DOCUMENTATION

THE IMPORTANCE OF GOOD RECORD KEEPING FOR NURSES

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MINI EXERCISE: CHARTING CHALLENGE – WHAT'S WRONG HERE?

Patient seems okay. Gave meds late because I was busy. No complaints. BP good. Will keep watching.

- Identify at least 3 errors or poor practices.
- Rewrite the note correctly.
- Share reasoning with the group.

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DOCUMENTATION

Refers to any written or electronicaly generated information about a client that describes the client's status, or the care or service provided to that client.

Documentation is not separate from care and it is not optional.

It is an integral part of a nurses practice.

It is a tool that nurses use to ensure high quality care.

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WHAT DOES THE NMC STATE ABOUT DOCUMENTATION?

- The Code of Professional Conduct (NMC, 2002a) advises that good note-taking is a vital tool of communication between nurses. It states that nurses 'must ensure that the health care record for the patient or client is an accurate account of treatment, care planning and delivery. It should be written with the involvement of the patient or client wherever practicable and completed as soon as possible after an event has occurred. It should provide clear evidence of the care planned, the decisions made, the care delivered, and the information shared'.

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TYPES OF DOCUMENTATION

- **Recording**
- Is a brief account of the personal history, medical history, results of diagnostic tests, findings in physical examination, treatment and nursing care, progress notes and condition on discharge.
- **Charting**
- Is a permanent, written and complete record of the health history and sociological information obtained from a person under your care by listening, looking and treating them.

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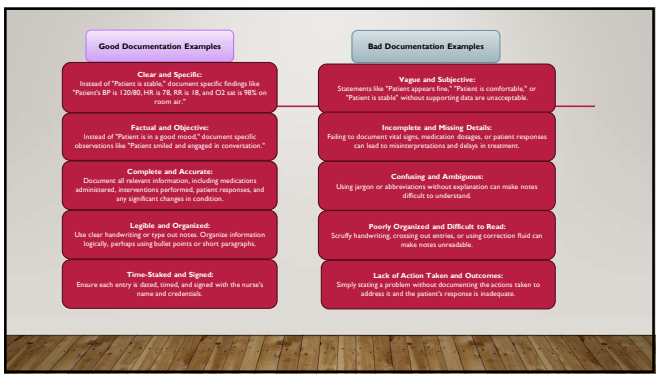

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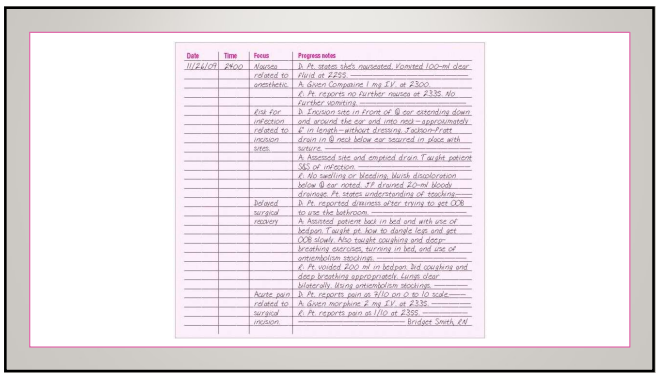

Date	Time	Focus	Progress notes
11/24/09	2400	Nausea related to anesthetic	D: Pt. states she's nauseated. Vomited 100-ml clear Fluid at 2255. —— A: Given Compazine 1 mg IV at 2300. —— E: Pt. reports no further nausea at 2330. No further vomiting. ——
		Risk for infection related to incision sites	D: Incision site in front of ⓑ ear extending down and around the ear and into neck - approximately 6" in length - without dressing. Jackson-Pratt drain in ⓑ neck below ear secured in place with sutures. —— A: Assessed site and emptied drain. Taught patient S/S of infection. —— E: No swelling or bleeding. Mild discoloration below ⓑ ear noted. JP drained 20-ml bloody drainage. Pt. states understanding of teaching. ——
		Delayed surgical recovery	D: Pt. reported dizziness after trying to get OOB to use the bathroom. —— A: Assisted patient back in bed and with use of bedpan. Taught pt. how to dangle legs and get OOB slowly. Also taught coughing and deep-breathing exercises, turning in bed, and use of antiembolism stockings. —— E: Pt. voided 200 ml in bedpan. Did coughing and deep breathing appropriately. Lungs clear bilaterally. Using antiembolism stockings. ——
		Acute pain related to surgical incision	D: Pt. reports pain as 7/10 on 0 to 10 scale. —— A: Given morphine 2 mg IV at 2330. —— E: Pt. reports pain as 1/10 at 2355. —— Bridget Smith, RN

