Documentation

Client Identification

Updated Dec 2024

What is Documentation?

- Documentation means to give written information that is proof or support of something that has been done or observed.
  - A medical record is the record of all care that is provided. If it is not recorded, it did not happen.
  - If it is recorded incorrectly, it happened incorrectly.
- Documentation provides a clear picture of the status of the resident, the actions of the nursing staff, and the patient outcomes.
- Ensure you are documenting on the correct resident, using Health PEI Client Identification process.

Health PEI Policy: Client Identification

- All health care providers, in partnership with the client and their family/partner in care are required to confirm a client's identity using two client identifiers during their first encounter.
- The RN verifies the identity using the MRN and date of birth on health card with the CIS printed label and the InterRai-HC assessment with the Resident and/or Substitute Decision maker.
- Once verified visual recognition/photo can be used as an identifier

Ongoing Client Identifiers in LTC – Photos

- Photo identifiers must include the date it was taken and be labeled with the client's name, date of birth and MRN
- Photo identifiers must be retaken every year, or when a client's appearance has changed
- The photo identifiers must be attached to Care Plans, Medication profile and/or their room if appropriate.
- Evacuation Tags must be prepared in advance and placed on the resident during evacuation.

Client with the same names

- Client health records must be flagged with a Same Name Alert when clients are admitted to a care area with the same first and last names.
  - In Long-Term Care: use the client's middle name to differentiate the people who have the same name
  - For same or similar name – the Chart must have a sticker indicating name alert

PSMS – Reporting Errors

- If an error in client identification does occur then it must be reported as per HPEI Patient Safety Incident Reporting and Management Policy.

What is focus charting?

- Focus charting:
  - reflects nursing care that is provided to a resident based on observations, concerns and strengths, which have been identified by staff, in collaboration with resident and family
  - provides a framework for promoting holistic and person-centered care
  - Improves the quality of documentation

Focus Charting - Advantages

- Provides a clear overview picture of resident's condition
- Reduces charting time
- Reflects the nursing process
- Identifies focus of priority care
- Reduces duplication
- Promotes nursing assessment and care planning
- Simplifies the auditing process

The chart must be:

Legal	Concise and factual	Organized
Provide information that is easily accessible	Accurate	Current
Include all nursing observations, interventions	Include response to interventions	Audited on regular intervals

Charting – 4 parts, all required

- Date
- Time
- Focus
- Facts

NOTE: All chart forms require a resident label to be placed on it. The resident label includes the following information: Name, Date of Birth and MRN

DATE	TIME	FOCUS	FACTS

Focus

- A statement that describes what a resident is experiencing
  - Actual problem – pain
  - Potential problem – risk for altered skin integrity
  - Strength – Social interaction
- Avoid vague focus
  - Shift summary
  - Status

Examples of Focus

- Activity
- Abdominal Pain
- Appetite
- Appointment
- Behavior
- Care Plan
- Constipation
- Elimination
- Fall
- Fatigue
- Fear
- Respirations
- Family concern
- Comfort
- Fever
- Medication
- Mental status
- Mobility
- Nutrition
- Skin integrity
- Sleep
- Bloodwork/Venipuncture

Subjective Data

- This is the nursing part of the health assessment that involves collecting information through communication.
- This is the information the resident is telling you and it often describes physical symptoms about how they feel. It can also pertain to certain beliefs, attitudes and perceptions that they may have.

Objective Data

- This data is collected through the health professional's observations by seeing, hearing, smelling and touching.
- This can include behaviors, actions and information gathered from test measurements or from a physical exam.

Facts – recording in D.A.R.P

- Data - subjective and objective assessment
  - Describes what you see, hear, and/or what the resident is telling you
- Action- interventions
  - Describes what you did related to the focus
- Response – outcome of your action
  - Did intervention work or not work?
- Plan –
  - What happens next? Update care plan as needed

General Guidelines for Documentation

- Use Person Centered Care language
- Select the correct chart and verify the resident's name
- Completed documentation in black or blue ink only. Use red ink for documenting allergies only.
- Write the date as Month/Day/Year.
- Document using the 24-hour clock
- Document clearly, concisely, and legibly with correct spelling. Print if needed.
- Chart in an organized, chronological order.
- Chart as soon a reasonably possibly and indicate the resident concern, nursing assessment, nursing interventions and resident response.

General Guidelines for Documentation

- Do not use abbreviations
- Be factual and concise
  - Describe the event
  - Chart facts only
  - Document using concise phrases. Complete sentences are not required. Begin each phrase with a capital letter
  - Use objective, un-biased, non-judgmental words
  - Do not use generalities (i.e. appears, seems or apparently)
  - Place quotation marks around subjective descriptions, as quoted by the resident.

