

THE PATIENT'S CHART



PURPOSE OF THE PATIENT'S CHART

- Communication between doctor & hospital staff
- Planning patient care
- Educational purposes
- Research



The chart is a legal document...

- Protects:
 - patient
 - physician
 - staff
 - health care facility
- Health Information Services:
 - analyzes & checks chart for completeness
 - maintains in an acceptable manner
 - statute of limitations, litigation



DOCUMENTATION

- All entries in ink
- Must be legible & accurate
- Entries must never be obliterated or erased
- All entries must include date & time
- Only use approved abbreviations



International Time or Military Time

- Utilizes all 24 hours in a day
- Each hour has its own name
- Rather than repeating hours and using AM and PM
- No colons needed
- Eliminates confusion
- See 24 hour clock pg 119

CONFIDENTIALITY

- Privileged information
- Release of information - third party payer
- HUC custodian of patient records on unit
 - identify those accessing chart
- Record belongs to health care facility
- Information belongs to patient

Record management considerations...

- Name alert - 2 or more patients with same last name
- Split or thinned chart
- No Information, No Publication (NINP)
- Correct sequence in chart rack
- System for tracking charts removed from unit
- “Stuff” charts according to agency policy:
 - chronological, reverse chronological
- File diagnostic reports after review
- Review charts frequently for new orders

Methods of Error Correction

- Never erase or obliterate:
 - scribble over
 - correction fluid or tape
- Documentation error:
 - single line through error, “mistaken entry”, date, time, signature & status
- Imprint error:
 - cross over, “mistaken entry”, date, time, signature & status
 - imprint with correct information

Supplemental Chart Forms

- Used only for specific situations:
 - Anticoagulant Therapy
 - Diabetic Record
 - Consultation
 - Operating Room Records
 - Therapy: Dietary, PT, Respiratory
 - Parenteral Fluids / Infusion
 - Vital Signs > q 4 hr



Face Sheet

- Information sheet - originates in admitting
- Patient demographics
- Admitting diagnosis
- Third party payer
- Copies distributed:
 - hospital departments
 - attending & consulting physician



Medication Administration Record (MAR)

- HUC responsibility varies per agency
- Transcription of medication orders
- Documentation of medications administered to patient
- Pharmacy charges



Consent Forms

- Invasive procedures - diagnostic / surgical
- Informed consent:
 - physician's responsibility
 - not signed before physician explains: procedure, risks, alternatives, outcomes
- HUC responsibilities:
 - imprint, all written entries in ink
 - complete physician name
 - complete procedure
 - no abbreviations
 - correct spelling, legible



Witnessing Consents

- Patient signature
- Patient not under the influence of mind altering substances
- Mental competency
- Patient 18 years of age or older



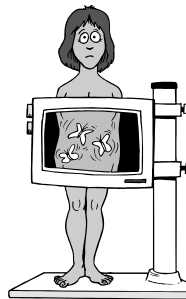
Consents / Releases

- Side rails
- Refusal to permit blood transfusion
- Consent to receive blood transfusion
- Consent for HIV testing



Additional Standard Patient Chart Forms

- Conditions of Admission form pg 123
- Advance Directive checklist pg 124-125
- Physicians Orders pg 126
- Physicians Progress Record pg 127
- Nurse's Admission Record pg 128-129
- Nurse's Progress Notes pg 131-134
- Graphic Record pg 135-136
- MAR pg 137
- H&P pg 140-141
- Clinical Pathways pg 143
- Miscellaneous, pgs 144-154



In Summary

- The purpose of the forms is the same for each hospital, but the sequence of forms in the chart and the placement of blank forms that are added may differ from hospital to hospital.