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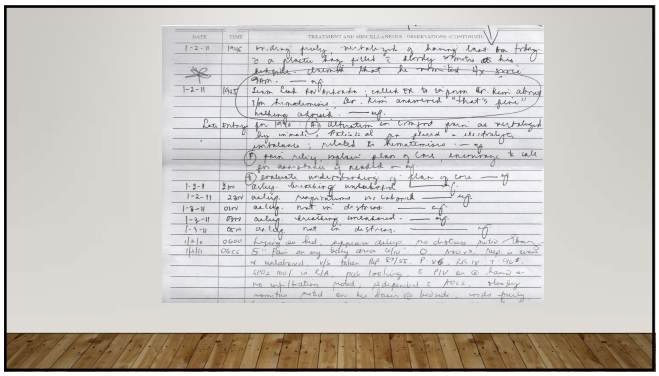

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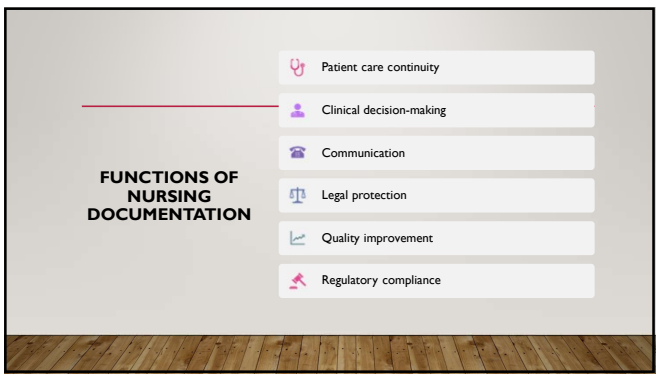

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METHOD OF DOCUMENTATION

- Narrative documentation – is the traditional method for recording nursing care provided. It is a story like format to document information specific to the client's conditions and nursing care.
- Data is recorded in the progress notes without following a framework. It oftens requires the reader to sort through information to locate the required data.

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METHOD OF DOCUMENTATION

- Focus Charting (sometimes referred to a DAR – Data, Action, Response)
- This method of documentation consists of notes that include
- Data, both subjective and objective.
- Action or nursing interventions
- Response of the client.

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METHOD OF DOCUMENTATION

- SOAP - a problem-oriented method of note-taking that's used to record and review ongoing client care.
- Subjective – the client's observations.
- Objective – the health professional's observations and tests.
- Assessment – the health professional's understanding of the problem.
- Plans - goals, action, advice.

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PSYCHIATRIC SOAP NOTE EXAMPLE

Subjective: Elaine is still feeling very depressed and isolated. She states that she occasionally "hears voices, but I can't make out what they are telling me." She doesn't like the side effects of her prescribed medication but reports that it helps her symptoms.

Objective: Elaine's clothing looks unwashed, and her appearance is disheveled. She speaks in a rushed fashion.

Assessment: The lack of progress is concerning. Elaine has auditory hallucinations, a key indicator of schizophrenia.

Plan: Elaine's medication is being changed to Olanzapine 10mg. The next session with Elaine is in three days.

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ADULT NURSING SOAP NOTE EXAMPLE

Subjective: "My right foot has been hurting for a few days, and it's hard to walk on it. "History: Type 2 diabetes for 15 years, controlled with Metformin. Reports that he noticed redness and tenderness around the big toe two days ago. No known injury. Denies fever but says the foot feels "hot" at times. Pain: 6/10, throbbing. Worse in the evenings.

Objective: Vital Signs: BP: 138/82mmHg, HR: 88 bpm, Temp: 37.6°C, Resp: 16/min, BGL (pre-breakfast): 10.2 mmol/L
Physical Exam: Right foot: mild swelling, erythema around the big toe, warmth to touch. No open wounds or ulcers. Capillary refill < 2 sec. No signs of cellulitis spreading above ankle. Mobility: Walks with mild limp. Footwear: Standard issue; shoes appear to fit properly.

Assessment: Likely early diabetic foot complication (possible mild infection or pre-ulceration). Risk: progression to ulceration or cellulitis.
Needs podiatry referral and closer BGL monitoring.

Plan: Clean and dress foot area daily. Monitor for signs of infection (fever, spreading redness). Refer to GP for possible oral antibiotic if no improvement in 48 hours. Request urgent podiatry review. Educate patient on foot hygiene and importance of prompt reporting. Continue Metformin, recheck BGL in 48 hours. Encourage patient to reduce walking/standing as able.

