Level 1 – Level one of *Nursing Documentation Using Electronic Health Records* includes chapters 1, 2, 3, and 4. These early chapters deal with the history and development of the EHR and trace the impact of standards development, certification, and the government's involvement with the EHR in the healthcare community. The theory, purpose, and types of nursing documentation are discussed with a focus on the MAR and the relevance of NIC and NOC. In Level one, students are also introduced to SpringCharts™ and learn essential documentation on an industry standard EHR program. They are introduced to the Nurse Note and are given hands-on practice in documenting chief complaints, vitals, and physical assessment on ten different disease case studies.

Chapter 2 – Nursing Documentation Overview

Chapter 2 examines the theory, purpose, and methods of nursing documentation. The Medication Administration Record (MAR) is examined and the importance of standardizing nursing language through nursing diagnoses, nursing outcomes and nursing intervention classifications is highlighted.

Learning Outcomes

After completing Chapter 2, the students will be able to:

2.1 Describe the role of documentation in nursing practice.
2.2 Identify the purposes of documentation.
2.3 Identify and explain different types of documentation methods.
2.4 Explain documentation of medication administration using an electronic Medication Administration Record (eMAR).
2.5 Explain the importance and relevance of nursing diagnoses, NOC, and NIC in nursing documentation.

Key Terms & Definitions

Terms and abbreviations encountered in Chapter 2:

Accreditation: A process whereby a healthcare organization is evaluated for adherence to standards of care; indicates that the facility provides quality care.

Ambulatory Healthcare: Provision of healthcare services in brief episodes to patients who are not admitted overnight to a hospital; may include, but is not limited to, outpatient clinics, urgent care centers, emergency rooms, ambulatory or same-day surgery centers, diagnostic and imaging centers, primary care centers, community health centers, occupational health centers, mental health clinics, and group practices.

Charting by Exception (CBE): Method of documentation in which normal parameters are delineated; only documentation of deviations to the pre-established parameters is required.

Computerized Charting: Use of electronic sources and databases to record data relating to patient care.

Critical Pathway/Care Map: A comprehensive, pre-established, interdisciplinary, standardized plan of care for stable patients experiencing a particular disease process or procedure; outcomes are usually predictable.

Database: A computer-based, comprehensive collection of related information organized for convenient access.

Diagnostic Related Group (DRG): System to classify patients into one of approximately 500 groups which are expected to have similar hospital resource use; developed for Medicare as part of the prospective payment system. DRGs are grouped by medical diagnoses, procedures, age, gender, and the presence of complications or co-morbidities; healthcare agencies are reimbursed a predetermined amount per DRG or procedure regardless of the patient's length of stay or cost of treatment.

Documentation: Act of recording patient information and patient care activities in written or electronic format; serves as legal evidence of care provided and poses ethical concerns regarding a patient's right to privacy.

eMAR: Electronic Medication Administration Record. Computerized method for documentation of drug administration.

Focus Charting/DAR: Documentation format in which all entries are related to a patient problem, or focus, which may be expressed as a nursing diagnosis. D (data), A (actions), R (response) are recorded for each focus using a three-column format to chart patient assessment data, actions taken based on the assessment, and the response of the patient to the actions.

Inpatient Care: Care provided to patients in a hospital or long-term setting that involves staying overnight after admission is ordered by a primary care provider.

The Joint Commission: An independent, nonprofit organization that sets standards of quality for healthcare organizations and evaluates compliance with these standards, providing accreditation for organizations that demonstrate excellence.

MAR: Medication Administration Record. Form used to document drug administration.

NANDA-I: North American Nursing Diagnosis Association-International. Organization responsible for developing standardized diagnostic terminology to reflect nursing practice (nursing diagnoses).

Narrative Charting: Chronologic recounting of relevant patient information throughout the course of the nurse's time with the patient; documentation is recorded in paragraph form.

NOC: Nursing Outcome Criteria. Standardized classification of statements for evaluating the effectiveness of nursing interventions.

NIC: Nursing Interventions Classification. Standardized classification of actions performed by nurses, both independent and collaborative.

Nursing Standards of Care: Statements that describe a nurse's responsibilities and accountabilities; indicate the minimum acceptable level of nursing care.

PIE: P—problem, I—interventions, E—evaluation. Method of documentation that focuses on patient problems or nursing diagnoses, interventions to address/resolve the problems, and evaluation of the effectiveness of the intervention; PIE notes are in narrative format and are labeled according to the patient's problems.

Problem-Oriented Medical Record (POMR): Method of documentation that emphasizes the patient's problems; data are gathered and organized, a problem list is generated followed by a nursing plan of action to alleviate the problems; PIE, SOAP, and SOAP(IER) are traditional POMR formats.

Quality Improvement (QI): The continuous efforts of healthcare professionals, patients and caregivers, to make the necessary changes that will lead to better patient care outcomes and better system performances.

