What’s wrong with the patient? What medications has the patient received? Did they work? Questions like these are asked and answered daily by members of the patient’s healthcare team as they piece together facts in order to make a diagnosis.

Assessments, test results, and opinions of specialists are some of the facts that lead the healthcare team to determine what’s wrong with the patient and the treatments that restore the patient’s health. And all are recorded in the patient’s chart.

Think of the patient’s chart as a database, a body of knowledge about the patient, the one source that has everything the healthcare team needs to return the patient to daily activities of life.

In this chapter, you are introduced to the various styles of charts and learn about the healthcare facilities that use them. You’ll also learn what to write in a chart—and what not to write in a chart—and how to avoid common errors and what to do if they should occur.
A Patient’s Record

Charting is the task of creating a patient’s medical record is called the patient’s chart. The chart contains information describing the patient’s previous and current medical conditions and healthcare that the patient received and will receive from the healthcare team.

A chart has progressed from a clipboard hanging from the foot of the patient’s bed to electronic charts that enable the healthcare team to access and update patient information from computer workstations throughout the healthcare facility and from remote locations. During this transition from paper charts to electronic charts, many healthcare facilities use large loose-leaf binders to hold a patient’s record.

The chart is used to document a patient’s medical condition and treatment among the healthcare team. Charting begins when the patient arrives at the healthcare facility when the admitting clerk enters the patient’s name, address, medical insurance, and other nonmedical information into the chart.

The nurse completes the admission packet through an interview process. This is where the patient’s medical history, social history, current medical problem, current medication list, and the nurse’s physical exam, including vital signs, are added to the chart. Next, the physician completes the patient’s history and physical and that becomes part of the medical chart. The physician will also write or enter orders for medical tests, treatments, and medications. The healthcare team updates the chart after carrying out each order.

A patient is monitored by a nurse 24 hours a day while in the healthcare facility. Their observations are recorded several times a shift in the patient’s chart.

CHARTS BEYOND THE HEALTHCARE TEAM

The patient’s chart is used by others besides the healthcare team for purposes other than providing the patient healthcare.

The healthcare facility and the patient’s medical insurance carrier use the chart for billing and reimbursements. Medical tests, medications, medical procedures, and other treatments listed in the patient’s medical chart are itemized on an invoice prepared by the facility’s billing department based on Medicare’s Diagnosis-Related Group (DRG). The invoice is submitted to the patient’s carrier who refers to the patient’s chart to determine if care given to the patient was necessary and customary.

Government agencies and accreditation organizations such as JCAHO (Joint Commission on Accreditation of Healthcare Organizations) audit patients’ charts to determine if the healthcare facility and the healthcare team are in compliance with laws and rules designed to assure that patients receive quality healthcare.
CHAPTER 1  Charting Basics

Management of the healthcare facility use patients’ charts to determine the cost and quality of care and whether or not care is efficiently provided to patients. Charts also serve as a performance baseline and are used by managers and staff to decide if current performance meets acceptable levels.

Medical and nursing students use charts as a puzzle to learn how to care for patients. Students piece together a patient’s diagnosis and medical history, physician orders, test results, and progress notes to understand why those orders were issued and how treatment resolved the patient’s condition.

Medical researchers find charts contain a treasure trove of raw medical data to study and analyze. They pour over this empirical data looking for clues to improve medical science and patient care.

The patient’s chart is key evidence in legal challenges to a patient’s medical care. Each element of the chart documents care given to the patient. Attorneys take the position that if care isn’t charted, then that care wasn’t given to the patient.

Types of Charts

Healthcare institutions adopt a charting system that complements the type of care given to a patient. There are five commonly used charting systems. These are:

Narrative: The narrative charting system begins with the patient health history and assessment. This information is used to develop the patient’s care plan that describes details of how the health team will care for the patient. Progress notes (Figure 1-1) and flow sheets are entered in each shift to describe the patient’s status and the care that was given to the patient during the shift. The narrative chart concludes with the patient’s discharge summary. The narrative charting system is used for ambulatory care, acute care, home care, and long-term care.

