Book Review

Charting made incredibly easy! (3rd edition)

Contact details of publisher:
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Written as a training manual for nursing staff, 13 specialists including nurses, educators and lawyers have contributed to the content of this new publication. The purpose of the book is to provide guidance on clinical ‘charting’ — a term which we would translate to refer to nursing documentation within the medical record. Explanations of a wide variety of documentation techniques are provided with discussion on their application. Each chapter of the book contains a range of illustrations of completed forms accompanied by tips and examples.

One of the values of this book for Health Information Managers lies in the detailed information it contains about clinical documentation techniques, including: critical pathways; Problem Oriented Medical Recording (POMR); narrative progress notes; Problem-Intervention-Evaluation (PIE); Focus; Charting by Exception (CBE); graphic records; Flow sheets; Assessment; Concise notes; Timely entries (FACT); and Data-Action-Evaluation (DAR).

In addition to information on charting systems, the book provides clear generic guidelines with many examples relating to documenting objectively, concisely and legibly, and includes advice on correction of errors. These guidelines are relevant to medical and allied health clinicians in addition to the nurses who are the intended readers of the book. Detailed instructions give advice on documenting special situations such as incidents and many clinical procedures, including lumbar punctures, mechanical ventilation, and peritoneal dialysis.

This would be a useful resource for health information services, and could be used to update Health Information Management understanding of current nursing practice to assist effective communication with clinicians and the design of clinically appropriate medical record forms. Examples and guidelines from the book could be adapted to local situations to assist with the development of training materials, policies and guidelines, and documentation auditing criteria for evaluating medical record content.

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