Record: All information pertaining to the patient; includes electronic and handwritten data.

SOAP: S—subjective, O—objective, A—assessment, P—plan. Method of charting that focuses on gathering both patient-reported and nurse-observed data, drawing conclusions about the problems the patient is experiencing, and creating a plan to address the problems; commonly used in both inpatient and outpatient settings.

SOAPIE: S—subjective, O—objective, A—assessment, P—plan, I—intervention, and E—evaluation. Method of charting that adds documentation for interventions and evaluation to the SOAP note and enables nurses to detail the nursing process more thoroughly.

SOAPIER: S—subjective, O—objective, A—assessment, P— plan, I—intervention, and E—evaluation I—interventions, E—evaluation, and R—revisions; Expanded method of documentation that allows for documentation of nursing actions, evaluation of patient response to those actions, and changes to the plan of care based on progress toward outcome attainment; used in many areas of nursing since it reflects the nursing process.

Source-Oriented Charting/Source Records: Form of narrative charting in which each discipline documents in a separate section of the chart.

Presentation Outline

LO 2.1 Introduction to Documentation

Power Point Slides: 1,2,3,4,5.

Concept Checkup 2.1

A. Several concerns have been raised by critics of electronic documentation. List four of these concerns.
Answer:
1. Confidentiality of patient records
2. Power outages
3. Computer "crashes"
4. Computer viruses

Rationale: In addition to privacy concerns, opponents fear that EHRs may be subject to power outages, computer "crashes," and computer viruses that may alter patient data without the knowledge of the healthcare team or the patient.

B. What are some advantages of electronic documentation?
Answer:
1. Readily accessible information
2. Elimination of illegible handwriting
3. Automatic alert systems
4. Decision support
5. Reduction in duplicate diagnostic testing

Rationale: As indicated in Chapter 1, healthcare providers and organizations are increasingly implementing EHRs in order to enhance the quality of documentation and ultimately promote safe, effective patient care. In review, some benefits of the EHR include readily accessible information, elimination of illegible handwriting, automatic alert systems, decision support, and reduction in duplicate diagnostic testing.

C. What is the ultimate purpose for the implementation of EHRs?
Answer: To enhance the quality of documentation and ultimately promote safe, effective patient care.
Rationale: As indicated in Chapter 1, healthcare providers and organizations are increasingly implementing EHRs in order to enhance the quality of documentation and ultimately promote safe, effective patient care. In review, some benefits of the EHR include readily accessible information, elimination of illegible handwriting, automatic alert systems, decision support, and reduction in duplicate diagnostic testing.

D. What are the primary purposes of HIPAA?
Answer: The primary purpose of HIPPA is to protect the privacy of patient health information. Other purposes include giving patients access to personal records, requiring consent for release of records, and providing recourse for violations of privacy.
Rationale: In April 2003, healthcare organizations became responsible for adherence to the Health Insurance Portability and Accountability Act (HIPAA) that was passed in 1996 to protect the privacy of patient health information. All healthcare members, teams,

and systems are held accountable to this legislation, which gives greater control to patients for their care, provides patient education on privacy protection, ensures patient access to personal records, ensures patient consent prior to release of medical information, and provides recourse if privacy violations occur.

LO 2.2 Purposes of Documentation

Power Point Slides: 7,8,9,10,11.

Concept Checkup 2.2

A. Name three characteristics of good documentation.

Answer:

1. Comprehensive
2. Concise
3. Clear

Rationale: Documentation should be comprehensive, concise, and clear.

B. List five purposes of documentation.

Answer:

1. Prevent medical errors
2. Communicate with other healthcare providers
3. Demonstrate the delivery of care to ensure appropriate reimbursement
4. Adhere to accreditation standards
5. Provide a source of evidence in the event of legal proceedings

Other acceptable answers may include: to promote knowledge development through research and to promote patient safety.

Rationale: All patient care must be documented in the patient's record in order to: 1) prevent medical errors, 2) communicate with other healthcare providers, 3) demonstrate the delivery of care to ensure appropriate reimbursement, 4) adhere to accreditation standards, 5) provide a source of evidence in the event of legal proceedings, and 6) to promote knowledge development through research. Documentation is critical for patient safety.

C. List three common errors in documentation.

Answer:

1. Failure to record pertinent health or drug information
2. Failure to record nursing actions
3. Failure to record medication administration

Other acceptable answers may include: failure to record drug reactions, changes in a patient's condition, and discontinued medications

Rationale: To ensure patient safety, healthcare providers must avoid documentation errors, such as the failure to record pertinent health or drug information, nursing actions,

medication administration, drug reactions, changes in a patient's condition, and discontinued medications.

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D. What is the purpose of a DRG?

Answer: DRGs are used to establish the quantity of services for which a hospital, ambulatory care center, or home health agency will receive payment.

