LABRADOR-GRENFELL HEALTH

DOCUMENTATION GUIDELINES

For The
REGIONAL NURSE

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GENERAL GUIDELINES

The Client Health Care Record utilized by Regional Nurses is laid out in the following manner:

a) A Cumulative Patient profile
b) Outpatient Register Record
c) Laboratory component
d) X-Ray Component
e) ECG Component
f) Correspondence / Consult Component
g) Discharge Summary Component / OBS notes

The nurse ensures that all components of the client record are maintained in the outlined manner.

All forms in the client health record must include:

- Client's Name
- Address
- Telephone Number
- MCP Number
- Date of Birth
- Next of Kin
- Appropriate Community Clinic Site.

A Health Record register is maintained at all sites. It is organized in the following manner:

- Commences with 001 and proceeds in ascending number according the composition of new charts.
- Identifies the client's name (last name first), MCP number, Date of Birth and Next of Kin.
- Ensure that the red "Allergy" label and green "More than one with same Name" label is on the front cover of the clients chart as needed.

A Death Register is also maintained at all sites. It denotes the Health Care Record Number, Client's Name and Date of Death.

GUIDING PRINCIPLES

1. Follow policies of the institution

2. All entries must have date, and time entered at the commencement of documentation and the full signature of the nurse must follow the entry with qualifications, after the name. For all after hour visits and emergencies an Emergency Stamp is utilized to highlight the client visit.

3. Order is imperative. Do not mix points in the history with the physical exam.

4. Use the S.O.A.P. initials to divide the section clearly. Use indentations and spacing to accentuate the organization.

5. Record client information in system point form. Try to avoid paragraph writing.

6. Document in chronological style with the most recent occurrence first.

7. Record all data both positive and negative that contribute to the assessment.

8. Document what you observed and what you did.

9. Be objective. No hostile, judgmental, disapproving comments should be recorded in the file.

10. Only abbreviations approved in policy are to be used. Avoid basket terms

11. Documentation is to be done as soon as possible following the client visit.

12. Record <u>actual</u> time care <u>occurred.</u>

13. Document any follow-up to nursing interventions, pharmacological and non-pharmacological.

14. Record frequently, with increased risk and complexity;
***Remember nothing charted, nothing done.**

15. Avoid end of day charting, chart frequently.

16. If there needs to be a correction, one single line through text and initial. Indicate “mistaken entry” not error.

17. **DO NOT** delegate charting.

18. Write in ink

19. Do not write other peoples name in the chart

S.O.A.P. DOCUMENTATION POLICY

PURPOSE:

A) To communicate client health information.
B) Provide continuity of care.
C) Provide Quality Assurance.
D) Facilitate research.
E) Demonstrate accountability.
F) Legal Defense
G) Meet Legislative requirements
H) Research
I) Legal proof that health care was provided- nursing documentation is relied upon by the courts as evidence of what was done or not done when a patient sues.
J) Auditing

PROCEDURE:

S **Subjective Information**: Information which the examiner obtains from the client. This may include information obtained from the client's family/relatives.

This is the history of the client's current complaint and past health status.

Remember: Onset, Quality, Quantity, Severity, Location Radiating, Associative Symptoms, Aggravating or Alleviating Symptoms

O **Objective Information**: Information which the examiner obtains from examining the client.

It uses the techniques of inspection, palpation, percussion and auscultation. Information is also obtained from laboratory tests and X-rays.

A **Assessment**: The nurse's impression or conclusion reached through analysis of the subjective and objective data collected. This can be a diagnosis, an impression, or a change in the client's condition. The nurse then assigns an E-

Code to the diagnosis and notes it in the chart margin.

P **Treatment Plan:** Action regarding the client's problem.
Pharmacological and Non Pharmacological

Medical/nursing plans i.e. dressing changes, health teaching, ongoing assessment, referral, etc. Medications ordered; refill of prescription.

Self Directed Learning Instructions

The scenarios that follow describe a completely hypothetical case. It is recognized that the information provided may not normally occur in all cases.

Step 1. Read the case scenarios and complete the documentation on the Out Patient Register Record and applicable forms.

Step 2. Compare your documentation with Answer sheet.

Step 3. Write down any questions, comments, and or concerns to be discussed at the end of the allotted time.

