**Problem-Oriented Charting**

In the problem-oriented medical record (POMR, or problem-oriented record (POR), established by Lawrence Weed in the 1960s the data are arranged according to the problems the client has rather than the source of the information. Members of the health care team contribute to the problem list, plan of care, and progress notes. Plans for each active or potential problem are drawn up, and progress notes are recorded for each problem.

**Advantages:**

a. It encourages collaboration

b. The problem list in the front of the chart alerts caregivers to the client’s needs and makes it easier to track the status of each problem.

**Disadvantages:**

a. Caregivers differ in their ability to use the required charting format.

b. It takes constant vigilance to maintain an up-to-date problem list

c. It is somewhat inefficient because assessments and interventions that apply to more than one problem must be repeated.

Problem-oriented medical record (POMR) focuses on the client’s problem and employs structured, logical format.

There are four critical components of POMR/POR

- Database (assessment data)
- Problem list (client’s problems numbered according to when identified)
- Initial plan (outline goals, expected outcomes, learning needs and further data, if needed)
- Progress notes (charting based in the SOAP, SOAPIE, or SOAPIER format)
A prominent feature is the format in which progress notes are to be written (i.e., SOAP, SOAPIE, SOAPIER)

S: subjective data (what the client or family member states)

O: objective data (what is observed/inspected)

A: assessment (conclusion reached on the basis of data formulated as client’s problem or nursing diagnosis)

P: plan (expected outcome and actions to be taken)

SOAPIE and SOAPIER refer to formats that add the following:

I: intervention (measures taken to achieve expected outcomes)

E: evaluation (analyze effectiveness of interventions)

R: revision (changes in original plan)

An entry need not be made for each component of SOAP(IER) at every documentation. However, each problem must have a complete note every 24 hours if unresolved or whenever the client’s condition changes. The structured format makes communication between health care team members easier. Continuity of care is shown when the plan of care and interventions performed are documented plan of care and interventions performed are documented together. Some physicians use this format when writing progress notes.

**Principles or Elements of Effective Documentation**

1. Document accurately, completely, and objectively including any errors that occurred
2. Note date and time
3. Use appropriate forms
4. Identify the client
5. Write in ink
6. Use standard abbreviations
7. Spell correctly
8. Write legibly
9. Correct errors properly
10. Write on every line
11. Chart omissions
12. Sign each entry

1. **Accurate, Complete, and Objective**
   - Record just the facts—exactly what you see, hear, and do. For example, “Two 4 x s completely soaked with yellow green drainage in 20 minutes” is more accurate than “large amount of drainage”.
   - Never record opinions or assumptions
   - Chart relevant information relating to client care and reflecting the nursing process.
   - Remember, if is not charted it was not done. It is difficult to prove in court that an aspect of client care was provided if it was not documented.
   - Document information promptly; the information is more likely to be accurate and complete.
   - Important details may be forgotten if charting is left until the end shift, and those details may later become a legal issue.
   - Chart medications immediately after administration. This prevents errors such as another nurse administering pain medication when the first dose was not charted.
   - Avoid subjective statements such as “client is uncooperative”.
   - Record the client’s exact words using quotation marks, for example, client stated “I don’t want to take a bath, and I don’t want any breakfast”.

2. **Date and Time**
   - Be sure each entry is dated and has a specific time. Especially note the exact time of sudden changes in a client’s condition, nursing actions, and other significant events.
   - Do not chart in blocks in time, such as 7am-11am. This is vague and sounds like the client has had no attention during that time frame.
• If documentation cannot be done in a timely manner, explain the delay. For example, “chart in x-ray with client”. When an entry must be ahead after notes are completed, follow the facility’s policy for recording a late entry. Generally, the practice is to enter the date and time and note “Late Entry”. This indicates that the entry is out of sequence. Then the date and time the entry should have been made is followed by the information to be recorded.

3. Use of Appropriate Forms

Use the appropriate forms as required by the facility’s policy manual. The forms used are not the same from facility to facility. Some facilities use flow sheets instead or progress notes.

4. Identify the Client

Each page of the client’s record is to have the client’s name on it. This aids in preventing confusion and helps ensure that information is charted on the correct record. Many facilities use the addressograph to stamp the client’s name on each page.

5. Write in Ink

• The client’s record is a permanent document and information should be charted in ink or printed out from a computer.

• Only black ink should be used as it will photocopy well.

• Felt-tipped pens are not be use, especially on forms with carbons since they do not hold up under pressure to make a clear copy. Also, they often bleed through the paper.

6. Use Standard Abbreviations

Each health care facility has a list of approved abbreviations and symbols to be used in documenting information on their client records. This is to meet the Joint Commission on Accreditation of Healthcare Organization (JCAHO) standards and the regulations in many states, such a list prevents confusion. The use of some abbreviations causes ambiguity that could be misleading and endanger a client’s health.
7. **Spell Correctly**

- Misspelled words on client records may be confusing and certainly convey a sense of unprofessionalism. They may generate questions about the quality of the care provided, increase the chance of liability, and produce a loss of credibility of the writer, when you are unsure of how to spell a word, look it up.

- Most units in a health care facility have a dictionary and other books to use as references.

8. **Write Legibly**

- Legible handwriting is imperative for effective documentation.

- Sloppy writing hinders communication and possible errors in client care can occur. Trying to decipher illegible writing wastes time.