<table>
<thead>
<tr>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 Patient admitted for complaints of chest pain rated as 8 out of 10 on the pain scale. Nitroglycerin times 1 administered with relief. Resting quietly at this time.</td>
</tr>
</tbody>
</table>

Figure 1-1
Problem-Oriented: The problem-oriented charting system focuses on the patient’s problems. It too begins with the patient’s medical history and assessment. A problem list is created based on the patient’s assessment and a care plan is developed that details how the health team is going to address each problem. Progress notes are written at each shift and a discharge summary is prepared for when the patient is discharged. Information is entered into the chart using SOAP, SOAPIE, or SOAPIER formats. SOAP (Figure 1-2) is subjective data (what the patient says), objective data (data based on your observation and testing), assessment data (your conclusion based on subjective and objective data), and plan (your strategy for addressing the patient’s problem). SOAPIE (Figure 1-3) is similar except following the plan you record your intervention (the measures that you’ve taken to care for the patient) and evaluation (the effectiveness of the intervention). The SOAPIER format includes revision (changes to the plan) as the last step. Problem-oriented charting is found in acute, home, and long-term care facilities and in mental health and rehabilitation institutions.

Problem-Intervention-Evaluation: Problem-intervention-evaluation charting (Figure 1-4) is focused on ongoing assessment of the patient during each shift. A problem list is created following the patient’s history and initial assessment. The patient is then reassessed during each shift and the results are written in progress notes and flow sheets. This charting system is used mainly in acute care facilities.

<table>
<thead>
<tr>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 S: “I have a lot of pain to a level 10 out of 10” O: Sitting down, grimacing, clenching fists with movement A: Abdominal pain P: Medicate for pain</td>
</tr>
</tbody>
</table>

Figure 1-2

<table>
<thead>
<tr>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 S: “I have a lot of pain to a level 10 out of 10” O: Sitting down, grimacing, clenching fists with movement A: Abdominal pain P: Medicate for pain I: Medicated with MS 2 mg IVP E: Patient pain level decreased from 10 to 3 R: Continue with plan</td>
</tr>
</tbody>
</table>

Figure 1-3
FOCUS: FOCUS charting (Figure 1-5) uses a data, action, and response (DAR) format. *Data* refers to what’s going on with the patient such as the patient is having difficulty breathing. *Action* is what you did about it such as administration of 2 L of oxygen using a nasal cannula. *Response* is the patient’s response to your action such as the patient returned to normal breathing. FOCUS charting requires a patient’s history and initial assessment. A checklist of problems (nursing diagnosis) is created and a care plan developed. Flow sheets and progress notes are then used to document patient care. FOCUS charting is frequently seen in acute and long-term care facilities.

**Charting by exception** is an umbrella term covering the previously mentioned types of charting except for narrative charting, which requires charting of all findings about the patient. The charting by exception style of charting documents abnormal findings using the SOAPIE or SOAPIER format (see Problem-Oriented Charting) or FOCUS charting. The institution establishes standards and norms. Any deviations from these are entered into the chart. Some healthcare facilities find charting by exception efficient and cost effective. The charting by exception chart contains the patient’s initial assessment and problem(s). A care plan is developed to address each problem. Flow sheets and progress notes are then used to document the patient’s abnormal condition. This charting method is used in acute and long-term care facilities.
COMPONENTS OF A CHART

Each charting system contains a common set of components. These are:

Patient Information: Patient information consists of the patient’s name, address, telephone, occupation, employer, insurance carrier, and family contact information.

Patient History: Patient history provides a subjective description of the patient’s health and social history. It also contains information about the medical history of the patient’s family.

Episodic Information: This component documents the patient’s current complaint and initial physical assessment. It answers the question what brought you here today.

Psychosocial Information: Psychosocial information describes the patient’s mental and development stage based upon the patient’s age. It also describes the patient’s current living conditions and social support system, as well as marital status and/or number of children if not a minor.

Medical Orders: The medical orders component contains orders written by healthcare providers. These can be orders for tests, administration of medication, or procedures.

Lab Results: The lab results component identifies the laboratory tests that were performed and the results of those tests.

Tests Results: There can be one or more sections of the chart for test results depending on the charting system adopted by the healthcare facility. Some charting systems will have a section for commonly performed tests such as electrocardiogram (ECG), or diagnostics for x-rays. Test results usually contain the numeric or graphical results and a narrative that describes the examiner’s findings.

Progress Notes: A progress note describes an observation made by a healthcare provider, such as a physician, relating to the patient’s care.

Nurses’ Notes: Nurses’ notes contain observations of the patient made by the patient’s primary nurse. Many hospitals now utilize the multidisciplinary progress note so that all providers from the healthcare team are charting on the same record and the information is shared.