Rationale: Diagnostic-related groups (DRGs) are used to establish the quantity of services for which a hospital, ambulatory care center, or home health agency will receive payment. Healthcare organizations receive a standard payment for Medicare and Medicaid claims regardless of the time the patient received services or the type of services rendered. DRG determination is dependent on documentation. Documentation omissions may result in the assignment of a DRG that results in lower reimbursement.

LO 2.3 Documentation Methods

Power Point Slides: 12,13,14,15,16,17.

Concept Checkup 2.3

A. What is the key to documenting in a thorough, legal, and ethical manner?

Answer: The key to thorough, legal, and ethical documentation is to follow the nursing process to ensure the accuracy and comprehensiveness of the patient health record.

Rationale: The key to thorough, legal, and ethical documentation is to follow the nursing process to ensure the accuracy and comprehensiveness of the patient health record. Approaching documentation of nursing care in a systematic manner minimizes the risk of missed or inaccurate information.

B. What is a problem-oriented medical record?

Answer: The problem-oriented medical record allows for documentation based on the patient's problems. Data is organized by problem or category and a plan of care emerges from the problem database.

Rationale: The problem-oriented medical record (POMR) allows for documentation based on the patient's problems.. In the POMR, data are organized by problem or category and a plan of care emerges from this newly created problem database. Data are recorded using the PIE, SOAP, SOAP(IE), or SOAP(IER) formats.

C. What does SOAP(IER) stand for and why is it used frequently by nurses?

Answer:

S: Subjective Data
O: Objective Data
A: Assessment
P: Plan
I: Intervention

E: Evaluation
R: Revision

Rationale: SOAP, SOAP(IE), and SOAP(IER) are widely used among healthcare professionals, including nursing, because of the ability to chart assessment findings. However, the SOAP model is primarily a medical model and does not allow for nursing diagnosis and evaluation of interventions. Consequently, nurses often use the SOAP(IER) note format since this style allows for the entire nursing process to be addressed. SOAP(IER) represents:

- S – subjective data (verbalizations of the patient)
- O – objective data (measurable and observable data)
- A – assessment (diagnosis based upon data)
- P – plan (what the nurse plans to do)
- I – interventions (actions taken)
- E – evaluation (patient response to the intervention)
- R – revision (modifications to the plan based on the evaluation)

LO 2.4 Overview of MAR Documentation

Power Point Slides: 18,19,20,21,22,23.

Concept Checkup 2.4

A. What are the key components of documenting medication administration?
Answer: Documentation of medication name, dosage, route of administration, date and time of administration, and the signature of the nurse who administers the medication.
Rationale: While healthcare organizations use a variety of methods to record administration of medications, the critical aspects of recording medication administration remain the same. These critical aspects include documentation of the medication name, dosage, route of administration, date and time of administration, and the signature of the nurse who administers the medication. Patient allergies are routinely recorded on the medication administration record for ease of reference and to prevent administration of a drug to which a patient is allergic.

B. List three benefits of using an eMAR.
Answer:

1. Reduce the number of medication errors
2. Efficient tracking of medications within the healthcare system
3. Reduce time spent searching for missing medications

Rationale: Electronic MARs (eMARs) reduce the number of medication errors, protecting the patient from harm and the nurse from liability. In addition, eMARS allow for more efficient tracking of medications within the healthcare system. eMARs are usually user-friendly and reduce the time spent searching for missing medications.

LO 2.5 Standardized Nursing Language

Power Point Slides: 24,25,26,27,28.

Concept Checkup 2.5

A. How are nursing diagnoses, NOC, and NIC relevant to nursing documentation?
Answer: Nursing diagnoses, NOC, and NIC are relevant because of the need to communicate quality, effective standard terminology for nursing care.
Rationale: The need to communicate quality, effectiveness, and the value of nursing services led to the creation of databases accessible to all nurses to assist with accurate, legal, and reimbursable documentation criteria. In 1991 the National Center for Nursing Research of the National Institutes of Health recommended the development of standard terminology for nursing data. This led to the formation of standardized nursing diagnoses, nursing outcomes, and nursing interventions.

B. In what settings can nursing diagnoses, NOC, and NIC be used by nurses?
Answer: Traditionally in schools of nursing and inpatient care, but accurate patient care documentation is critical in any healthcare setting.
Rationale: The use of nursing diagnoses, NOC, and NIC has traditionally been limited to schools of nursing and hospitals where the focus is on inpatient care. However, accurate and appropriate patient care documentation is critical in any healthcare setting.

C. List three benefits of documenting the nursing plan of care using standardized nursing diagnoses, NOC, and NIC.
Answer:

1. Selection of diagnostic criteria enables the nurse to develop a plan of care in a variety of settings including hospitals, home health care, hospice, ambulatory care, schools, and nursing homes.
2. Standardized classification of outcomes and interventions.
3. Permits comparison of nursing care across settings.

