

SECTION: NURSING SERVICES

POLICY #: 405 CHARTING

POLICY: Client documentation will be completed on each individual utilizing services of Central Valley Health District.

PROCEDURE:

1. Standardized forms, developed by Central Valley Health District, along with state forms are used to document in client records. See client record policy for chart types and forms.
2. Record all entries permanently by using ink, usually black.
3. Documentation should be completed as soon as possible following the client's visit.
Basic Documentation steps:
 - a. Begin with date.
 - b. Be complete, brief and accurate.
 - c. Be legible and use correct spelling.
 - d. Do not leave spaces and use Central Valley Health District approved abbreviations. *See listing.
 - e. Cross out errors with a single line and initial. Do not erase, use white out or write over.
 - f. Sign or initial all entries.
4. Nursing staff may either hand write or dictate pertinent information in the client record. Dictations are turned into secretarial staff for transcription. Transcribed notes are reviewed by the nursing staff and nurse will sign. Narrative nurses notes are used for situations where a more detailed description is required.
5. All client contacts, including telephone, office visit, or home visit, will be documented in the client record on the flow sheet or nurse's notes of established clients.
6. Nursing staff are encouraged to document contacts to individuals who are not established clients. This includes nursing information given over the telephone. Documentation may be done on a daily log or staff appointment book. Detailed descriptions or concerns of non-established clients may require a client record, depending on the situation as determined by nursing staff.
7. All staff will sign the authorized signature list which is kept on file permanently in nursing supervisor's office.
8. Charts are filed numeric or alpha depending on type of record. All established charts must be numbered. See client record policy.
9. Central Valley Health District utilizes SOAP charting for narrative description.

SOAP Definition:

S: Subjective- Chief complaints what you are told by client. May use quotation marks if direct quote. If client cannot give information or is non relevant S may be noted as none.



POLICY AND PROCEDURE MANUAL CENTRAL VALLEY HEALTH DISTRICT

O: Objective: What you see, hear, feel, smell. General observations are noteworthy. Flow sheets are used for documentation of physical assessments. It is appropriate to list-see flow sheet.

A: Assessment (action)-Chart teaching or intervention done during the visit.

P: Plan-Is plan of action or nursing intervention related to problem. Mark chart when you plan to see client again.

SOAP charting should correlate to the nursing diagnosis.

10. Charting should be reviewed by nursing staff to ensure updated orders and care plans are in place.