise under the patient’s eye. |  |
| The patient complains of a stomach ache. |  |
| The patient’s temperature is 100°. |  |

Use what you have learned to guess the meaning of the following abbreviations.

q2h:

DOD:

Review the following narrative documentation. Then in the space below explain six problems with the report.

|  |  |  |
| --- | --- | --- |
| **Date** | **Hour** | **Progress Notes** |
|  | 3:00 p.m. | Mr. P looks normal, but he says that he feels worse than last time. |
|  | 2:45 p.m. | Will give meal to Mr. P in one hour. –Martin Roth, RN- |

1.

2.

3.

4.

5.

6.