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PAEDIATRIC SOAP NOTE EXAMPLE

Subjective: Mr. Doe states that his daughter Sally still stays in her room on her smartphone and is withdrawn a lot. But has participated in family dinners, which "is a positive step." Sally admits to feeling isolated but finds it hard to disconnect from her phone.

Objective: Sally has been attending family dinners without using her phone. This is the first session where Sally and her parents did not argue about her screen time.

Assessment: Sally is making progress in her plan, and no adjustments are recommended at this time.

Plan: Sally was provided a task to turn off her phone 30 minutes earlier at night for the next 2 weeks, per her plan. We will be meeting again next week.

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BENEFITS OF SOAP METHOD

- Improves note-taking efficiency
- Helps providers formulate treatment strategies
- Ensures completeness of progress notes
- Widely used in the social work & medical communities
- Helps providers communicate information with team members
- Organizes patient session documentation
- Reduces miscommunication between healthcare professionals

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SIX PRINCIPLES OF NURSING DOCUMENTATION

- Accessible.
- Accurate and relevant.
- Auditable.
- Clear, concise, comprehensive, and thoughtful.
- Legible/readable.
- Timely and sequential.
- Aligned with the nursing process.
- Retrievable on a permanent basis.

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HOW TO IMPROVE RECORD-KEEPING

1	2	3	4	5	6	7	8	9
Get into the habit of using factual, consistent, accurate, objective and unambiguous patient information;	Use your senses to record what you did, such as 'I heard', 'felt', 'saw', and so on;	Use quotation marks where necessary, such as when you are recording what has been said to you;	Ensure there is a reasoned rationale (evidence) for any decision recorded, for example, denying access to a visit from a family member;	Ensure notes are accurately dated, timed, and signed, with the name printed alongside the entry (initials should be avoided);	Write up notes as soon as possible after an event and, by law, within 24 hours, making clear any subsequent alterations or additions;	Document any objections you may have to the care that has been given;	Do not include jargon, meaningless phrases (for example 'slept well'), irrelevant speculation, and offensive subjective statements;	Write the notes, where possible, with the involvement and understanding of the patient or carer (NMC, 2002c).

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PROFESSIONAL AND LEGAL RESPONSIBILITY

- Law courts adopt the attitude that if something is not recorded, it did not happen and, therefore, nurses have a professional and legal duty to keep records.
- The NMC (2002c) states that documentation should demonstrate:
- A full account of the nurse's assessment and care planned and provided for the patient;
- Relevant information about the condition of the patient at any point;
- Measures the nurse has taken in response to the patient's needs;
- Evidence that the nurse has understood and honoured the duty of care, has taken all reasonable steps to care for the patient and that any action or omission has not compromised patient safety;
- A record of any arrangements the nurse has made for the continuing care of a patient or client.

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SAMPLE FLAWED NOTE:

"PATIENT SEEMS OKAY. GAVE MEDS LATE BECAUSE I WAS BUSY. NO COMPLAINTS. BP GOOD. WILL KEEP WATCHING."

Common Errors:

- Subjective language: "seems okay"
- Unprofessional justification: "I was busy"
- Lack of specifics: What meds? What time? What's "BP good"?
- Missing objective data

Improved Version:

"Patient alert and oriented when checked at 0730. Administered 20 mg Lisinopril at 0945 (scheduled for 0900) due to high patient volume. Blood pressure 132/84 mmHg at 0950. No current complaints. Will continue to monitor per protocol."

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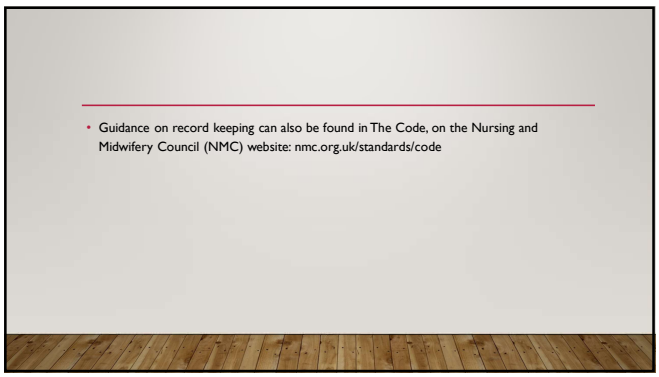
• Guidance on record keeping can also be found in The Code, on the Nursing and Midwifery Council (NMC) website: nmc.org.uk/standards/code

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