NOTE: Charting in advance is not permitted

Example of DARP focus charting

Date	Time	Focus	Facts
Dec 23/23	1600	Pain	D) Resident complaining of pain to left leg with a rating of
			6/10 and requesting something for pain. A) Resident's left
			leg assessed for Range of Motion and skin condition, both
			unremarkable and resident's stated 'Oh it is just my arthritis
			acting up again.' Tylenol 650mg po given as per PRN order
			R) Resident satisfied with same P) will ressess in one hour
			during 4P rounding.---------- HGoode LPN
Dec 23/23	1700	PRN	D) Resident is resting comfortablely in bed and is now rating
		Response	pain as 3/10. Notified the RN that Tylenol was given and was
			effective----------HGoode LPN

General Guidelines for Documentation

- Use Focus Charting Method (Data, Action, Response, & Plan)
- Sign all documentation with first initial, full last name and status or professional designation. Ensure your name and designation is legible.
- Make alterations/corrections appropriately
  - Do not erase, apply correction fluid or correction ribbon to cover an error
  - Draw a single line through the error, above it write ME and initial – ME (mistaken entry) is the only acceptable abbreviation
  - Write the date/time/correct entry and initial

General Guidelines for Documentation

- Ensure each line in the resident's record is filled
- Empty lines left at the bottom of the page should be crossed out with a straight line and there should not be a space left between the end of a chart entry
- Sign the last line of each page
- If an entry flows to the next page, sign the bottom of the page and continue to the next page. Write date/time/focus and 'continued' on the top of the next page in the integrated record. Continue Documentation.
- Chart late entries up to 48 hours past the actual event to be charted. Indicate late entries by charting the date/time of entry and include "Late Entry" for date/time of original care observations, then document focus, facts, and sign.

Example of DARP focus charting

Date	Time	Focus	Facts
March 5/24	0800	cough	D) Resident coughing this am and bringing up green sputum
			A)LPN HGoode notified.----------AMacDonald RCW
March 5/24	0900	respiratory	D) Resident complaining of cough and feeling chilled A) NP
			notified of cough, sputum, fever, and chest assessment.
			Resident placed on isolation precautions R) Orders received
			to obtain a Fluvid swab. ----------BBrown RN
March 5/24	0905	respiratory	**Late entry for 0830** D) Writer notified at 0815 regarding
			resident's cough and sputum. A) Vitals taken Temp 38 Resp
			24 Pulse 68 BP 142/84 O2 sat 94% and chest auscultated
			for decreased air entry throughout with an expiratory
			wheeze in the mid to lower lobe bilat and fine crackles at the
			bases bilat. R) RN BBrown notified----------HGoode LPN
March 5/24	1000	Fluid swab	D) Resident due for Fluvid swab A) Writer collected Fluvid
			swab at 0920 as per policy R) Taxi arrived at 0945 to
			transport the specimen to the lab P) Will check--BBrown RN

Example of Continued and late DARP –focus charting

Date	Time	Focus	Facts
March 5/24	1000	Fluid swab	**Continued** - swab results on Cerner in 1 hour ---BBrown RN
March 5/24	1130	Swab result	D) Swab results reveal resident is positive for Covid. A) NP
			updated of swab results. R) Orders received QID vitals and
			Oxygen via nasal prongs to keep O2 sat greater than 94%.
			----------BBrown RN
March 5/24	1200	Family	D) Writer contacted resident's family to provide an update
		notification	regarding symptoms, positive swab results, and the plan
			for care. Family appreciative of phone call and will be in to
			visit later today.----------BBrown RN
March 6/24	0730	Family	**Late note for March 5/24 at 1700** D) Resident's family in to
		Isolation	visit and questioning writer about isolation precautions and
		questions	length of time to remain in isolation. A) Explained to family
			that resident is to remain in isolation until symptom free
			and ok'd by infection control to remove precautions.
			Explained that isolation precautions means that all staff and
			Visitors are to gown, glove, mask, and use goggles when
			entering the room. R) Family satisfied with explanation and
			grateful for the care their loved one is receiving -BBrown RN

Care Plan

- Review a Resident's Care Plan
- The care plan should be reflective of the actual care needed.

Health PEI
One Island Health System

Getting to Know Me – My Care Plan

Insert Label Here

Save

Version Date: July 22, 2020

RN Completed Care Plan:

Date Completed:

How to show me respect? What is important to me? Intimacy/Privacy Needs?:

What makes me happy? What makes me uncomfortable? (traumatic events)?

