



COURSESTUDYGUIDE

Understanding Charting and the Nursing Process

BY: Lippincott Williams & Wilkins

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For a facility to remain accredited, caregivers must document care that reflects the care standards set by national organizations, such as the American Nurses Association and The Joint Commission. Some states also require facilities to be licensed; licensing laws, in turn, require each facility to establish policies and procedures for operation. A facility's accreditation and licensure may be jeopardized by substandard documentation. Besides being complete and accurate, documentation must also be readable. This requirement has driven many facilities to develop computerized systems. When a facility is cited for having poor documentation or for not meeting set standards, a warning is given and a target date is set for the facility to make necessary changes and corrections. A facility may lose its license if these changes aren't accomplished. In effect, accreditation is evidence that a facility provides quality care and is qualified to receive federal funds. The federal government works with states accrediting organizations to make sure facilities are eligible to receive Medicare reimbursement.

Accreditation and reimbursement eligibility require documentation that accurately reflects the care provided to patients. Good charting demonstrates that facility and state nursing policies have been followed. Nurse practice acts are state laws spelling out what duties nurses can perform in that state. State nurse practice acts are revised frequently; when nurse practice acts change, charting requirements usually change as well. With laws and regulations in a constant state of flux, you must be especially meticulous about charting your care to show compliance with standards. Accurate nursing documentation is evidence that you acted as required or ordered. Accountability means you comply with the charting requirements of your health care facility, professional organizations, and state law. With the source-oriented narrative method, caregivers (the source) from each discipline record information in a separate section of the medical record.

This traditional method of documentation has several serious drawbacks: Because charting is done in various parts of the record, information is disjointed, topics aren't always clearly identified, and information is difficult to retrieve. These issues keep team members from getting a complete picture of the patient's care and cause breakdowns in

communication. Collaboration among team members who use source-oriented narrative charting is more easily documented if everyone writes on the same progress notes. For example, doctors', nurses', and respiratory therapists' progress notes can be combined into what may be called patient progress notes. These notes serve as the primary source of reference and communication among health care team members.

A problem-oriented medical record (POMR) contains baseline data obtained from all departments involved in a patient's care. The problem-oriented charting method is based on the patient's chief complaint. Some facilities modify the source-oriented or problem-oriented method of documentation to suit their needs. If your facility does this, you're in a position to influence the type and style of documentation you use in medical records. For example, home health care nurses have created many specialized documentation forms—including an initial assessment form, problem list, day-visit sheet, and discharge summary—to reflect the unique services and the essential quality of care they provide. These forms meet their charting needs while complying with state and federal laws and other regulations.

Computerized charting is popular for completing medical records from admission through discharge. Finding time to conduct a thorough patient history can be hard. However, a few strategies can help you keep interview time to a minimum without sacrificing quality. Sometimes an interview isn't even necessary—you can simply ask the patient to complete a questionnaire about his past and present health status. Then you can quickly and easily document the patient's health history by reviewing the information on the questionnaire and filing it in the patient's chart. This method is most successful for patients who are to undergo short or elective procedures. The questionnaire can be completed before the patient's admission, which can save you time, in some acute care settings, modified questionnaires are used to evaluate language or reading problem the patient may have. The nurse then reviews sections that are completed by the patient.

The second half of the assessment process involves performing a physical examination. When conducting the examination, use inspection, palpation, percussion, and auscultation. The objective data you gather during the physical examination may be used to confirm or rule out health problems that were suggested or suspected during the health history. You rely on these findings when you develop a plan and when you conduct patient teaching. For example, if the patient's blood pressure is high, he may need a sodium-restricted diet and instruction on how to control hypertension.

A patient's ability to perform ADL's affects how well he complies with therapy before and after discharge. Assess your patient's ability to eat, wash, dress, use the bathroom, turn in bed, get out of bed, and get around. Some facilities use an ADL checklist to indicate if a patient can perform these tasks independently or if he needs assistance. Deciding early what your patient needs to know about his condition leads to effective patient teaching. During the initial assessment, evaluate your patient's knowledge of the disease process, self-care, diet, medications, lifestyle changes, treatment measures, and limitations caused by the disease or treatment. One way to evaluate your patient's learning needs is to ask open-ended questions, such as "What do you know about the medicine you take?" His response will tell you if he understands and complies with his medication regimen or he needs more teaching. Your assessment findings form the basis for the next step in the nursing process: the nursing diagnosis.