Care Plan: The care plan describes details on how the healthcare team will address the patient’s problems.

Legal: The legal component of the chart contains patient consent forms, living will, advanced directives, and other legal documents that direct how the patient wants to be cared for while in the healthcare facility.

Medication Administration Report (MAR): The MAR contains the record of medication ordered for the patient and when it was administered. Information on the MAR is pulled from the medical orders component of the chart.

Discharge Information: The discharge information component contains a checklist of things to do when discharging the patient and a record of whether or not it was performed. It also contains instructions that the nurse must give the patient before the patient leaves the healthcare facilities.
CHAPTER 1 Charting Basics

Tip An incident report is NOT part of the patient’s chart. An incident report must be written for errors and potential errors that occur during the patient’s care (see Chapter 2).

Writing in a Chart

It is important to keep in mind that you are telling the patient’s story when you write a chart. You’re telling members of the healthcare team and others who are involved with the patient information about the patient’s health and the care that the healthcare team delivered to the patient.

The nursing process, referred to as ADPIE, is a good approach to follow when documenting patient care. ADPIE is the acronym for assessment, diagnose, plan, intervention, and evaluation.

Assessment is the systematic collection of data and verifying the collected data. That is, symptoms reported by the patient are independently verified through observations and testing.

A diagnosis is the identification of the patient’s problem by looking for data clusters that lead to a pattern pointing to a problem. There are two kinds of diagnoses: medical and nursing. This difference becomes evident when using the ADPIE type of charting, which focuses only on the nursing diagnosis.

The plan details how the healthcare team will treat the patient. It lists who will do what and when it will be done. The plan is described in medical orders and in the patient’s care plan and serves as a map guiding the healthcare team as they resolve the patient’s healthcare problem.

Intervention is carrying out the plan. Each step of the plan that is performed is documented in the chart. The time, date, route, and who administered medications are entered into the MAR (see Medication Administration Report). Test results are entered into the chart along with interpretation of those results depending on the test. All interventions must be documented in the chart. The absence of documentation means that the intervention was not performed.

Evaluation describes what happened after the intervention. Did the intervention resolve the patient’s problem? The evaluations of interventions are documented in progress notes, nurse’s notes, and flow sheets. The healthcare team may continue, modify, or terminate the plan for treating the patient depending on the evaluation.

RULES FOR CHARTING

The patient’s life depends greatly on how well the patient’s chart is written. What may be simple, understandable errors such as illegible and slightly misspelled words can have a grave effect on a patient’s care.
Everything written in a chart must be legible. This is crucial if charting is not performed using a computer and instead entries are written. Countless errors occur when healthcare providers scribble orders, test results, or progress notes in order to quickly move on to the next patient.

Don’t assume. Illegible charting leaves others on the healthcare team one of two choices: guess at the meaning of what was written or verify it by contacting the healthcare team member who wrote it. Unfortunately, an educated guess often overrides the time-consuming task of trying to verify the order, which can lead to fatal errors.

Does it make sense? Take a moment and stop a second. Ask yourself if what you intend to document makes sense in terms of the patient’s health. Is what you are about to write is clearly related to the patient’s problem, treatment plan, or intervention? The chart should only contain concise relative information.

Only accurate facts should be entered into the chart. Chart your opinion, only state the facts as they present themselves. Others on the healthcare team are basing their decisions on what you write in the chart. It is always better to write facts that you personally observed. Always provide facts that lead you to any conclusion.

Chart in a timely fashion. Ideally chart at the bedside. If this is not possible, then chart immediately after you leave the patient when the information is fresh in your mind. Any delay in charting can lead to errors. You may not recall the information about your patient or you might confuse the information with information about another patient. Others on the healthcare team may make decisions about the patient based on outdated information.

Watch your spelling! Changing one letter in a word can have an altogether different meaning and have serious repercussions for the patient. Don’t guess at a spelling or phonetically spell a word. Take the time to look up the correct spelling.

Avoid abbreviations. Abbreviations save time and space when charting; however, abbreviations are the source of errors because the assumption is that everyone who reads a chart knows the meanings of abbreviations. It is always best to avoid using abbreviations when charting. Healthcare facilities always have a list of approved abbreviations for that institution.

Chart only for yourself. Don’t chart for other members of the healthcare team because you did not observe those facts yourself.

Date and sign each entry. Begin each entry into the chart with the time and date. Document your findings and then sign the entry followed by your title.

