

Preface

The fourth edition of *Nursing Documentation: A Nursing Process Approach* was written to provide readers with current information about documentation. Several factors influence contemporary nursing charting practices. The increased acuity of patients and the nursing shortage have decreased the amount of time available for documentation. Nurses are seeking information on how to refine charting practices or redesign charting systems to streamline charting. As organizations merge, charting practices in the new corporate structure must be integrated. Furthermore, nurses should be aware that patients are now more likely to sue nurses and other healthcare personnel than in the past; therefore legal issues related to charting are increasingly important as nurses become more concerned about protecting themselves from liability. Finally, nurses should recognize that a wide variety of regulatory agencies are scrutinizing their charting, including the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), peer review organizations, insurance companies, utilization managers, and quality management/quality improvement personnel.

This text is intended for student nurses, practicing nurses, and attorneys who wish to increase and update their knowledge of documentation. Nurse managers, case managers, and administrators who are looking for methods to improve the efficiency and effectiveness of their charting systems will also find this book helpful.

This fourth edition provides a systematic overview of the essentials of documentation and has been thoroughly revised and updated. Throughout this edition, timely topics have been included, such as common litigation issues in home care, maternal and child care, critical care, perioperative care, psychiatric care, and long-term care. This information will help readers better understand the need for proper documentation and will ensure that nurses understand the pitfalls of incomplete or inaccurate documentation. It will help attorneys interpret medical records. In addition, updated information on the trends in charting, along with legal issues, reimbursement issues, and issues surrounding changing an existing documentation system, have been included.

Furthermore, new information has been added on the development and use of clinical pathways. Information on outcome-oriented charting and clinical path charting is also new to this edition.

Chapter 1 describes the factors that influence documentation practices and decisions about changing a documentation system. Chapter 2 discusses the documentation of assessment findings on the initial data base. Chapter 3 covers the documentation of nursing diagnosis and planning and also updates the new forms of care planning, including critical pathways. Chapter 4 describes the documentation of implementation and the design and use of flowsheets. Chapter 5 covers the documentation of the evaluation of patient responses--the aspect of charting that some nurses have found to be the most difficult. Chapters 2-5 include the most current information about nursing standards of practice, the Nursing Outcomes Classification, and Nursing Interventions Classification.

Chapter 6 presents the legal aspects of charting, which are illustrated by nursing case law, in addition to highlighting defensive charting through the use of examples. Chapter 7 describes and compares the major charting systems currently in use and lists the factors that must be considered when selecting a documentation system. Chapter 8 presents current information about computerized medical records. Chapter 9 provides tips on implementing changes in a documentation system, which should be particularly helpful to staff development departments, members of documentation committees, and nurse managers.

The chapters in the latter part of this book describe the clinical issues pertinent to a particular specialty and include examples of case law. Chapter 10 focuses on documentation issues specific to obstetrical nursing, while Chapter 11 details aspects of neonatal nursing. Chapter 12 covers the basics of documenting the care given to pediatric patients, one of our most vulnerable populations. Chapter 13 describes critical care documentation in intensive care units, whereas Chapter 14 addresses charting in emergency departments. Chapter 15 covers perioperative documentation, including operating room suites. Chapter 16 addresses the charting of care given in the postanesthesia care units. Chapter 17 addresses documentation in psychiatric settings, and Chapter 18 covers home care nursing charting. Chapter 19 describes long-term care documentation.

ACKNOWLEDGMENTS

We are indebted to our contributors, who dedicated their time to share their knowledge of documentation in specialty areas. Examples of documentation forms are integrated throughout the text. As we gathered forms from a variety of sources, we learned that no one “perfect” form that every agency can use exists. We included the best examples from the forms available to us. We welcome any documentation forms sent by readers for possible inclusion in the fifth edition of this book. Much of the content of this edition is based on our experiences as educators, consultants, and agents for change. We have taught documentation programs throughout the United States and Canada and have learned a great deal from our participants.

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