

THE BASICS OF CHARTING: BEST PRACTICES IN PATIENT CARE

By Lisa Bond, RST, RPSGT

Charting is one of the most basic and important aspects of patient care. Unfortunately charting is also one of the most often slighted duties by sleep technologists. By slighted I mean that it is frequently deemed as unimportant and therefore overlooked, done sloppily, at too minimal a level, inaccurately or, sadly, even not done at all. Charting is a very vital and important part of any healthcare provider's job, including that of the sleep technologist.

Charting says a lot about the patient, true, but it also says a lot about you as a technologist when content, depth and accuracy are assessed. A professional will work to make sure that their charting is accurate and complete as they know their charting is a reflection of themselves as a professional, as well as good patient care.

So let's talk about charting. What is it? Charting is documentation in a legal medical record that communicates crucial information to other members of the healthcare team so that they can make accurate and informed decisions about the patient's medical treatment. Think about that definition, don't just skim past it but actually think about that definition and what it implies. Your charting is a LEGAL document that can be used in a court of law. Your charting impacts the decisions that will be made about the patient's healthcare trajectory. Charting is important, vitally important. You are the eyes and ears of the physician who is not physically present during the study and therefore you must provide the information they need. Not everything can be garnered from the signals you record and maintain. Those signals are important, but so is charting.

The first thing any medical professional is taught about charting is that if it is not documented, you didn't do it. This sounds pretty basic but let's think about that for a moment. Your job is to monitor the patient. If you do not chart regularly on that patient what means do you have to prove you actually did monitor them? Remember this is a legal document. If you are summoned to court what means do you have to prove you were monitoring the patient? Your word and your co-worker's word will not be sufficient. The law wants facts and supporting documentation;

proof. So if you are not charting regularly on a patient throughout the collection, then as far as anyone is concerned, you did not actually monitor that patient. The accuracy of your charting shows not only that you are good at your job, but also that you were actually paying attention. So if you chart that the patient is sleeping, and they are actually awake according to the recording, that is a problem.

There should be a policy in your sleep center about how often to chart during the recording and what to chart. If your policy is not comprehensive don't do just the bare minimum but don't go overboard either. Maintain an appropriate balance. Lengthy notes do not always mean relevant notes. Keep things brief, to the point and document facts.

So what should you chart during the study collection as compared to after? During the study, you are charting what is going on right now with the patient. If you notice that the patient is talking in their sleep, that needs to be documented as it is happening, so that later it can be determined if it is important to the patient's diagnosis. Did this occur when the patient was in rapid eye movement (REM) or non-rapid eye movement (NREM) sleep? Before an arousal or after an arousal? Remember that you are the eyes and ears of the physician, providing important information that supplements and enhances the signals recorded. Information like this is time-sensitive and should be charted as it happens.

During the study, regardless of the type, you should be routinely charting the patient's current sleep stage, heart rate (HR), respiratory rate (RR), SpO₂ and body position along with a general observation since your last charting. When you do this you are providing facts that prove you are observing the patient. You are also providing a back up to the signals that are being recorded. If you say that patient is supine but the signal derivation states left lateral, then you know you need to correct that signal so that the record is a true reflection of what is actually going on with the patient. If you are performing a diagnostic study, you should also make comments about snoring intensity and frequency, as well as if the patient qualifies for a split-night study or not and why.

If you are performing a titration study then you should also be making comments about the pressure the patient is on and if this pressure is controlling respiratory events and snoring. General comments should include basic factual information about how the patient has done since your last charting.



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Have they had respiratory events and are they increasing or decreasing? If there is an artifact, you should be documenting the type of artifact seen and how you have or are going to correct it. For example; maybe you note that the patient has a sweat artifact. You could document that sweat artifact is present and that at the patient's next arousal you will go in to flip the patient's pillow or turn down the temperature. However, you also need to follow through and actually do that at the patient's next arousal, and then chart that you were in the room and doing just that right after the intervention. As always, if you don't document it, you did not do it!

Chart facts, not guesses. You will note that what I have been listing are simple facts. A guess leaves you open to looking unprofessional and possibly incompetent. Make sure what you are charting is pertinent to the study and appropriate. Be specific and objective; avoid generalizations and subjective statements. What does that mean? If you chart that the patient appears upset that would be subjective. Upset can mean many different things and doesn't say about what. An objective observation states facts and includes signs, symptoms and timing. An example would be to chart that at 22:15 the patient was crying, breathing rapidly and made a specific statement indicating a fear of sleeping tonight without the continuous positive airway pressure (CPAP) they have been using for the past 10 years.

We also need to talk a bit about inappropriate charting. Nothing you chart should be of a personal nature about the patient. Your patient may be mean, rude, smell badly, and be a curmudgeon, but that is inappropriate to chart. It is also inappropriate to chart that the patient is sweet, pretty/handsome, wears nice perfume/cologne or is adorable. Nor should your charting ever include anything about your feelings, or any excuses or departmental problems. Examples of what NOT to chart include:

- “The patient refuses to put down her stupid tablet and is still playing Candy Crush.”
- “The patient's blasted phone rang AGAIN.”
- “I have asked management three times to get me a new belt because this one is malfunctioning but they have not done it yet therefore I am unable to fix this artifact.”
- “I am so bored right now, the patient doesn't even snore; why they are here is beyond me.”

Many systems have preset charting notes that pop up for you to check off during the recording. Be very careful when using this type of charting system. These systems provide basic static charting notes that reduces your work, but they lack individuality and you can easily miss pertinent information that may impact

the patient's care. There is also the potential to simply check off standard information without actually observing the patient. If you use this type of a system you will always need to supplement these chart notes with your pertinent observations. Your assessment is integral to your patient's care. Check boxes cannot cover everything. It is never appropriate to pre-fill this type of charting note because if things change there is the potential that your charting will not reflect what is actually happening with the patient.

Summarizing the night is another type of charting that you need to do. You cannot rely solely on charting during the study and you also cannot rely solely on summaries. Your summary gives those following after you, the scoring technologist and clinician, a brief overview of what is inside all those detailed individual notes and your general observations. This will assist them to quickly determine pertinent information that can impact the patient's care and outcome.

Summary notes are often templates that help to reduce the charting workload and provide some consistency. Be very careful that you are completing that template accurately and correctly and are not simply copying and pasting or leaving inaccurate or incorrect information in the summary. A prime example is a template statement that indicates: “The respiratory events were noted to be worse when sleeping supine.” If this particular patient either did not, or was unable to, sleep supine at all during the study this would be an inappropriate and inaccurate statement. Another example would be to find the final charting including an unedited statement like: “This is a XX-year-old male/female patient that presented for a diagnostic/split/CPAP titration/Bi-level titration/ASV study.” Templates can be helpful but they can lead to the dangerous practice of simply copying and pasting and being incomplete and inaccurate.

As a professional, you need to take responsibility for your charting. It is an integral part of the care you provide for your patient. You must realize that the patient chart, when it is accurate and well done, is a lifeline to better care, and a badly done chart is not just detrimental to the patient, but also potentially to you professionally.

A final thought for you about charting. When you chart, you are documenting not just what happened with the patient, but you are also charting all that you do as a sleep professional. You work hard to take good care of your patients, why not get the appropriate credit for doing that by making sure your charting reflects your accuracy, and the care and attention you have given to the patients while they were in your care. ❖