Nursing Documentation

Remember the old saying, “if it wasn’t documented, it wasn’t done.” The purpose of the medical record is to provide a clear and accurate picture of the patient while under the care of the healthcare team (Campos, 2009). General documentation requirements are outlined below, however, nurses must also have a solid understanding of the specific governing laws in their state of practice, the policies and procedures of their institution of practice, and the guidelines from their applicable specialty organization (Campos, 2009).

 Documentation is an essential element of nursing that serves to (Springer, 2007):
- Record the course of the patient’s hospitalization, treatments and response to treatments.
- Facilitate the coordination and continuity of health care.
- Provide data for research and clinical trials.
- Demonstrate that the patient and/or family were informed about the patient’s condition, care options, and ways to optimize outcomes.

The medical record also provides supporting information for (Hess, 2014):
- Financial reimbursement
- Legal documentation in cases of injury or other legal matters
- Quality-assurance and peer-review committees, state licensing agencies, and regulatory agencies when assessing quality of care
- Regulatory compliance and the accreditation process

Documentation should follow the nursing process: (ANA, 2015)
- Assessment: document relevant data in a retrievable format.
- Diagnosis: document diagnoses in a manner that support the expected outcomes and plan.
- Expected Outcomes: document as measurable goals.
- Planning: document the plan using standardized language or recognized terminology.
- Implementation: document implementation and any modifications, including changes or omissions, of the identified plan.
- Document the coordination of care.
- Evaluation: document the results.
- Document nursing practice in a manner that supports quality and performance improvement initiatives.

- Documentation should be:
  - Accurate, relevant, and consistent
  - Clear, concise, and complete
  - Legible/readable (written and/or as displayed on electronic health record system screens)
  - Logical, timely and sequential

- Utilize a patient-centered approach
  - Include the patient’s perception of their condition and their response to interventions.
  - Document symptoms using the patient’s own words.

- Include actual work of nurses: education, physical, and psychosocial support.
  - Documentation includes, but is not limited to: vital signs, change in patient’s condition, all medications, treatments, interventions, and reassessments.
  - Document all patient teaching, including preoperative, postoperative, and discharge instructions, who was present, and the content provided. Document that the patient understands what has been taught and that the patient was given the opportunity to ask questions.

- Present objective clinical judgment of the nurse.
  - Document what is seen and heard directly from the patient in a descriptive way; do not include speculation or opinion.
  - If not directly observed, document the source, for example: “family member stated…”

- Satisfy legal requirements:
  - Each page of the medical record (electronic or written), must include the patient’s name and medical record number.
  - All entries into the record must be signed, time and date stamped.
    - Include original signature, full name and professional title (or electronic signature if electronic health record used)
    - Include current date, month, year, and time (either a.m./p.m. or military time) immediately before, during, and after adverse events or when notifying another caregiver that a problem exists.
  - Incorrect entries must be identified clearly.
  - Entries must be made by the nurse performing the intervention at the time of the intervention or close to that time.
  - Use only approved abbreviations and standardized terminology.

- Document in chronological order, avoiding gaps.
  - Provide separate entries for each narrative item.
• Chart an omitted note or late entry as a new entry. Do not backdate or add to previously written notes. Note: check with your state regulations regarding late entries and how they should be documented.
  o Ensure the timeline makes sense.
  o Never squeeze in entries.
• Document using appropriate forms (if no electronic health record).
  o Fill in forms completely.
  o Use “N/A” in blanks that do not apply.
  o Ensure forms are easy to read, not cut off, or photocopied too light.
  o Use blue or black ink that cannot be erased; do not use pencil or felt-tip marker or ink that fades or bleeds through paper.
• Once an entry is made, it cannot be altered. NEVER use whiteout, erase, or delete an entry.
  o To correct an error, draw a single line through the entry, initial and date the error, and write the correct information above the wrong entry.
  o If the correction cannot fit above the error, a corrected note should be made in the same day’s notes, dated and signed with the reason for the correction noted.
  o Electronic health records have specific pathways for correcting errors. Be familiar with the correction procedures for each system used within your institution.
• Carefully document adverse events using an objective description: what was observed, assessments, interventions, and follow-up care relating to the event.
  o Include statements made by the patient/family and what information was given to them, and by whom.
  o If an incident report has been filed, do not allude to this in the patient’s chart.
  o Document the intervention performed, who was notified, and that the problem was resolved appropriately.
  o Corrections or additional entries after a serious adverse event should be written carefully. Do not speculate as to the cause of the adverse event or assign blame.
• Document the use of a healthcare interpreter or interpretation service if utilized. If a family member or a non-healthcare personnel is used as an interpreter, document the patient’s approval and the name of the person interpreting.
• Accurately document a patient’s refusal or failure to comply with treatment recommendations.
• Document all telephone interactions, including time and date of the call, content of the discussion, advice given and to whom.
• Always document the patient’s baseline mental status.
• Always assess the patient at the time of discharge or transfer; it is important to know the status of a patient before and after your care.
• Document that the patient and family members were informed of the patient’s condition, treatment, progress, and self-care recommendations.
• Avoid disagreeing with another caregiver in the chart.
• Avoid words such as accidentally, assume, confusing, could be, may be, miscalculated, mistake, unintentionally, inadvertently, unexpectedly, appeared, apparently, and seems to be.
• Never document medications as given before you administer them.
• Never document an acute abnormality found during physical exam without documenting the intervention initiated and never document the intervention initiated without documenting the evaluation/response of the patient.
• Never document a body system abnormality without details as the deficit may worsen over time.
  o For example: detail the level of neurologic deficit.
  o Use quantifiable data with descriptions for wounds (measurements for depth, etc.).
• Do not document for another health care provider or sign off on another practitioner’s interventions.
• Do not correct or destroy a colleague’s notes.
• Verbal orders should be cosigned by the healthcare provider giving the order and accepted by only those authorized to take orders.

Additional Documentation Standards for Advanced Practice Nurses (ANA, 2010):
• Plan-of-care communications
• Rationales for plan-of-care changes
• Collaborative discussions to improve healthcare consumer outcomes.

References:


