NURSING DOCUMENTATION AND RECORDING SYSTEMS OF NURSING CARE

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ABSTRACT
Documentation is the written and legal recording of the interventions that concern the patient and it includes a sequence of processes. Documentation is established with the personal record of the patient, which constitutes a base of information on the situation of his health.
The importance of nursing documentation is neuralgic, provided that without it, there cannot be a complete qualitative nursing intervention and not even an effective care for the patient.
In the purposes of nursing documentation are included the research on a more effective care of the already detected problems, the programming of care through the organization and modification of the plan on patient's care and the more direct communication between the professionals of the health system, who collaborate on the patient's care.
The methods of documentation are multiple and among the most basic ones are the method directed towards the source or the problem, the system problem-intervention-evaluation, the focused registration, the focusing diagram, the registration by exception, the electronic files and the home documentation.

Key - Words: nursing documentation, nursing file, nursing registration systems, nursing report

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INTRODUCTION

The effective communication between the professionals of the health system is of vital importance for the quality of care which is provided to the patient. Usually, the members of the therapy group communicate between them in written or orally.
The *discussion* is an informal oral study on a subject from one or more than one members of the therapy group, having as a purpose the determination or the recognition of a problem as well as the recovery of strategies and its solution methods[1].
The *report* is oral, or written, or based on the communication through the PC, study, so that the information is being transferred to others. For example, nurses always inform in written of the situation of the patients at the end of their service (duty)[2].
The *file* is written or registered in the PC. The recording process in the file of a patient is called record keeping, diagram or documentation. The clinical file, which is called as well historical or patients' file, is an informal and legal document, which substantiates the care of the patients. At several sanitary services different systems and documentation methods are being used. But, various file types of patients obtain similar information[2].

In each health care organization, policies are applied regarding the record keeping and the registration of the patients' data, and each nurse is responsible for his actions, which ought to follow the clinical standards. The nursing organizations indicate which nursing estimations and interventions should be kept in record along with the nursing notes and which ones shouldn't. Moreover, there are formal nursing protocols regarding the observance of documented files of the patient, as well as the existence of a nursing diagram, which ought to be opportune, complete, accurate, confidential, and individuallized[1,2,3].

Purpose of the Nursing Documentation

A basic purpose of the nursing documentation is the creation of a data base in which the patients' files are included. The patient's file is kept for many reasons, from which the most important ones are[4,5] :

- *Communication* among the professionals of the health system, through the exchange of information that concerns the patient.
- *Creation of the Patient Care Plan*

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Each scientist uses documents from the patient's file to prepare the care plan of the particular patient.

- *Control of the health organizations.*

The control is a review of the patient's file with the view to confirm the provided quality.

- *Research*

The information, that is contained in a file can form a valuable source of elements for research. The care plan can bring up useful information on the care of many patients.

- *Education*

Students in various schools of the health science often use patients' files as educational tools.

- *Compensation*

The documentation also assists in obtaining easily a compensation from the public and private insurances. In order to obtain a compensation, the file of the patient's clinical situation should have the right diagnosis, which should be included in the group of illnesses that are being compensated and also report that the appropriate care has been provided.

- *Legal documentation*

The patient's file is a legal document and is often acceptable at the court as an evidence.

- *Analysis of the Health Care*

The information of the files can assist the professionals of the health system to point out the needs of the particular nursing institution, as well as the hospital's services.

Documentation of the nursing activities.

The patient's file should describe his current situation and reflect the entire nursing process. Regardless of the documentation system that is used by an institution, nurses register constantly various evidence of the nursing activity, throughout the duration of the care benefit[6].

Nursing evaluation during the entry

The initial estimation of the situation of the patient is taking place during his entry to the nursing unit and is called initial data base, nursing background or nursing evaluation. The initial evaluation of the situation is being carried out with the systematically clinical examination and with the examination of the functional capabilities of the patient, the investigation of the health problems and the possible dangers. The nurse generally records the oncoming evaluations or reevaluations on leaves of flow or in nursing progress notes[2].