According to NANDA International (NANDA-I), a nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems or life processes. Nursing diagnoses are used in selecting nursing interventions to achieve outcomes for which the nurse is accountable. Each nursing diagnosis describes an actual or potential health problem that a nurse can legally manage. A diagnosis usually has three components, first, the human response or problem—an actual or potential problem that can be affected by nursing care, second, the related factors—factors that may precede, contribute to, or be associated with the human response, third, the signs and symptoms—defining characteristics that lead to the diagnosis.

The nursing process consists of six distinct phases: assessment, nursing diagnosis, outcome identification, planning care, implementation, and evaluation. The nursing care plan, the fourth step, is a written plan of action designed to help you deliver quality patient care. The care plan is based on problems identified during the patient's admission interview. The plan consists of nursing diagnoses, expected outcomes, and nursing interventions. The care plan becomes a permanent part of the patient's record and is used by all members of the nursing team. Remember, patients' problems and needs change, so review your care plan often and modify it if necessary. To write a care plan, you can use three steps.

The first step is assigning priorities to the nursing diagnoses. The second is selecting appropriate nursing interventions to accomplish expected outcomes. Finally, you need to document the nursing diagnoses expected outcomes, nursing interventions, and evaluations. Nursing interventions are actions that you and your patient agree will help him reach the expected outcomes. Base these interventions on the second part of your nursing diagnosis, the related factors. For example, with a nursing diagnosis of *impaired physical mobility related to arthritic morning stiffness*, select interventions that reduce or eliminate the patient's stiffness, such as mild stretching exercises. Write at least one intervention for each outcome statement. How do you come up with interventions? There are several ways.

First, consider interventions that you or your patients have successfully tried before. For example, if the patient is having trouble sleeping in the hospital and he tells you that a glass of warm milk helps him get to sleep at home, this could work as an intervention for the expected outcome *sleep through the night without medication by 11/9*. You can also pick interventions from standardized care plans, ask other nurses about interventions they have used successfully, or check nursing journals for evidence-based interventions. If these methods don't work, try brainstorming with other nurses.

Evaluation statements should indicate whether expected outcomes were achieved and should list evidence supporting this conclusion. Base these statements on outcome criteria from the care plan, and use action verbs, such as *demonstrate* or *ambulate*. Include the patient's response to specific treatments, such as medication administration or physical therapy, and describe the condition under which the response occurred or failed to occur, and document all patient teaching and palliative or preventive care as well. After evaluating the outcome, be sure to record it in the patient's chart with clear statements that demonstrate his progress toward meeting the expected outcomes.

Author: Lippincott Williams & Wilkins. Textbook: Maryland Wolters Kluwer Health, 2009) pp 3-40.

Understanding Charting and the Nursing Process
Pre-Test

1. _____ is evidence that a facility provides quality care and is qualified to receive federal funds.
 - a. accreditation
 - b. accuracy
 - c. support
 - d. potential

2. A POMR, or _____ - _____ medical record contains baseline data obtained from all departments involved in a patient's care.
 - a. progress-oriented
 - b. progress-obvious
 - c. problem-oriented
 - d. problem-obvious

3. _____ means you comply with the charting requirement of your health care facility, professional organizations, and state law.
 - a. accountability
 - b. difficulty
 - c. denial
 - d. credibility

4. _____ charting is popular for completing medical records from admission through discharge.
 - a. diagnostic
 - b. paper
 - c. professional
 - d. computerized

5. The _____ you gather during the physical examination may be used to confirm or rule out health problems that were suggested or suspected during the health history.
 - a. personal information
 - b. correct information
 - c. objective data
 - d. finger prints

6. Some facilities use a (an) _____ checklist to indicate if a patient can perform daily tasks independently or if he needs assistance.
 - a. job
 - b. opening
 - c. ADL
 - d. closing

7. According to NANDA-International, a nursing _____ is a clinical judgment about individual, family, or community responses to actual or potential health problems or life processes.
- a. degree
 - b. chart
 - c. opinion
 - d. diagnosis
8. The fourth step of the nursing process is _____
- a. planning
 - b. evaluating
 - c. testing
 - d. nursing diagnoses
9. Nursing _____ are actions that you and your patient agree will help him reach the expected outcomes.
- a. majors
 - b. interventions
 - c. jobs
 - d. decisions
10. _____ statements should indicate whether expected outcomes were achieved and should list evidence supporting this conclusion.
- a. opinion-based
 - b. evaluation
 - c. hypothesized
 - d. diagnostic

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