Child Health Charting by Exception Guidance

Definition
The medical record is legal documentation of the patient assessment and care, treatment and interventions and response to care. Documentation by exception (DBE) format records the patient information as exceptions or variation from what is expected, standard, normal or usual. DBE is usually accomplished using standardized flowsheets which support the specific care being provided, for example, ICU flowsheets in the acute care setting or the Bright Futures Tool and Resource Kit (BFTRK) forms in ambulatory pediatrics. Documentation by exception means “all standards have been met with a normal or expected response unless otherwise documented.”

Bright Futures Examples
Bright Futures forms are set up as flowsheets to focus on the normal development and growth of children and youth. Documentation should capture parental concerns, developmental delays, abnormalities in the physical exam—any deviation from normal or expected. For example, when using the Bright Futures Visit form:
• exceptions to normal and physical activity should be charted as “6 hours of screen time/day” or “6 - 8 high fructose drinks/day” or “BMI >95%”; or
• abnormal physical exam findings would be documented immediately under the physical exam check boxes as “II/IV murmur LLSB” or “macular papular rash check and upper extremities”.

Requirements
Clinicians should have a clear understanding of:
• the ranges of normal growth and development findings for specific age groups; and
• the ranges of normal and expected responses to treatment, medication, or intervention.

The agency will have in place a quality improvement framework to assure appropriate and accurate documentation which includes the following:
• policies and procedures to support DBE including the standards or definitions for “normal and expected” (see recommendations), licensure requirements for specific assessments, approved abbreviations and documentation timelines;
• initial and ongoing competency assessment for clinicians documenting by exception to include knowledge of normal or expected findings and appropriate documentation of variances; and
• a quality assurance or audit process to regularly assess compliance with the clinical documentation standards.

Recommendations
The Child Health program recommends the following resources to support documentation by exception:
• Age specific physical examination and history taking: Bates’ Guide to Physical Exam and History Taking, Eighth Edition;
• Age specific growth and development and anticipatory guidance: Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents, Third Edition; and

Resources
• Regional Child Health Nurse Consultants
• Journal of Nursing Administration. 2000 Jul-Aug;30(7-8):342. Patient documentation; Murphy and Burke

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