Nursing care plan

The certification committees of the health care organizations require, the clinical documentation to include elements from the evaluations of the patients, the nursing diagnosis and / or the patients' needs, the nursing interventions, the results that the patients showed and the elements of a current nursing care plan. Depended from the documentation system that is used, the nursing care plan can be different from the patient's background, can be included in the nursing notes or be incorporated in a multidimensional care plan. There are two types of nursing care plan: the traditional and the standardized one. The *traditional care plan* is written for each patient. The type varies from organization to organization according to the needs of the patient and the department. Most types have three columns: one for the nursing diagnosis, a second for the expected results and a third one for the nursing interventions. The *standardized care plans* are developed in order to save time during the registration. These plans can rely on the steady practices of the organization, contributing thus in the benefit of high quality in the care. The standardized care plans should be individualized by the nurse, in order to satisfy the individual needs of each patient[7,8].

Leaves of flow

A leave of flow gives the nurses the opportunity to register the nursing data quickly and comprehensively and provide a legible documentation of the patient's situation in the course of time. The leaves of flow can be [9,10]:

- Diagrams, in which the temperature of the body, the pulse, the rhythm of the respiration, the arterial and venous blood pressure, the weight, the date of entry, the date of conduct of a chirurgical operation, the mobility and the function of the intestine, the appetite and the daily activity is registered.
- Diagrams, in which the entrance and the quantity of the engaged and the eliminated liquids is registered.
- Leaves of flow of the pharmaceutical medication.
- Registration diagrams of the skin situation or the turning in degree.

Progress notes

The nurse's progress notes provide information regarding the progress of a patient towards the establishment of the desirable results. So, except for the evaluation and the reevaluation elements, the progress notes contain information related to the problems of the patient and the nursing interventions. The plan used, depends on the

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documentation system that is applied in the particular organization [11].

Nursing Discharge Card and Report Summaries

A discharge card and a report summary is completed when the patient takes this card and is transferred to another health organization or to his home, where a visit from a communal nurse is required. Many institutions provide prepared summary forms. Some documentation plans combine the discharge note with care instructions and the final progress note. Other plans contain also control lists, so that the registration of the elements is facilitated [12,13].

Documentation of Long-lasting Care

Long-lasting therapies which are provided from the health organizations, usually include two types of care: specialized and intermediate care. The patients who need specialized care require a more extensive nursing care or special nursing abilities. On the other hand, patients are provided with intermediate care, when they have chronic illnesses and they might need help only in activities of their daily life, such as the individual hygiene. The documentation of the long-lasting nursing care is based on certain patterns, on public regulations and on the organization's tactics, where chronic care is provided. The registration should also comply with the needs for care of over-aged people and the needs for help at house. It is necessary for the nurse to be familiarized with the regulations that affect the type and the frequency of the registration which is required by the long-lasting care and therapy departments [9,14].

Documentation of the Home Care

The contemporary units of the home care use two types of files: α) a certificate of the home care along with a therapy plan form and β) a medical briefing along with an information form on the situation of the patient. The nurse usually assigns to the patient, whom he is taking care of at the house, to fill in the necessary documents, which are signed by the nurse and the doctor in charge. At the same time some Home Care Centres provide the nurses with portable computers so that the patients' files are directly available. Using a modem, the nurse can add new information regarding his patient to his file which exists in the offices of the care centers, without going there himself [4,15].

Report

The purpose of the report is to be transmitted valuable information to a person or a group of persons. A report, either oral or written, ought to be brief and to include all the relevant information, without further details. Moreover, the report during the change of shift and the report through the telephone, can also include the exchange of information or ideas with other colleagues and other professionals of the health system relatively to the care provided to the patient [5].

Report of the shift change

The report of the shift change is the report that is given to all the nurses of the next shift. Its purpose is to provide constant care to the patients, giving to the employees of the new shift a brief summary of the needs of the patients and instructions for their care. The reports during the shift change can be given written or orally, either by personal communication between the nurses or by a recording cassette. The report person by person allows the listener to make questions during the report. The written and recorded reports are usually shorter and less time is wasted [5,16].

