Documenting and Reporting Patient Status

Date: **Instructor:**

Description: This inservice gives information on charting patient status and care, how to give report, and what to report to the charge nurse.

Objectives:
On completion of this inservice, participants will be able to:

Describe general charting guidelines

List what not to do when charting

Describe how to give report

List changes in the patient's condition that should be called to the charge nurse

Outline:

General charting guidelines

What to chart

Errors

What not to do when charting

Giving report

Calling the charge nurse

Changes in the patient's condition

Documenting and Reporting Patient Status

Lesson Plan and Speaking Notes

Charting the care you've given the patient and giving report on the patient's status are vital ways to maintain the chain of communication between all health care team members.

Conscientious documentation and report habits help to assure that the patient's quality of care and safety is maintained.

If it isn't charted, it did not happen. If it isn't reported, you are negligent.

Remember, the chart is a legal document.

General Charting Guidelines

Chart as soon as possible after giving care.

Make sure each page used is stamped with the patient's identifying information.

Begin the entry with the complete date and time of its initiation.

Use permanent ink so that entries cannot be erased.

Use black ink – other colors do not Xerox as well.

Write legibly.

Use only abbreviations approved by the agency –Ask your charge nurse for a complete list of agency approved abbreviations.

Do not leave blank or partially blank lines that would allow insertions or raise the question of whether information has been omitted. Draw a single straight line through any blank areas.

Sign the entry with your first initial, complete last name, and title.

When documentation continues from one page to the next, sign the bottom of the first page. At the top of the next page, write the date, time and "continued from previous page."

Document objective facts, observations, and data, and what you actually did for the patient. Don't chart your opinions, assumptions, or make subjective statements.

What to Chart

Care given, Procedures
Acute conditions
Changes of condition
Unusual occurrences
Incidents
Any call to the physician or family
Intake and output
Vital signs

Include the following information when documenting nursing procedures:

What procedure was performed
When it was performed
Who performed it
How it was performed
How well the patient tolerated it
Adverse reactions to the procedure, if any

Errors

Mark through the erroneous lines with one straight line of ink, and initial and date the entry.

Do not use white out or an eraser.

For charting omissions: Write the date and time you are actually charting. At the beginning of the entry write – "late entry for (date and time charting about)".

Do Not

Never refer to an incident report in the nursing notes.

Never amend someone else's documentation.

Never chart a symptom, problem, or complaint without also charting what you did about it.

Do not give excuses for not giving care such as inadequate staffing or a medication being unavailable.

Do not use language that is derogatory or suggests a negative attitude toward the patient, such as crazy, nasty, or outrageous.

Do not record staff comments or conflicts.

Do not refer to a second patient by name – this would violate that patient's confidentiality.

Giving Report

If your documentation is adequate, the report you give to the next shift or staff member will essentially be a summary of your notes.

Included in your report would be anything that you didn't chart, such as impending visits from other staff members, appointments, or perhaps agency-related information.

Do not leave other staff members guessing. There should never be any unnecessary surprises for anyone who follows your shift.

If you have been unable to perform part of your work, you should have already informed your charge nurse of this, and this information should be given in report too.

Before you leave, ask the replacing staff member if she has any questions for you, and make sure she has truly understood the information you have given.

Calling the Charge Nurse

The charge nurse should be called at any time you have questions about your assignment or the patient's care or status. When in doubt, call. It is better to be safe than sorry. Know who to call and what to do if you cannot reach the charge nurse.

Document in the chart when and why you placed the call, and the results of the call.

Never assume anything. If you are uncertain, place the call.

What are some changes in the patient's condition that should be called to the charge nurse?

Changes in the Patient's Condition

Abnormal vital signs
New or unusual complaints, symptoms, or observations
Incidents, Falls, or Injuries
Decreased strength or activity tolerance
Decreased mobility
Increased confusion
Signs or symptoms of acute illness
Altered mental status
Altered level of consciousness
New or unusual behavior
Sensory changes
Inadequate or unusual intake or output
Signs and symptoms of dehydration
New or increased pain
Skin breakdown

Post-Test

Title: Documenting and Reporting Patient Status
Instructor:
Date:
1. It is permissible to erase errors in charting. True False
2. Name three things that should be charted.
3. Incidents and staffing shortages should be charted. True False
4. Giving report is unnecessary if everything has been charted. True False
5. List three changes in the patient's condition that should be reported to the charge nurse.