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RSPT 1101
Introduction to Respiratory Care

The Medical Record

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The Medical Record

- = written report of a patient's history, examinations, diagnosis, progress, therapies, response to therapies, prognosis
- Doctor has 1 in his office
- New 1 started each time patient is admitted to hospital

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The Medical Record

- With increasing specialization, now are many practitioners for each patient
- Patient may see
  - Several nurses
  - Several doctors
  - Pharmacists
  - Nutritionists
  - Therapists

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The Medical Record

- Careful documentation & communication is vital to
  - Plan continuous quality care
  - Coordinate care
  - Communicate constantly to keep each other up to date on patient's condition & Rx's
  - Furnish data for continuing education & research

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The Medical Record

- = single best source of info about a patient & for this reason, it is a legal document, admissible as evidence in a court hearing or trial
- = legal proof of the quality of care you provided & carries much weight in a courtroom
- ***Failure to document is assumed by the court that you failed to provide care or failed to observe/assess***

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Types of Medical Records

- Formats for organization
- 2 types
  - Source method
  - Problem-Oriented Medical Record (POMR)

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Source Method

- Chronological/sectional organization (material organized chronologically in sections)
- Type of medical record hospitals use

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Sections - Admission Sheet

- Contains personal data
  - Name
  - Address
  - Sex
  - Diagnosis
  - Date of admission
  - Nearest relative
  - Occupation
  - Marital status
  - Employer
  - Insurance co.
  - Religion
  - Hospital no.

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Sections - Physician Orders

- Usually only physicians can write here or someone authorized to take doctor's orders
  - Nurse practitioners
  - Nurses
  - Therapists
- Makes duplicate copies

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Sections - Physician Orders

9/14/02 0830 O2 by nasal cannula.
v.o. Dr. Baker / Hansen RRT

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Sections

- History & Physical
  - Dictated/typed record of doctor's physical exam & patient history at time of admission
- Progress Notes
  - Must have an entry each day
  - Entries made by dr./pa/nurse practitioner or whoever is on call for him

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Sections

- Nurses Notes
  - Record of nursing care: treatments, response to treatments, patient behavior, assessments, etc.
- Graphics
  - Graphs & records of vital signs (T, P, R, BP), patient daily weight, cardiovascular information
  - Recorded by nurses

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Sections

- Medications
  - Meds given, times, dosages
- OR/PAR
  - Consents, pre-op assessment, VS graphics, dictated/typed description of surgery
- ICU
  - q24° records

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Sections

- Separate sections for
  - Laboratory
    - Microbiology, pathology, hematology, cytology
  - Radiology
    - X-rays, MRIs, CT scans, PET scans, nuclear medicine
  - Physical Therapy
  - Respiratory Therapy

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- Drawback to Source method = must consult several sections to get a clear picture of patient's condition & progress
- Failure to consult all separate records could have disastrous clinical consequences for the patient

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POMR

- = Weed System
- Uses same chronological approach
- Difference is that all members of the HC team combine all info related to Dx & Rx for each situation
- = used in clinics & doctor's offices
- Separate POMR created with each visit

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Sections

- Database
  - Hx, c/o, physical exam, lab reports
- Problem List
  - Lists physical & psychological conditions related to present problem
- Plan
- Progress Notes
  - Sequential, detailed listing of everything done to care for the patient

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Format

- S: subjective data
- O: objective data
- A: assessment
- P: plan of action

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Subjective:	Patient complains of shortness of breath while in bed.	
Objective:	Physical Exam:	Patient diaphoretic. R - 28/min, P - 112/min, moderate use of accessory muscles of respiration
	Laboratory:	ABGs drawn: pH - 7.36, $PaCO_2$ - 48 mmHg, PaO_2 - 42 mmHg, HCO_3^- - 30 mEq/l.
Assessment:	Patient moderately hypoxic.	
Plan:	Administer O_2 at 4 lpm, observe closely, obtain ABG in 45 min.	

Signature: _____

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Source vs. POMR

- Both kinds use time-charting:
  - Record hour-by-hour care given to patient
    - Who
    - What
    - When
    - Where
    - Why
  - Clinician observations
  - Patient responses

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The Medical Record

Documentation

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Documentation

- Varies from hospital to hospital
- General guidelines -----

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General Guidelines

- Make an entry into the chart for each med, Rx given
  - Gives exact, sequential record
  - Aids doctor in Dx
  - Shows daily progress
  - Provides info on diagnostic tests
  - Legal evidence in court

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General Guidelines

- Since is a legal document, legal action can be taken if a record is falsified or if a person is an accessory to the falsification of a hospital record ***for any reason***, including:
  - To conceal the real nature of an incident
  - To protect oneself, someone else or hospital
  - To deceive an insurance company

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General Guidelines

- Chart is hospital property - it does not belong to the patient or family
  - "right to access" laws in all states
  - "right to direct access" laws in some states
- May be used for case studies to further educate but patient's identity must be concealed

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General Guidelines

- Idle conversations should be eliminated or limited to a controlled group and then only as it pertains to care of the patient
- Chart notations must be neat and clear
- Charting done only ***after*** med or treatment given & only with doctor's order

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Protect Yourself Legally

- Use correct forms
- Document in ink according to hospital protocol
- Be sure patient name & number on on every page
- Record complete date/exact military time for each entry

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Protect Yourself Legally

- Be specific - avoid general or vague terms:

Incorrect: Took a good Rx.

Correct: Tol. Rx w/o adverse reaction, RR- 24/12, BS- rhonchi t/o all lobes before Rx, heard in only LLL after Rx, P- 82 t/o Rx, dry cough, pt. coop.