Nursing visits

The nursing visits are processes in which two or more nurses visit selected patients [11]

During the visits the nurse determines records a brief summary of the nursing needs of the patient and the interventions which have been applied. The nursing visits offer advantages to the patients as well as to the nurses. The patients can participate in the conversation and the nurses can observe again the patient's health situation and the equipment that is required [10,17].

Recording Systems of the Nursing Care

There is an important number of recording systems, which is used today [16,17]:

1. The recording focused on the source
2. The recording focused on the problem
3. The recording model problem-intervention-evaluation (PIE)
4. The focused recording
5. Charting by exception
6. Recording to the computer
7. Case Management

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1. The recording focused on the source

The most widely used data recording method is the one that takes place based on the source of information. Each person or professional branch manufactures symbol systems for a specific area or pieces of the patient's diagram. For example, the entry department has an entry leaf, the doctor has a medical background leaf, instruction leaves and progress notes. Nurses use the nursing notes and the other professional branches, which are occupied with the patient, have their own files [4,5,17].
In this type of recording, information over a specific problem is distributed all over the file. The *descriptive diagram* constitutes a common department of recording based on the source. This consists of written notes which include the routine care, the usual results of it and the patient's problems. The registrations based on the source are useful because those who provide care can easily locate the forms in which they are going to record the data and it's easy to discover some specifically registrated information. The disadvantage is that the information related to a problem is scattered all over the diagram, and as a result of that it's difficult to find chronological information over the problems and the patient's progress [10,18].

2. The recording focused on the problem

At the registration focused on the problem, the data is recorded according to the problems of the patient and not the source of information. All the members of the therapy group complete the problem list, the care plan and the progress notes [10,16,19].
The plans on each active or possible problem are stereotyped and the progress notes are recorded for each problem. The advantage of this recording method is that: a) it encourages the collaboration and b) the list of problems at the first part of the diagram sets on guard those who provide care to the patient's needs and that way it's easier to observe the situation of each problem. The disadvantages are that (a) people who provide care vary on the ability to use this type of registration, (b) plenty of time is demanded to complete daily the list of problems and (c) it is sort of inadequate because evaluations and interventions, which are made for more than one problems, must be repeated[14,15,16].
The registration focused on the problem has four (4) basic components:

- Data base
- List of problems
- Care plan
- Progress notes

Furthermore, the forms of surveillance (flow) and the notes are added in the file as required [9,19].

Data base
The data base consists of all the available information on the patient, when he is entering the hospital or visiting a sanitary service for the first time. It includes nursing evaluation, medical history, social and family elements, and the results of the clinical examination and the basic diagnostic control. The data is always informed according to the changes of the patient's health situation [7].

List of Problems

The list of problems emanates from the data base. It is usually used in front of the diagram and it is used as an indicator, so that the entries are numbered in the progress notes. The problems are recorded in the list, so that they are recognized, and the list is always informed as far as new problems are concerned and as far as the solved ones as well [9].

Care Plan

In the care plan the active problems are recorded. The care plans are created by the people who locate the problems. The doctors record medical instructions or medical care plans and the nurses record nursing instructions or nursing care plans [15].

Progress Notes

During the recording where the problem is focused, the progress notes are written by all the professionals of the health system who are involved in the patient's care. [14].

3 . The recording model problem – intervention – evaluation PIE

In the registration model PIE the information is divided into three categories. The PIE is decisive for the problems, the interventions and the evaluation of the nursing care. This model consists of an evaluation diagram on the patient's care and the progress notes. The diagram uses certain evaluation criteria with a particular structure, such as human needs or functional health patterns [7,8,20].

4. The Focusing Diagram

In the focusing diagram the patient, his worries and his faculties constitute the centre of care.

The focusing diagram provides a total depiction of the patient and his needs. The three components of the PIE don't need to be recorded in a certain order

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and each note doesn't need to have all three categories. The diagrams and the control lists are often used in the focusing diagram, so that the duties of the nursing routine and the evaluation data are recorded [8,11].

