Unlocking the Power of School Nursing Documentation

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School nurses may be underestimating the power of their documentation to advance the visibility of their work and the needs of the students they serve. The first step toward unlocking the value of their documentation is recognizing the role that quality documentation plays in advancing these goals. The purpose of this article is to demonstrate the utility of the nursing process for improving the quality of documentation and provide examples of how to use nursing documentation formats.

Keywords: documentation; data; quality improvement; nursing process; advocacy

Have you ever been asked to recall an interaction you had with a student? Or during a student's education plan (individualized education program [IEP]) meeting, a question is asked about an event earlier in the year where your colleague had a different recollection of the event than you did? Maybe you had to go back and look at your documentation. Were your notes clear enough? As nurses we learned in nursing school to document to decrease vulnerability to litigation. Yet documentation can unlock so much more. School nurses may be underestimating the power of their documentation to advance the visibility of their work and the needs of the students they serve. The first step toward unlocking that power in their documentation is recognizing the role that quality documentation plays in advancing these goals. Every time a school nurse cares for students, data are generated. When a school nurse documents their care of students, valuable information is created that can lead to improved knowledge about the needs of students and how school nurses meet those needs. This knowledge adds to the wisdom that becomes available to advance the practice of school nursing (American Nurses Association [ANA], 2016).

School nurses collect vast amounts of data that has the potential to improve visibility, inform policy, and promote student health (Bergren & Maughan, 2019; Johnson, 2020). The quality of documentation directly affects the usability of this data. If documentation is incomplete or limited to check marks in an electronic health record, you may be missing an opportunity to illustrate school nurses' critical thinking skills and expertise. High-quality nursing documentation is accurate, complete, and follows the nursing process (ANA, 2015). It provides evidence that demonstrates nursing's contributions to student health and academic outcomes. Incomplete nursing documentation threatens the validity and weakens the usefulness of nursing data (Jones, 2016; Westra et al., 2015). To facilitate the data's usability, it is incumbent on the nurse to document using the nursing process.

Standards and Quality

Nurses use the nursing process to organize and document the delivery of care. This structured format increases the usability and quality of the information in documentation. Documentation that is useful provides the information needed to improve visibility, adhere to legal standards, promote continuity of care, and advocacy for student needs (Bergren et al., 2013; Bergren & Maughan, 2019; Johnson, 2019; Johnson & Bergren, 2011; Maughan et al., 2018). The *School Nursing: Scope and Standards of Practice* (ANA & National Association of School Nurses [NASN], 2017) defines the professional and legal standards for which all school nurses are held accountable and identifies the nursing process as the standard of practice for documentation.

The nursing process is a scientific model that provides a systematic approach to providing nursing care. The model is dynamic and emphasizes the ongoing assessment and evaluation of responses to nursing interventions. The six steps of the nursing process are contained in the mnemonic ADPIE and includes *A*ssessment, *D*iagnosis, *P*lanning (which includes outcomes identification), *I*mplementation, and *E*valuation (ANA, 2015). The school nurse engages critical thinking for each step of the nursing process and demonstrates evidence of

DOI: 10.1177/1942602X20928053

Box 1. Explanation of Documentation According to the Nursing Process (ANA & NASN, 2017)

Documenting assessment–A: The nurse collects all pertinent data and information that is relative to the student's health or situation. Both subjective data and objective data are collected. The student's reason for visit or chief complaint is included in the documentation.
Subjective data includes the student's words and should be documented as a direct quote or in a paraphrased statement.
Objective data is observable and measurable and includes observable signs and symptoms, physical assessment findings, response to medication or treatments, and relevant diagnostic test results. Assessment documentation reflects the nurse's critical thinking and decision making and leads to a nursing diagnosis or problem statement that must be evidenced in the documentation.

Documenting diagnosis–D: The nurse documents their analysis of the assessment data and the clinical judgement used to determine diagnoses, problems, and issues. Diagnoses can focus on existing problems, potential problems, and health promotion. Nursing diagnoses will provide basis for interventions that will facilitate the desired outcome.

Documenting planning–P: Planning includes outcomes identification and the plan to meet those outcomes.
Outcomes identification: The nurse identifies expected outcomes for a plan individualized to the student or the situation based on their nursing diagnosis. The outcome criteria for evaluation are developed from the goals (and nursing diagnoses). Goals are stated in clear, concise, and measurable terminology that can be understood by relevant school staff and have some element of time attached to them.
Planning: The school nurse develops a plan that prescribes strategies to attain expected, measurable outcomes. Emergency care plans (ECPs) and individual health plans (IHPs) demonstrate supporting evidence of planning.

