

Documentation

Documentation includes reporting and recording & it is the major communication technique used by health care providers to direct client-based decision making and continuity of care. The medical record serves as a legal document.

Purposes

1. Communications.
2. Accountability(response for action).
3. Research & education.

Forms for Recording data

There are several types of forms used in record keeping:

- Kardex.
 - Flow sheets.
 - Nurses' progress notes.
 - Discharge summaries.
- All of these forms are designed to:
- Facilitate record keeping.
 - Reduce duplicate activity.
 - Ensure quick and easy access to the information.

Kardex

- It is a summary worksheet reference of basic client care information that traditionally is not part of the medical record.
- Used as reference throughout the shift and a during change of-shift reports.
- Kardex come in various sizes, shapes,& types.

The Kardex usually contains

1. Client data: Name, age, marital status, religious.
2. Medical diagnoses: Listed by priority
3. Nursing diagnoses: Listed by priority
4. Medical orders: Diet, medications, IV therapy, treatments,

5. Diagnostic tests and procedures.

Flow sheets

Flow sheets have vertical and horizontal columns for recording dates and times to show assessment and interventions, making it easy to track changes in the client's condition.

- Because it have small spaces for recording, we use the approved abbreviations to chart data.
- Flow sheets in critical care settings are more comprehensive than are those on a medical-surgical unit.

Nurses' Progress Notes

Are used to document the client's condition, problems, and complaints; interventions; response to interventions; and achievement of outcomes.

It include the following forms:

Nurses' notes, medication administration report, personal care , teaching reports, intake and output forms, vital sign reports, nursing procedures, and specialty forms (e.g., diabetic flow sheet and neurologic assessment form)

Discharge Summary It includes:

- The client's status at admission and discharge.
- A brief summary of the client's care.
- Intervention and education outcomes.
- Client instructions regarding medications, diet, follow-up instructions, and other special needs

Reporting

- Reporting is the verbal & written communication of data regarding the client's health status, needs, treatments, outcomes, & responses.
- As with recording, reporting is based on the nursing process, standards of care, and legal and ethical principles.
- It can be through a medical or nursing walking rounds.

Methods of Documentation

1. Manual documentation.
2. Computerized documentation.

Guidelines for documentation

1. Use the common vocabulary.
2. Should be legible and organized.
3. Use only authorized abbreviations & symbols.
4. Should be factual and organized according to its time .
5. Should be accurate and specific.
6. Use the direct quotes.
7. Should be clear & concise.
8. Record all relevant information.
9. Respect confidentiality.

criteria for documentation

1. Should be Meet the legal standards.
2. Errors avoidance.
3. Avoid leaving the Blank spaces
4. Signature is very important.
5. Using of abbreviations & terminology.