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Protect Yourself Legally

- Use standard abbreviations
- Use a medical term only if you are sure of its meaning
- Document symptoms by using patient's own words
- Document patient's response to meds & Rx
- Document any action you take in response to a patient's condition

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Protect Yourself Legally

- Document safeguards you use to protect patient: "raised bed rails" or "applied Posey restraint"
- Document "incidences" on an Incident Report form (falls, wrong med, wrong Rx time, wrong patient, etc.)
- Document each observation- normal & abnormal

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Protect Yourself Legally

- Document procedures after you perform them
- Write on every line - don't leave empty spaces
- Sign every entry
- Document only your own care & observations - ***NEVER*** chart for anyone else = cause for dismissal

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Protect Yourself Legally

- Chart an omission as a late entry - never back date or add to previously written entries
  - Chart when you remember it - never try to squeeze it into the original charting:

10/9/02 1025 Late entry - SVN Rx of 10/9/02 @ 0805, 0.5 ml Mucomyst 20% given with Rx. ---- VHansen,RRT

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Most Common Pitfalls

- Chart clearly, accurately & completely
  - No matter how trivial something seems or how tired you are
- No personal opinions
  - Record what you saw, heard & did
    - If patient says he's mad, record it
    - If you think he's mad because he's quiet, record only that he's quiet

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Subjective	Objective
She reported good relief from Ventolin Rx.	Wheezes in R lung decreasing, RR16, pt. states "feel less short of breath now."
Normal BS present.	BS are equal, bilateral and clear t/o.
Pt. expectorated a moderate amt of mucus.	Pt. expectorated 5 cc of thin, white mucus.
Pt. was nervous.	Pt. repeatedly asked about length of hospital stay, expected discomfort from Rx's and competency of doctors.
Pt. using IS on own.	Pt. states she "practiced on IS for 10 breaths 3 times since last IPPB Rx.
Pt. appears combative.	Pt. is thrashing around in bed pulling at IV tubing. Restraints applied x 4.

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Most Common Pitfalls

- No subjective charting
- Omissions
  - In a lawsuit, the court may assume that you failed to perform any task that you didn't record & then suspect that you omitted info with the intention of covering up incriminating evidence!!

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Most Common Pitfalls

- Late charting
  - Record patient info promptly - the longr you wait, the more likely you are to forget important facts
  - If unable to chart immediately, use note paper to jot down key info
- Improper abbreviations
  - If not sure, don't use it

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Most Common Pitfalls

- Illegible - write clearly - if you can't print
- Incorrect spelling - use a dictionary
- Improper correction of errors

IPPB treatment with 0.5 ml ~~Ventolin~~ (error) Bronkosol (vh)

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Most Common Pitfalls

- Improperly signing your entries - use 1st initial, last name, credentials

VHansen, RRT

Leaving blank spaces - don't leave any -----

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cough with Rx.----------T. Smith, RRT

Non-productive cough noted after Rx.----------T. Smith, RRT

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3/7/90 1240 IPPB Rx given with 0.5 cc Ventolin/3 cc NS x 10' via mp, 20 cmH_2O, 100% O_2, with HOB up 45°. Tol without adverse

(continued on next page)----------

effects. BS- crackles and rhonchi heard t/o all lung fields, clearing slightly with productive cough of 6 cc thick, yellow sputum.

P 88/90/92 R 18/20/20 Pt. cooperative----------T. Smith, RRT

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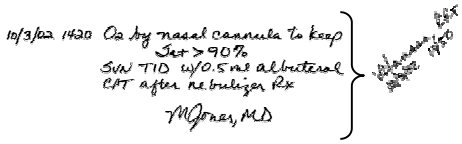
Most Common Pitfalls

- Incorrect notation of doctor's orders -



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"Charting By Exception"

- Charting assumes events went in a standardized way - you only chart what was "out of the ordinary"

SVN Treatment

Assume	*Chart*
Pt. ↑ 45°	HR, RR, BS
Lasted 10 min.	Meds given
Tol well w/o adverse effects	Noseclips?
Given with mp @ 6-8 lpm O_2	MS, TC, Briggs?
	Bed flat, pt. ↑ EOB?
	Given w/air?

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Summary

- Learn to observe the patient
- Learn how to differentiate between symptoms, c/o, reactions, statements that could be of importance in assessing the patient's condition or in determining the patient's prognosis

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Summary

- Charting should include:
  - What you did
  - Technique used
  - Meds & dosages
  - Length of Rx's
  - Patient's response (good & bad)
  - If patient refuses & why
  - Special circumstances or precautions to be observed by next HCG
  - Date/time/signature

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Summary

- Good patient care is your best defense against being sued for malpractice - if you are sued clear, accurate documentation of the care you provided will be the best defense in court

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Summary

- Reread your entries after you write them to make sure they say exactly what you intend!!
- Which brings us to □ □ □ □ □

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The Lighter Side of Charting!

- Patient has chest pain if she lies on her left side for over a year.
- On the second day the knee was better and on the third day it had completely disappeared.
- The pelvic exam will be done later on the floor.

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The Lighter Side of Charting!

- Large brown stool ambulating in the hall.
- Discharge status: Alive but without permission.
- Vaginal packing out. Doctor in.

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The Lighter Side of Charting!

- At the time of onset of pregnancy, the mother was undergoing bronchoscopy.
- She stated that she had been constipated for most of her life until 1989 when she got a divorce.
- Patient was alert and unresponsive.

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The Lighter Side of Charting!

- And my personal favorite:

  Exam of the genitalia reveals that he is circus sized.