What my friends say about me? My lifework:

Funeral Home:

Spiritual Needs:

Family Supports:

My Best Day

Daytime:

Evening:

Night:

My Allergies:

My Name:

My Home: Select

My Room:

My Household:

My Diagnosis:

Move-in Date:

Health PEI
One Island Health System

Getting to Know Me – My Care Plan

My Clinical Considerations/Goals

Goals/Concerns:	How to best support my goals:	Expected Outcomes:

Immediate Needs: Select Date Initiated:

Other Care Needs:

Restraint: Select Type: Safety Check: Select

Teeth: Bowel and Bladder: Select Ostomy: Select Catheter: Select

Hearing Aids: Select Glasses: Select

Diet:

Copy of My Care Plan Given to Family: Select... Date: Next Care Plan Date:

Example of DARP focus charting

Date	Time	Focus	Facts
Nov 26/24	0900	Emotional	D) Resident stating “I think people are looking at me through
		distress	my window” A) Some reassurance provided to the resident
			and reported to the RN BBrown. ----------JRowe RCW
Nov 26/24	0905	Emotional	D) Writer in to assess resident. Resident still stating that
		distress	people are looking at her through the window. A) Writer
			checked around the window and looked outside the window
			and it was noted that no one was present. Reassurance
			provided to resident that there was no one outside the
			window and writer closed the blind and the curtains.
			R) Resident more at ease at this time. P) Will up date the care
			plan ---------- BBrown RN
Nov 26/24	0930	Care plan	D) Resident’s care plan updated to include information about
		update	closing the blinds and curtains in the resident’s room when
			the resident thinks people are outside her window BBrown RN

RN documents that the care plan was updated.

When to Chart – Accreditation Standards

- A change in resident's health status
- A safety incident has occurred
- A change in the care plan
- A change in resident's medications
- When a resident is transitioning to another level of care
- All documentation should include service provided, any interventions and/or conversations with resident or family

When and Where to Document – Nursing Notes

- Document each time the Physician or Nurse Practitioner is contacted
- Document any communications with the resident and/or family
- Complete documentation each time the resident leaves and returns to the nursing home and with whom
- Document all assessments/interventions as the resident's status changes
- Document any infection control measures, including q-shift assessments while on isolation precautions.
- All new move ins require 1 nursing note per shift for the first 48 hours.
- RN/LPN may change the frequency of documentation based on resident's condition and the complexity of his/her health status and should be documented in the Care Plan

When and Where to Document – Flow Sheets

- Use the resident care flow sheet for daily routine cares:
  - The care provider completes and signs the flow sheet (with initials) during their shift, which is the responsibility of the RCW but can be delegated to nursing designations as needed.
  - Signing the flow sheet is confirming that all information in the flow sheet is accurate
  - Document Medication Administration in the Medication Administration Record (MAR) is the responsibility of the LPN/RN.
    - RCW is responsible to document any treatments they provide (suppositories, or fleets etc) on the MAR - Second hand charting is not acceptible. LPN cannot document "given by RCW"

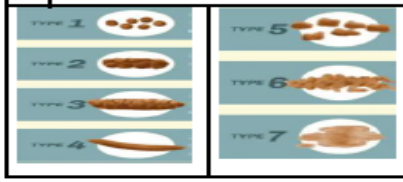
Health PEI
One Island Health System

Santé Î.-P.-É.
Un système de santé unique

RESIDENT CARE FLOW SHEET

☐ Beach Grove Home ☐ Prince Edward Home ☐ Colville Manor ☐ Riverview Manor
☐ Summerset Manor ☐ Wedgewood Manor ☐ Stewart Memorial Home ☐ Sherwood Home
☐ Maplewood ☐ Margaret Stewart Ellis Home

Date Started: _____ (D/M/Y)

		Sunday			Monday			Tuesday			Wednesday			Thursday			Friday			Saturday		
		N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E	N	D	E
Hygiene	Tub / Bed Bath / Shower (T, BB, S)																					
	Skin intact (if not notify LPN and document																					
	Cares																					
	Nail Care/Hair Wash (N,H)																					
	Ostomy /g-tube site care																					
	Dental/Mouth Care																					
Elimination	Voided (if no void notify LPN and document)																					
	Catheter Care/Incontinence Care																					
	Bowel Movement (Sm, M, L)																					
	Bristol Scale (1-7 see chart)																					
	Notify LPN of Concern (document)																					
Diet	Breakfast (percent of intake)																					
	Dinner (percent of intake)																					
	Supper (percent of intake)																					
	Snacks (percent of intake)																					
	Fluids (percent of intake)																					
	Tube Feeding																					
Activity	Bed Rest as per Care Plan																					
	Sleep (percent of shift)																					
	Braden interventions as per Care Plan																					
	Up in Chair (0, x1, x2, x3 etc.)																					
	Walked (0, x1, x2, x3 etc.)																					
	Range of Motion/ Daily Exercise																					
	Therapeutic Activity																					
	Out on Leave (Document)																					
Safety / Comfort	Restraint in Use																					
	Falls Interventions as per Care Plan																					
	Safety Interventions as per Care Plan																					
	Document Safety Concerns																					
	Safety Check as per Care Plan																					
	Hourly 4P Rounding																					
	O2 Therapy/CPAP (O,CP)																					
	 Signature and Initials																					