Scenario # 1

Mrs. Mary Smith, aged 77 (date of birth 22 01 26, MCP # 236 349 181 020, telephone # 960-0271, health record # 038) was brought to the Community Clinic of Port Hope Simpson on March 12, 1998 by her husband George complaining of pain in the mid abdominal region. In discussion with her and her husband the nurse learns the following information:

- Pain commenced two days ago. Started as an irregular sharp, stabbing pain but now is a constant burning pain radiating to all quadrants of the abdomen. She has never experienced this type of pain before. Her bowel movements are regular.
- Medications are:
  - Enteric Coated ASA 325mg OD
  - Inderal 10 mg tid
  - Colace 1 tablet bid
  - Nitro 0.3mg prn.
- Upon assessment the following was noted:
  - Temperature 37.5 C
  - B/P 140/76
  - Pulse 88 irregular
  - Neurological signs normal
  - Abdomen examined
    - Bowel sound diminished in all quadrants
    - Guarding of abdomen midline
    - Percussion exhibited low resonance midline.
  - Chest auscultated – normal breath sounds heard throughout.
  - Mucosa of the mouth dry
  - Skin tergor poor
  - Skin dry
  - Rectal –examination – dark stool noted on glove. Stool hard and rectum full. While doing rectal exam Mrs. Smith said the she stopped taking her Colace because it made her move her bowels too many times.

Diagnosis – Acute abdomen may be due to constipation, irritable bowel or bowel obstruction.

Scenerio #1 con't

Stool for occult blood x 3
Discuss with physician if unable to clear bowels in 24 hours.
Stool for occult blood – postitive
Stool sample collected for C & S
Patient was encouraged to drink plenty of fluids.
Enema give with good results.
Teaching about the importance of taking her medication was provided.

EXAMPLE ONE:
SCENARIO ONE:

S Complaint of abdominal pain 2/7.
States that the pain is irregular, stabbing and radiating throughout abdomen.
It's a constant burning pain, never had this pain before.
Normal bowel movements.
No nausea and vomiting.
No fever.
Stopped taking Colace x ? ½
NKA

O 27 year old female accompanied by husband, looks pale and is garding abdomen

V/S- T – 37.5 oral B/P 140/76 Rt arm sitting HR – 88 irreg
Mouth – dry
Integ – dry – poor turgor no tenting
Chest – clear A/E throughout
Abd – bowel sounds decreased
dullness noted in midline
palpitation normal
Psoas and abutrator sign – negative
PR – stool hard and dark- OB positive
Urine – negative

A Acute abdominal pain secondary to constipation.

P Consult DMO
Stool for OB x 3 and C & S
Advised to take meds as prescribed, to increase exercise, fluids and fibre.
RTC in 1/12 for F/U. If unresolved, consider Dietician referral.

Jane Doe RN

EXAMPLE TWO:

S Request Meds

O N / E

A Med refill

P HCT 25 mg once a day # 3/12 100
Due for well woman check x 1/12
Will do B/W and B/P checks then
Advised client to book appointment

Jane Doe RN

EXAMPLE THREE:

S For Blood work

O N/E

A Blood work

P Blood collected for CBC, U & E, LFT, FLP
RTC PRN

Jane Doe. RN

Scenario # 2.

Mr. Charles Jones, 58 years old (date of birth 40 11 22, MCP # 340 218 639 020, telephone # 939-6428, health record # 422), was brought to the Community Clinic in St. Lewis on June 10, 1998 at 1000 hours by his son Paul because his wife Jane was in St. Anthony for an appointment. Mr. Jones complained of central chest pain which is radiating to neck and left arm. In discussion with him the nurse learns the following information:

Pain commenced yesterday after supper. The client states that he taught it was gas and took some Mylanta which helped a little. The pain stayed in his chest but he didn't want to bother the nurse so he stayed at home and rested. When Paul visited this morning he saw that his father was in pain and brought him to the clinic.

- He is not on any regular medications but takes Mylanta for upset stomach occasionally and Tylenol for pain when needed.
- Upon Assessment the following was noted:
  - Temperature 37.5 C B/P 178/102 Pulse 108
  - Neurological signs normal, Client Diaphoretic
  - Client's complexion pale
  - 12 Lead ECG done, indicative of ST elevation
  - Heart Sounds auscultated: normal
- Client has labored breathing. Chest auscultated and clear.
- Client placed on Propaq monitor for pulse, rhythm strip and Sp O2.

- Diagnosis – Chest pain may be due to angina or Myocardial Infarction.
- Treatment Plan:
  - Monitor v/s
  - Commence Oxygen 4L/min
  - Compare ECG to previous ECG
  - Discuss with physician
  - ASA 80mg x 2 PO
  - Bed Rest
  - Blood Work for Cardiac Enzymes
  - Nitro 0.3mg S/L

Client continues to have chest pain. ER Physician, Dr is contacted, ECG is faxed and report given. It is decided that a medevac would be arranged. The Aeromedical Evacuation team will arrive at the site in approximately 2 hours. The physician also request that an IV Normal Saline be commenced to keep the vein open and Nitro 0.3 mg S.L be given immediately.

Please complete SOAP documentation and send to your Clinical Coordinator