Documenting implementation–I: The school nurse documents the implementation of the plan. This includes actual nursing care given, student's response to the interventions, coordination of care, and any teaching and/or health promotion efforts.

Documenting evaluation–E: The school nurse evaluates progress toward attainment of goals and outcomes. This includes determining if goals have been met, if interventions need to be modified, and if the nursing diagnosis still exists or if a new one has developed.

Table 1. Comparison of the Nursing Process and the SOAPIE and DAR Documentation Formats

Nursing process (ADPIE)	SOAPIE	DAR
Assessment	**S**ubjective and **O**bjective	**D**ata
Diagnosis	**A**ssessment	
Plan	**P**lan	**A**ction
Implementation	**I**mplementation	
Evaluation	**E**valuation	**R**esults

meeting the standards through their documentation (ANA & NASN, 2017).

The full description of the nurse's critical thinking of the nursing process includes

- assessment of the student's presenting symptoms and identification of a nursing diagnosis or reason for visit;
- nursing interventions to address the reason for visit; and
- expected outcomes of the intervention (Blair & Smith, 2012; Johnson, 2017).

There are several charting methods that support documenting the nursing process. The SOAPIE (*S*ubjective, *O*bjective, *A*ssessment, *P*lanning, *I*ntervention, *E*valuation) and DAR (*D*ata, *A*ction, *R*esponse) formats are two such examples (Blair & Smith, 2012; Johnson, 2017). Box 1 explains documentation of the nursing process; while Table 1 compares the nursing process with the SOAPIE and DAR formats for documentation. Each charting method has its own limitation; it is important to ensure that the nurse's critical thinking skills are evidenced in the documentation to demonstrate school nurse expertise. This is especially true when electronic documentation systems limit the nurse to checking a box or choosing an item from a dropdown menu without prompts to provide supporting evidence for the nurse's decision.

School nurse documentation provides a history of student care and supports communication with essential school team members (Johnson, 2017). It is important that documentation is accurate, complete, timely, sequential, auditable, readable, retrievable, and reflects the nursing process. Charting should occur contemporaneously (in real time) or as soon as possible from the time when care was rendered and include any adverse findings or changes in the student's condition (ANA, 2015). The school nurse should use standardized languages and formats that are universally accepted to support the meaningful use of student health data to support policy, evidence for practice, and resource allocation (Johnson, 2017).

School nurses may ask how to do this during a busy day in the office and when the electronic health record only has check boxes and a text box. It can be done. Use the following two vignettes to practice using the nursing process in charting using the DAR and SOAPIE formats.

Table 2. Documentation in SOAPIE Format (Subjective, Objective, Assessment, Plan, Implementation, Evaluation)

S O	• Chief complaint or reason for visit: shortness of breath, chest tightness • Subjective data: Gabriel states her symptoms started when she was "chasing a friend at recess." She denies symptoms prior to recess and reports taking her maintenance Flovent MDI at home as prescribed. • Objective data: cough dry and nonproductive, BP = 98/68 mmHg, HR = 78 bpm, Temperature = 98.6°F, RR = 26 bpm, SpO_2 = 98%, lungs auscultated with bilat upper lobe wheezes noted on expiration; PEFR = 220, high yellow zone.
A	• Diagnosis is derived from assessment data (asthma) • Nursing diagnoses (At risk for impaired breathing due to asthma symptoms)
P	• Outcomes: Gabriel will report improved breathing after ProAir MDI administration • Plan is individualized to the student: Follow Gabriel's Asthma emergency care plan
I	• Implementation of care: Administered ProAir MDI 2 puffs at 10:34. Gabriel reports improved breathing after inhaler administration. BP = 98/68 mmHg, HR = 84 bpm, Temperature = 98.6°F, RR = 22 bpm, SpO_2 = 100%. Lungs clear bilat, no wheezes on auscultation. PEFR = 230, low green. Mother contacted, advised of Gabriel's symptoms and treatment, discussed importance for Gabriel to continue taking her maintenance medication at home as prescribed, mother will call PCP if symptoms persist. Student instructed to report to health room before recess for MDI. Gabriel released back to class.
E	• Evaluation of the outcomes of the plan: Goal met. Gabriel reports improved breathing after ProAir MDI administration and reports her plan to come to the health room for her MDI before recess.

Note. MDI = metered-dose inhaler; BP = blood pressure; HR = heart rate; bpm = beats per minute; RR = respiratory rate; SpO_2 = oxygen saturation; PEFR = peak expiratory flow rate; PCP = primary care physician.