June 30, 2021

Long Term Care – A Place to Live, Learn…Grow
Les foyers de soins de longue durée : là où il fait bon vivre, apprendre et s'épanouir

Monthly Charting

Charting requirements **should** be identified in the **clinical goals and considerations of the care plan**

Every Care Plan should be individualized for the resident

Interventions could include a timeframe for charting (ie, resident is a high falls risk and is on safety checks, one intervention could be document safety concerns weekly)

Monthly Charting

- Monthly Charting Requirements:
  - Vital signs – on graphic record
  - Braden Scale – on Braden flow sheet
  - Weight – on graphic record
  - Any other documentation based on immediate needs or concerns as outlined in the care plan.

Monthly Charting requirements – Nursing Notes

- There must be one nursing note entry per month for each resident.
- Near the end of each month the charts will need to be checked to ensure there is already a nursing note
- If the chart does not have a nursing note then one must be written pertaining to the resident's care plan
- If the chart has a nursing note but it only about going out on a pass then this is not sufficient and a nursing note will need to be written pertaining to the resident's care plan

Monitoring Safety Risks

4 P Hourly Rounding will be standard process for all residents to assess and identify safety risks.

It is the **RN's responsibility** to ensure all safety concerns are updated in the care plan including all interventions.

All restraints and safety checks need to be documented in the care plan.

Documenting Treatments

- All treatments are to be documented on the treatment sheets located in the resident's chart.
  - It is the responsibility of the RCW to Initial each section when the treatment has been administered.
  - If there are any changes to the area receiving the treatment, then a nursing note must be completed and and must be reported to the Team Leader – RN/LPN
  - It is the responsibility of the LPN/RN to follow up on any concern, an assessment is required including documenting the assessment.
- If the treatment ordered can only be performed by a LPN/RN then this treatment sheet will be located with the MAR. It is the responsibility of the LPN to ensure all treatments in the MAR are completed.
- It is the responsibly of the RN that all treatment sheets are recopied each month, the first recopy may be delegated to LPN. RN must do the second check.

Documenting PRN Treatments

- All treatments are to be documented on the treatment sheets located in the resident's chart.
- If a treatment is ordered as PRN then a time needs to be included with the staff initials
- When administering a PRN treatment then a nursing note should be written as well

Health PEI
One Island Health System

☐ PE Home ☐BGH ☐ Colville
☐ Riverview ☐Summerset ☐Wedgewood
☐ Stewart Memorial ☐ Margaret Stewart Ellis
☐ Maplewood ☐ Sherwood Home

Resident ID

A- refused **B**-Hospitalized **C**- Leave of Absence **D**- Hold **E**- See Integrated Records

RESIDENT TREATMENT SHEET

ORDER:

Ordered By:

RN/LPN SIGNATURE

RN CO-SIGNATURE

SPECIFIC DESCRIPTION OF TREATMENT AREA

Order Date:

Start Date:

Stop Date:

Reassess Date: (if applicable)

MONTH **YEAR**

- → Initial each section when treatment has been administered, a signature is only required once.
- ★ → Staff are required to **document** all changes in condition in the **Integrated Record** and report to the LPN Team Leader or RN Supervisor
- → If order is PRN, add time of treatment with your initial
- → Initiate a new treatment sheet each month

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Time	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

Signature/Initial:	Signature/Initial:	Signature/Initial:
Signature/Initial:	Signature/Initial:	Signature/Initial:
Signature/Initial:	Signature/Initial:	Signature/Initial:
Signature/Initial:	Signature/Initial:	Signature/Initial:

RIM Guidelines

- All information about the resident must be located in the resident's chart and thinned as per the chart guidelines in the front of the chart.
- No other binders should contain resident's information with the exception of the MARS.
- The thinned charts must be located at the home in a secure storage area and accessible as needed.
- Once the resident has passed away, the chart can be transferred to a central storage are off site and maintained based on RIM guidelines.

https://src.healthpei.ca/records-and-information-management-rim

References

- Health PEI (2016) . *Long Term Care – Resident Management and Documentation Policy*.
- Health PEI (2015) . *Chart Documentation Standard*
- Accreditation Canada (2023). *Standards for Long Term Care Services - HSO*
- Accreditation Canada (2023) . *Required Organizational Practices Handbook*
- College & Association of Registered Nurses of Alberta (2023). *Documentation Standards For Regulated Members*
- College of Registered Nurses of Manitoba.*(2022) Documentation Guidelines for Registered Nurses*.
- Nurses Association of New Brunswick (2022). *Standards for Documentation*.
- College of Registered Nurses Prince Edward Island. *(2020) Documentation Standards*.
- Health PEI (2022) Client Identification Policy (next review Aug 2025)

Questions