Be complete in your charting. Specify an intervention and evaluation for each problem that you document. If you write that the patient has difficulty breathing, then be sure to write what you did to solve the problem.

**Tip** It is best to use black ink when charting. Black ink shows up better when charts are photocopied or faxed.
CHAPTER 1  Charting Basics

VERBAL ORDERS

Physicians and other members of the healthcare team who are authorized to issue orders must explicitly write those orders in the patient’s chart. In extreme emergencies, a nurse can take verbal orders over the telephone, which is then followed up with written orders once the healthcare provider arrives at the healthcare facility.

Here are guidelines to follow when taking verbal orders.

Don’t accept a verbal order if the healthcare provider is in the healthcare facility unless there is a system in place that directs the physician to enter the order into the computer or write the order in the chart within 24 hours of giving the verbal order. Always know the correct policy for your institution for guidelines related to taking verbal orders.

Ask the healthcare provider to fax the order if possible. The fax should contain the healthcare provider’s signature. Always know the correct policy for your institution for guidelines related to faxing printed orders.

Read back the order to the physician to avoid errors when taking verbal orders. Write down the order during the call. Make sure the patient is correctly identified and the right medication, dose, routine, and time are indicated if it is an order for medication.

Clarify any portion of the order that doesn’t make sense. Ask the healthcare provider to spell the patient’s name and names of medications. Realize that the healthcare provider can be mistaken.

Verify the order by reading what you wrote to the healthcare provider. Also compare the verbal order to information in the patient’s chart to assure you are dealing with the correct patient and that the order doesn’t conflict with current orders.

Talk directly to the healthcare provider. Don’t take verbal orders from anyone who is not authorized to issue an order.

Write the verbal order in the chart. Sign the healthcare provider’s name followed by your name indicating that this is a verbal order. The healthcare provider must countersign the order within 24 hours.

What to Write

Your objective is to clearly report on the patient’s progress using as few words as possible. That is, make your point and avoid writing everything that went on in the patient’s life that day. Your writing provides other members of the healthcare team facts about the patient that helps them continue caring for the patient.

It is critical to chart facts and not your opinion. For example, “had a good day” or “did not appear to be in that much pain” are opinions, not facts. On the other hand, “patient reported a pain of 2 (0–10)” is fact.
Likewise, charting “physician was called” is a fact; however, “when I called the physician about this patient, he sounded tired and not interested in what I had to say” is an opinion.

Avoid writing words that could defame someone. Charting is not the place to attack the good name and reputation of the patient or anyone on the healthcare team.

Throughout this book we’ll show techniques of keeping your charting to the minimum amount of words while still conveying important facts about the patient. It isn’t easy to keep your notes brief and to the point. For example, Figure 1-6 shows a rather long-winded way to chart the patient’s pain. A better description is shown in Figure 1-7.

A common trick used by experienced nurses is to draw a mental picture of the patient’s problem and then describe that image in the chart. Let’s say that you are describing a wound. Picture the wound in your mind and then describe the wound in the chart such as “large abdominal dressing intact with 1 cm of red/brown wound drainage noted.”

Another trick is to think logically and systematically when charting. Use a head to toe approach and describe each system completely before moving on to the next system. This is illustrated in Figure 1-8 where the progress notes begin with the neurological system and then to the respiratory system.

<table>
<thead>
<tr>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 patient complained about a lot of pain and when I asked what the number was on the pain scale, he said that it was a 10.</td>
</tr>
</tbody>
</table>

**Figure 1-6**

<table>
<thead>
<tr>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30 Complaints of pain; 10 on 1–10 pain scale</td>
</tr>
</tbody>
</table>

**Figure 1-7**
Fixing Errors

Expect to make errors when writing in a chart because it happens to everyone. Typically, you are adding information on a page that already contains information entered by others on the healthcare team; therefore simply ripping up the page and starting over isn’t an option when you entered an error on the chart.

Instead you must draw a single line through the error and place your initials above the line. Don’t cover up the error with white out or heavily cross out the text making it unreadable. The error must be legible and clearly indicate it is an error. Making the error illegible might lead someone to believe that the error is being concealed.

**Tip**  Visitors and relatives are not authorized to see the chart. Never leave the chart open or visible to unauthorized personnel (see HIPAA in Chapter 2).

Summary

Charting is the task of creating a patient’s medical record called the patient’s chart. The chart contains information describing the patient’s previous and current medical conditions and healthcare that the patient received and will receive from the healthcare team.