Rationale: NANDA-I nursing diagnosis classifications are used to guide nursing decisions and plans of care for individual patients. Selection of diagnostic criteria enables the nurse to develop a plan of care in a variety of settings including hospitals, home health care, hospice, ambulatory care centers, schools, and nursing homes. NOC and NIC reflect nursing practice and permit comparison of nursing care across settings. NOC and NIC are comprehensive and can used in any healthcare setting. They are research-based from patient-driven encounters and are easy to use and apply to a variety of patient situations. NOC and NIC are linked to nursing diagnoses.

Chapter 2 Review Key

Using Terminology

1. I
2. E
3. B
4. A
5. J
6. F
7. G
8. C
9. D
10. H

Rationales:

1. NIC: Nursing intervention classification is a form of standardized language used to describe the actions that nurses take when providing nursing care.
2. eMAR: An Electronic Medication Administration Record is the mechanism for documenting drug administration via computer.
3. Computerized charting is the electronic mechanism for documentation of patient care in a variety of settings.
4. Inpatient care is health care provided in an acute care setting that requires that the patient remains overnight.
5. Quality improvement involves a continuous cycle of evaluating current performance through data collection, taking action to upgrade that performance and monitoring the results of that action.
6. Critical pathways are multidisciplinary, disease specific care plans used to delineate the typical course of care for stable patients.
7. NOC: Nursing outcome classification is a form of standardized language used to describe short and long-term goals of patient care that result from nursing interventions.
8. Ambulatory healthcare is care admitted in an outpatient setting.
9. Documentation is the process of noting patient observations, care rendered, and the evaluations of that care to provide a legal record.
10. NANDA-I is an international organization that developed standardized language to describe nursing diagnoses.

Checking Your Understanding

11. T
12. F
13. T
14. T

15. F
16. T
17. T
18. T

Rationales:
11. Documentation may impact reimbursement through indicating the accurate DRG and/or services rendered, facilitating reimbursement.

12. Increased Internet security systems, the acquisition of highly skilled informational technologists to monitor the patient system, and increased computer and documentation education for healthcare team members, concerns over the privacy and security of EHRs are diminishing.

13. Subjective and objective (S, O) data are collected to allow for the assessment (A) or nursing diagnosis. During the planning (P) phase, the desired nursing outcomes are determined followed by interventions (I) to help the patient achieve these goals. In the evaluation (E) phase, the patient's response to the interventions is measured and adjustments to the plan of care are made during the (R).

14. In 1991, the National Center for Nursing Research of the National Institutes of Health recommended the development of standard terminology for nursing data. This led to the formation of standardized nursing diagnoses, nursing outcomes, and nursing interventions.

15. Electronic MARs are for documentation purposes only and do not replace any of the "rights" of medication administration.

16. Electronic MARs (eMARs) reduce the number of medication errors, protecting the patient from harm and the nurse from liability.

17. One of the primary purposes of documentation is communication among caregivers.

18. Clear, concise, comprehensive documentation helps prevent medical errors, enhance communication, ensure reimbursement, demonstrate adherence to standards, provide legal evidence, and promote research.

19/20. Purposes of documentation (any three). Examples may vary.

A) Prevent medical errors
B) Enhance communication
C) Ensure reimbursement
D) Demonstrate adherence to standards
E) Provide evidence of care rendered
F) Promote research

Rationales: See section 2.2

21/22. Responses will vary. See Figure 2.5

23. B & C
Rationale:
Violations of HIPAA may result in civil penalties up to $25,000 and criminal penalties of up to $250,000 and up to 10 years in prison.

24. A
Rationale:
Failure to document important health information may result in a medical error through failure to communicate accurately with other healthcare professionals.

25. B
Rationale:
Chart reviews communicate the information gathered and care rendered by other healthcare professionals.

26. A
Rationale:
Narrative documentation allows the nurse to document full descriptions of observations and interventions.

27. C
Rationale:
During the planning phase of the nursing process, the nurse determines desired outcomes or goals of nursing care, expressed as NOCs. This coincides with the "plan" component of the SOAPIER note.

28. D
Rationale:
The need to communicate quality, effectiveness, and the value of nursing services led to the creation of standardized nursing language to assist with accurate, legal, and reimbursable documentation criteria.

29. A, B, & C
Rationale:
In addition to documenting medication administration, nurses must document when a medication is not given as ordered to prevent the appearance of an error of omission. Withholding a medication may occur for various reasons. The nurse must notify the primary care provider and document the notification and provider response when a medication is not given. (Documentation Tip)

30. B
Rationale:

Every nurse's encounter with a patient begins with assessment and gathering subjective and objective data. Similar assessment data are grouped together in logical categories in order to select the priority nursing diagnoses.