



Outcome 2

Use documentation structures suitable to the FCN's practice setting.

■ Structures Supporting Documentation

What structures support the FCN's ability to appropriately document?

Key Term: Paper documentation system is the use of an organized set of paper forms to enter handwritten information about the patient and the care delivered to the patient. The set of paper forms for a single patient is maintained as the *patient record*.

Key Term: Electronic documentation system is the use of an electronic means, usually a computer, to enter patient information and an account of care delivery into a digital patient record. This record may also be called a computer-based documentation system.

Paper Considerations

A paper-based documentation system may contain a variety of structured forms. It is important for the FCN to have forms that will create patient records that are manageable and appropriate for the FCN's type of setting and population served. The forms should also contain formatting and data entry areas that will systematically structure documentation and support standards of documenting care delivery, including individual patient encounters and group activities such as support groups, screening events, and health education programs.

- **Patient record.** When an FCN has an encounter with a new patient, an initial patient record is created for that individual to be used for future encounters. The FCN should include any available background information in the record, such as care provider, phone, email, emergency contact, and address. The patient record always includes the FCN's documentation of the initial and subsequent interactions with the patient. The contents of the patient record should reflect care delivered that is based on the nursing process, including assessment data, problems identification, planning of interventions and outcome goals, implementation of the care plan, and evaluation of problem resolution (Potter et al., 2017).
- **Narrative documentation.** If using narrative charting, the FCN should choose a method of systematically organizing the information. Methods such as SOAP/IER, DAR, and PIE are approaches to documenting that reflect the application of the nursing process in the FCN delivery of care (Potter et al., 2017). (Review descriptions of these methods in Appendix B, Methods of Organizing Documentation.)

- **Flow sheets.** FCNs may use forms that allow for quick documentation of routine or repetitive patient data such as flow sheets, checklists, or graphic sheets. These forms also provide the FCN with the ability to follow changes in the patient's health data and status over time. They are useful for tracking patient information when there is a series of patient encounters. These forms must be maintained as a component of a patient record, such as monitoring an individual's blood sugar, or when the encounter is part of a group screening, such as blood pressure screenings during a health fair (Potter et al., 2017). Flow sheets can also be used in conjunction with narrative charting, in which the FCN documents details related to any variances in pattern of data on these forms (Potter et al., 2017). The FCN should document actions and patient responses related to any adverse variances on these forms. When the FCN documents by using both flow sheets and narrative charting, the FCN should conscientiously avoid double-documenting, thus reducing the risk for errors.

Critical Thinking

What elements of an FCN's practice setting most influence the structures that are most suitable to support documentation?

Electronic considerations

The shift to electronic documentation has spurred efforts to enhance communication and patient safety by the American Recovery and Reinvestment Act (ARRA) of 2009 (Potter et al., 2017). The initiation of electronic medical records (EMRs) that describe single encounters or visits, and electronic health records (EHRs) that comprise a lifelong record of all health encounters for an individual patient, is supported by many professional organizations and accrediting bodies. Experts believe that implementing EHRs across the healthcare delivery system will eventually lower costs and improve the quality of patient care (Potter et al., 2017). Electronic health records can enable the FCN to gain prominence as a partner to the movement to transform healthcare using population health promotion and disease prevention as cornerstones. Potter (2017) reports that 80 percent of eligible hospitals participated in meaningful use of EHR by 2013. FCNs must appreciate the potential benefits of the use of EMRs and EHRs to their practice in the light of healthcare practice changes.

Some advantages of computer-based documentation systems:

- Documentation is quicker and more efficient.
- Data input on the various forms replaces handwritten entries.
- Evaluation of data is enhanced, as the system can aggregate data efficiently.
- Individual nursing diagnoses, outcomes, and interventions can be tracked, as well as data from group activities.
- Quality of documentation is improved.

Questions in Appendix C, Considering Paper and Electronic Documentation are helpful for thinking through these considerations.

Choosing Work Space

The FCN will need to find locations where client encounters can take place without others being able to view what the FCN is documenting during the encounter. For example, during blood pressure (BP) screenings in a public location, the FCN should ensure that the space allows for private client encounters in which others cannot view the results on the BP machine or the FCN's documentation of the client's BP results.

Choosing the Location to Document

FCNs tend to have client encounters in various settings beyond the faith community location, such as in homes, hospitals, and in the community during health screenings. At times the FCN may unexpectedly be called aside at an event or worship service to consult on an urgent client situation. The FCN should use professional judgment

Critical Thinking

Choose what you believe are the most effective documentation formats for the FCN; give the rationale for your choices.

Can electronic documentation improve or advance the overall practice of faith community nursing?