5. Charting by Exception (CBE)

In the documentation by exception are reported only unnatural or important discoveries or exceptions. In this registration model there are three basic elements:

1. Diagrams. Such examples are the thermometrical diagram, the recording of the liquid balance, the recording of daily care, the recording of the medical-nursing instructions that concern the patient, the recording of the patient's exit and the recording of the skin situation [11].
2. Criteria of the nursing care. The registration which is based on the standards of the nursing care averts the repeated registration of the daily care [21].
3. Access to the diagrams next to the nursing bed.

The advantage of this registration model is the avoidance of long and repeated notes and the fact that the changes in the patient's situation are more apparent and more directly observed [6].

6. Recording to the Computer

The recording systems through the PC are developed as a method of settlement and management of the enormous piece of information which is required in the modern care health. Nurses use the computer in order to store the patient's data, to add new data, to create and repeat care plans and to record the progress of the patient. Some contemporary nursing institutes have a small manually-operated terminal next to the patient's bed, which helps at the immediate recording of the nurse's care, which has just been provided to the patient [1,8,11].

PC's render the planning of nursing care a rather easy process. In order to register the nursing interventions and the reactions of the patients, the nurse selects either certain lists with knowledgeable terms out of the stored programs of the PC or types of descriptive information stored in the PC. Today, the technology of automated voice recognition allows nurses to enter data using their voice in order to change the written information. The online connection of the nursing institutions and departments render possible the transmission of registered information from one care unit to another. At the same time, an effort is being made today to create standards for the collection and registration of specific, necessary nursing data, so that these are included in the PC's data base [2,9,22].

Preservation of confidential and private files in computers

Because of the increased use of the patients' computerized files , the sanitary organizations have developed policies and procedures for the preservation of the patient's confidential and private information, which is found stored in the computers [2,23]. All of the bellow constitute suggestions on the confidential preservation of the computerized files [9,14,15]:

1. A personal code, is necessary to enter and complete the work in the computer files. Don't share this code with anyone else, included the rest of the family members..
2. After you have completed the procedure, don't ever leave the computer on without your presence there.
3. Don't leave the patient's information exposed on the computer's screen, because other people might see it.
4. It is not necessary for all the elements to appear on the computer's work surface.
5. Be aware of the manners and the procedures for the correction of a mistake.

Follow the institution's procedures for the documentation of sensitive information, such as AIDS' diagnosis.

7. Case Management

This documentation model emphasizes on the quality and the cost of care effectiveness, which is provided throughout the patient's stay at the nursing institute. This model uses a multi-disciplinary approach in the designing and recording of the patient's care, using also critical thought. At the same time, this is useful for the determination of the daily results of care, which are expected out of certain groups of patients, after specific interventions which take place every day [12,20,22].

Conclusions

The documentation of the provided nursing care composes a piece of the nursing activity of vital importance. A great percentage of the nursing time is dedicated in the registration of the executed nursing work. The documentation in the health system takes place in order to fulfill administrative

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and clinical purposes, while in the bibliography various nursing documentation types are reported: notes of narrative type, the files which are directed to the problem, the files which are directed to the source, the recording by exception, the Kardex, the recording of each case and the electronic files. Even though the rules for a successful nursing documentation are many, qualitative nursing documentation should remain the focus point so that sufficient and individualized care of the patients is ensured.

It is doubtful, the fact that the role of the nurse is determined by the output and the documentation of the nursing work in the health system. The strengthening of Nursing should be focused on the need of revision and readjustment of the subordinate models and patterns of care benefit, while it is quite important the fact that the resolution of the problems of the patients requires the collaboration between the members of the sanitary team. For these reasons, the written speech remains at the center of communication as the safer, more complete and legally secured way of communication in all of the health departments.

Deductively, nursing documentation is an extremely essential process of nursing practice and an integral piece of each nursing intervention. Its contribution to the course of the patient's health is undeniable for the reason that it organizes his care, and facilitates the communication among the members of the therapy group. The nursing files, no matter how they are created and reserved, they have the ability to be modified dew to new data, and that renders nursing documentation a dynamic process.

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