- Illegible handwriting creates a poor impression of the person who did the writing and damages that person’s credibility.

- Print rather than use cursive writing; it is usually easier to read.

9. **Correct Errors Properly**

- Promptly correct any error you make in documenting on a client’s record. Know and follow your facility’s policy for correcting errors.

- Generally, the following is accepted for charting errors. Draw a single line through the mistaken entry so that what was written can be still read. Carefully write above it “Mistaken Entry” followed by your initials and the date (Brooke, 2002; Pethel, 2000; and Dumpel, James, & Philips, 1999).

- The original entry must still be readable. NEVER scratch out, erase, or use correction fluid (white-out) on a mistaken entry. Using these methods makes it look like something is being hidden. Be sure the mistaken entry is still readable.

10. **Write on Every Line**
• Fill each completely. Leave no blank lines or partially blank lines.

• Draw a line through the empty part of the line. This prevents others from inserting information later than may change the meaning of the original documentation.

• On forms, when information requested does not apply to a particular client, write “NA” (not applicable) or draw a line through the space. This indicates that every item on the form has been addressed.

11. Chart Omissions

Charting is supposed to show implementation of the medical and nursing plans of care. Whenever a part of the plan is omitted, document the reason why. For example, a treatment was not provided or medication was not administered because the client was in x-ray.

12. Sign Each Entry

• Each entry on the nurse notes (progress notes) is to be signed with your first name or initial, full last name, and professional licensure (i.e., LVN, LPN, RN).

• The signature should be at the end of the entry on the far right side.

• When there is not enough room on the last line of the documentation, draw a line from the last word to the end of the line and on the next line, leaving enough room to sign the entry at the far right.

• For a long entry that will conclude on another page, record “(Continue on next page) and sign your name. Begin the next page with “(Continued from previous page)”, finish the entry, and sign your name.

Documenting a Medication Error
Facilities require nurse to report medication errors on incidental reports. It should be remembered that the purpose of the medical record is to report any care or treatment the client receives, including any errors made. However, no mention is made of an incident report being completed.

When a medication error occurs, the following documentation should be done. The error should be documented in the nurses’ notes with the following information: name and dosage of the medication; time it was given; client’s response to the medication; time it was given; client’s response to the medication; name of the practitioner who was notified of the error; time of the notification; nursing interventions or medical treatment to counteract the error; and client’s response to treatment.

Medication Incident Report

Some health care facilities are now using a specific medication incident (variance) report for situations related to medications. This provides the facility with information that can be used to possibly change policies or procedures that will work to prevent medication incidents.

SUMMARY

- Effective documentation requires clear, concise, accurate recording of all client care and other significant events in an organized and chronological fashion representative of each phase of the nursing process.

- Use only agency approved abbreviations.

- Add a late entry or correct a mistaken entry following the agency-approved method.

- Sign each entry appropriately.

- Client safety requires appropriate reporting and recording of medication errors and other occurrences, in compliance with the facility’s policy.

Computer-Based Client Records
Electronic medical records (EMRs) or computer-based patient records (CPRs) permit electronic client data entry and retrieval by caregivers, administrators, accreditors, and other persons who require the data. The Computer-Based Patient Record Institute, established in 1992, identified four ways the EMR could improve health care; (a) constant availability of client health information across the life span, (b) ability to monitor quality, (c) access to warehouse (stored) data, and (d) ability for clients to share in knowledge and activities influencing their own health.

Because of the way computers provide access to EMRs, providers easily retrieve specific data such as trends in vital signs, immunization records, and current problems. The systems can be designed to warn providers about conflicting medications or client parameters that indicate dangerous conditions. Sophisticated systems allow replay of audio, graphic, or video data for comparison with current status. All text is legible and can be searched for keywords.

There are several areas of concern with EMRs. Maintaining the privacy and security of data is a significant issue. One way in which computers can protect data is by user authentication via passwords or biometric identifiers (e.g., fingerprint or retinal scans) –only those persons who have a legitimate need to access the data receive the password. Additional policies and procedures for protecting the confidentiality of EMRs are evolving as the use of computer systems become more widespread.

Following several previous reports, the ANA developed a position statement on privacy, confidentiality of medical records, and the nurse’s role. One role of the nurse informaticist, an expert who combines computer, information, and nursing sciences, is to developed policies and procedures that promote effective and secure use of computerized records by nurses and other health care professionals.

Currently, there are no national standards for EMRs: neither for the specific data that should be included, nor for how the record should be organized. HIPAA regulations are playing a key role in establishing these. Nurses need to be involved in the design, implementation, and evaluation of EMRs to maximize their use and effectiveness.

Different from an EMR is a personal health record (PHR), which is an electronic document that contains the client’s medical, personal, and health information but is controlled by the client, rather than the health care provider. It is defined by the National Alliance for Health Information...
Technology as “an electronic record of health–related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual”. The PHR can be stored on a computer database, in an electronic computer file, or on a portable “smart card” similar to a credit card. A significant advantage of a PHR stored in a commonly accessible format (e.g., word processor document or portable document format [pdf]) is that clients can transport and give the information to any care provider they wish, whenever necessary. A challenge is to keep the information current, however. Since nurses provide a majority of the health information, and standardized format for PHRs would increase their usefulness, it is critical that nurses be involved in the design and testing of PHRs (Thedes, 2008)

References: