RSPT 1101
Introduction to Respiratory Care

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

The Medical Record

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

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

Types of Medical Records

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

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

Sections - Admission Sheet

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

Sections - Physician Orders

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

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

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
The Medical Record

Sections

• Medications
  – Meds given, times, dosages

• OR/PAR
  – Consents, pre-op assessment, VS graphics, dictated/typed description of surgery

• ICU
  – q24° records

Sections

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

• 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
The Medical Record

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

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

Format

S: subjective data
O: objective data
A: assessment
P: plan of action
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, PaCO₂ - 48 mmHg, PaO₂ - 42 mmHg, HCO₃ - 30 mEq/l. Assessment: Patient moderately hypoxic. Plan: Administer O₂ at 4 lpm, observe closely, obtain ABG in 5-10 min.

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

The Medical Record

Documentation
Documentation

- Varies from hospital to hospital
- General guidelines

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

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
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

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

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
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.

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

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
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
**Subjective**
- She reported good relief from Ventolin Rx.
- Normal BS present.
- Pt. expectorated a moderate amt of mucus.
- Pt. was nervous.
- Pt. using IS on own.
- Pt. appears combative.

**Objective**
- Wheezes in R. Lung decreasing. RR 16. Pt. states "feel less short of breath now."
- BS are equal, bilateral and clear t/o.
- Pt. expectorated 5 cc of thin, white mucus.
- Pt. repeatedly asked about length of hospital stay, expected discomfort from Rx's and competency of doctors.
- Pt. states she 'practiced on IS for 10 breath 3 times since last IPPB Rx.
- 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 longer 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
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 Bronkosol

Most Common Pitfalls

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

Hansen, RRT

Leaving blank spaces - don’t leave any

[Signature]
The Medical Record

Most Common Pitfalls

• Incorrect notation of doctor’s orders -

“Charting By Exception”

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

SYN Treatment

<table>
<thead>
<tr>
<th>Assume</th>
<th>Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt. ↑ 45°</td>
<td>HR, RR, BS</td>
</tr>
<tr>
<td>Lasted 10 min.</td>
<td>Meds given</td>
</tr>
<tr>
<td>Tol well w/o adverse effects</td>
<td>Noseclips?</td>
</tr>
<tr>
<td>Given with mp @ 6-8 lpm O₂</td>
<td>MS, TC, Briggs?</td>
</tr>
<tr>
<td></td>
<td>Bed flat, pt. ↑ EOB?</td>
</tr>
<tr>
<td></td>
<td>Given w/air?</td>
</tr>
</tbody>
</table>
The Medical Record

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

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

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
Summary

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

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.

The Lighter Side of Charting!

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

The Lighter Side of Charting!

• And my personal favorite:

Exam of the genitalia reveals that he is circus sized.