Charts are used for purposes other than providing patient healthcare. They are used for billing, reimbursements by medical insurance carriers, accreditation and licensed organizations, managing the healthcare facility, legal matters, and researching and learning about patient care.
There are two commonly used charting systems. Charting systems are either narrative or problem-focused charting by exception which is now most commonly used. When using the charting by exception method, the nurse can choose between one of three common types of problem charting which are problem-oriented, problem-intervention-evaluation, and FOCUS. The institution where you work will have a policy that indicates the type of charting used in that institution for nursing and other healthcare providers. Each of these systems has common components that provide general information about the patient including the patient’s medical history, current problem, assessments, test results, diagnosis, medical orders, treatment plan, and discharge teachings.

When writing in a chart it is important that you keep in mind that you are telling the patient’s story to other members of the healthcare team. Write legibly. Present only facts. Make sure what you write makes sense. If you make an error, draw a single line through the error and initial it.

Quiz

1. At change of shift, the nurse you are relieving forgot to update the patient’s chart with the latest vitals. She gives you a slip of paper and asks you to enter it into the chart. What is the best response?
   a. Enter the vitals as requested.
   b. Say that you’ll do it this time only.
   c. Take your own set of vitals and enter it into the chart.
   d. Explain that policy requires each nurse to do their own charting.

2. You are supervising a student nurse who makes an error when charting progress notes. What should you do?
   a. Explain that errors occur and the draw a single line through the error and initial it.
   b. Explain that errors occur and give the nursing student a new page to rewrite everything that is on the page that contains the error.
   c. Explain that errors are not acceptable and order the student nurse off the floor.
   d. Explain that the error information is close to being correct and it won’t matter because the patient is being discharged anyway.

3. You are reviewing a patient’s chart and notice a component that doesn’t belong in the chart. Which of the following should be removed from the chart?
   a. Care plan
   b. Medical insurance information
c. Opinions from a specialist who reviews test results

d. An incident report

4. A nurse is called to testify in a malpractice case. The patient’s attorney claims the chart shows that the important treatment was ordered but nothing in the chart shows that it was performed by the nurse. The hospital’s attorney places the nurse on the stand to testify that she performed the treatment. What is the judge likely conclude?

a. The treatment was performed but not charted.
b. The nurse is lying.
c. The treatment wasn’t performed because it wasn’t charted.
d. Charting the treatment is irrelevant to the case.

5. A new nurse asks what abbreviations can be used in a chart. The best response is.

a. Review hospital policy.
b. Only use abbreviations that are found in standard nursing textbooks.
c. Never use any abbreviations.
d. Always use abbreviations to save time and space in the chart.

6. A new nurse is having difficulty reading a medical order in the patient’s chart. What is the best course of action to take?

a. Ask another nurse to help interpret the written order.
b. Ask another nurse supervisor to help interpret the written order.
c. Call the healthcare provider who wrote the order for clarification.
d. Ask the physician on call to interpret the written order.

7. After administering scheduled medication, where would you document it in the chart?

a. Medication administration report
b. Progress notes
c. Nurse’s notes
d. Update the care plan

8. Which of the following isn’t appropriate to write in a chart?

a. The patient had a bad day and won’t get out of bed to exercise.
b. The patient in bed, two rails up.
c. The patient refused to eat breakfast, saying that he wasn’t hungry.
d. 135/70, R 20, P 72, T 98.7
9. A student nurse asks how the patient’s chart is used for reimbursement of medical expenses. The best response is
   a. The patient’s diagnosis is listed in the chart and is compared to Medicare’s Diagnosis-Related Group, which is used to determine reimbursements of medical expenses.
   b. The billing department faxes the entire chart to the medical insurance company for review.
   c. The billing department reviews the chart to itemize all the expenses related to caring for the patient.
   d. The chart is not used for reimbursement of medical expenses.

10. A student nurse asks how a patient’s chart can be used to learn about patient care. The best response is
   a. You can piece together assessments and test results to see how the healthcare provider diagnosed the patient and then see why specific medications and treatments were prescribed to address the patient’s problem.
   b. You can look up medical words and tests you see in the chart, so you understand what is happening to the patient.
   c. After reviewing the chart, you can call the healthcare provider and ask why medications and treatments that are listed in the chart were prescribed.
   d. The chart isn’t a good tool to use to learn about patient care.