

## Documentation System Definitions

**ALERT.** A charting system used primarily in long-term care in which the patient's chart is tagged to indicate that special charting procedures/precautions need to be initiated and followed for a specified time.

**CBE.** Acronym for *Charting By Exception*, a system for documentation that eliminates the need to chart repetitious findings and tasks. The health care provider uses specially designed admission history and flow sheets that highlight important findings and trends. Only significant findings or exceptions to established standards of care and protocols are documented in the progress notes.

**CLINICAL PROGRESSION.** A critical path that has been enhanced by the addition of (1) nursing diagnosis, (2) intermediate and discharge goals, and (3) variance tracking. This type of plan is usually used for longer hospital stays not requiring critical care.

**CORE.** A documentation system designed to support the nursing process. Key elements include database, care plans, flow sheets, progress notes, and discharge summaries. Progress notes use a three-column format and are organized using patient database; action of the health care provider; and evaluation of patient outcome.

**CRITICAL PATH.** A cause-and-effect grid that outlines usual interventions by health care providers against a timeline for a case type (diagnosis-related group) or otherwise defined homogeneous patient population. This type of plan is usually used in cases requiring critical care.

**DAR.** Acronym for the organizing structure for writing progress notes using *Focus Charting*®. Each Focus entry includes *Database* describing the current patient condition; *Action* taken by the health care provider; and *patient Response* or *outcome* to the intervention.

**FACT.** Acronym for a documentation system including these key elements: *Flowsheets* for specific patient populations; *standardized Assessment* parameters printed on the chart form; *Concise* integrated progress notes; and *Timely* entries by health care providers at the time that care is given.

**FOCUS CHARTING**®. Trademark title for a three-column format for organizing

the progress notes in the patient record. The FOCUS column serves as an index. The body of the note is organized by identifying the *DATA*base describing the current patient condition; *ACTION* taken by the health care provider; and *patient RESPONSE* to or *outcome* of the intervention.

**PIE.** Acronym for a process-oriented documentation system. The progress notes in the patient record use (P) to define the particular *Problem*; (I) to document *Intervention*; and (E) to *Evaluate* the patient outcome. PIE charting integrates care planning with progress notes.

**POMR.** Acronym for *Problem-Oriented Medical Record*, a method of establishing and maintaining the patient's medical record so that problems are clearly stated. These data are kept in the front of the chart and are evaluated as frequently as indicated with respect to recording changes in the patient's problems as well as progress made in solving the problems. Use of this system may bring a degree of comprehensiveness to total patient care that might not be possible with conventional medical records. Internists, family practitioners, and pediatricians use the POMR system.

**SOMR.** *Source-Oriented Medical Record*; groups formation according to its source: laboratory work, x-rays, examinations, consultations.

**SOAP.** Acronym for an organized structure for keeping progress notes in the chart. Each entry contains the date, number, and title of the patient's particular problem, followed by the SOAP headings: *Subjective* findings; *Objective* findings; *Assessment*, the documented analysis and conclusions concerning the findings; and *Plan* for further diagnostic or therapeutic action. If the patient has multiple problems, a SOAP entry on the chart is made for each problem.

**SOAPIER.** Adds to the SOAP headings listed above: documentation of *Intervention* implemented to solve the identified problem; *Evaluation* of the effectiveness of the intervention; and care plan *Revisions* indicated.

**VARIANCE.** A task or outcome that does not occur as described or within the time frame identified on a critical path or clinical progression.