School Nursing Practice

Clinical Vignette 1

Gabriel is a 9-year-old female with a diagnosis of moderate persistent asthma who presents to the school nurse with complaints of chest tightness and shortness of breath. Gabriel tells the nurse that her symptoms started during recess when she was chasing a friend. Gabriel denies having symptoms prior to recess and reports taking her Flovent MDI maintenance medication at home as prescribed. The nurse has Gabriel's asthma emergency care plan (ECP) with medication orders to administer ProAir HFA 90 MDI prn for asthma symptoms and 15 to 20 minutes before exercise. The nurse observes that Gabriel has a dry, nonproductive cough. Blood pressure (BP) = 98/68 mmHg, heart rate (HR) = 78 bpm (beats per minute), temperature = 98.6°F, respiratory rate (RR) = 26 bpm, oxygen saturation (SpO_2) = 98%. Lungs auscultated with bilateral upper lobe wheezes noted on expiration. Peak expiratory flow rate (PEFR) = 220, high yellow zone. Nurse follows ECP and administers 2 puffs ProAir MDI. Reassessment: BP = 98/68 mmHg, HR = 84 bpm, Temperature = 98.6°F, RR = 22 bpm, SpO_2 = 100%; lungs clear bilat, no wheezes on auscultation; PEFR = 230, low green. Gabriel states breathing improved. Nurse calls mother to inform her about Gabriel's symptoms and treatment. Nurse advises on the importance of Gabriel to continue to take maintenance medication at home as prescribed. Mother informs nurse that she will call PCP (primary care physician) to discuss medication management if symptoms persist. Nurse reminds Gabriel to come to health room 15 minutes before recess for her MDI, and Gabriel acknowledges understanding. Gabriel returned back to class.

Table 2 outlines how a school nurse would chart the student encounter using SOAPIE; while Table 3 uses DAR for the same vignette. Both not only document what happened but also provide evidence not just of facts but of the critical thinking skills the nurse used during the encounter.

Clinical Vignette 2

Leigh is a 7-year-old female student who presents with a nosebleed. She tells the nurse it started during class and denies any injury. There is no external visible bleeding. There is a small amount of blood visible at the end of the nares. Student instructed to tilt head forward while pinching nose using a tissue. Symptoms were easily resolved. Student returned to class.

Use Tables 4 and 5 to create your own documentation using SOAPIER and DAR formats. Afterward, review Tables 6 and 7 for the correct answers.

Conclusion

There is power in data. School nurses collect vast amounts of student health data that can be used to improve student health outcomes. To access the power in student health data and show school nurses' critical thinking skills, school nurses should strive to document using the nursing process. Implementing this strategy will significantly improve the quality of documentation and usefulness of the data, thereby releasing the power of documentation.

The NASN has developed a program to utilize the power of data in school nursing documentation called the

Table 3. DAR Format (Data: Subjective and/or Objective; Action: Action, Nursing Intervention; Response: Student's Response to the Intervention)

D	• *Subjective* (shortness of breath, chest tightness. Gabriel states her symptoms started when she was "chasing a friend at recess," she denies symptoms prior to recess and reports taking her maintenance Flovent MDI at home as prescribed) • Objective data (cough dry and nonproductive, BP = 98/68 mmHg, HR = 78 bpm, Temperature = 98.6°F, RR = 26 bpm, SpO_2 = 98%, lungs auscultated with bilat upper lobe wheezes noted on expiration; PEFR = 220, high yellow zone)
A	• Follow Gabriel's asthma emergency care plan • Administered ProAir MDI 2 puffs at 1034, Gabriel reports improved breathing after inhaler administration. BP = 98/68 mmHg, HR = 84 bpm, Temperature = 98.6°F, RR = 22 bpm, SpO_2 = 100%. Lungs clear bilat, no wheezes on auscultation. PEFR = 230, low green. Mother contacted, advised of Gabriel's symptoms and treatment, discussed importance for Gabriel to continue taking her maintenance medication at home as prescribed, mother will call PCP to discuss medication management if symptoms persist. Student instructed to come to health room before recess for her MDI. Gabriel released back to class
R	• Gabriel reports improved breathing after ProAir MDI administration • Gabriel reports her plan to come to the health room for her MDI before recess

Note. MDI = metered-dose inhaler; BP = blood pressure; HR = heart rate; bpm = beats per minute; RR = respiratory rate; SpO_2 = oxygen saturation; PEFR = peak expiratory flow rate; PCP = primary care physician.

Table 4. SOAPIER Practice Table

S	Subjective
O	Objective
A	Assessment
P	Outcomes and Plan
I	Implementation
E	Evaluation

Table 5. DAR Practice Table

D	Data: Subjective, objective and nursing diagnosis
A	Action: Plan and implementation
R	Results: Evaluation

Table 6. Answer Table–SOAP Format (S: Subjective; O: Objective; A: Assessment; P: Planning)

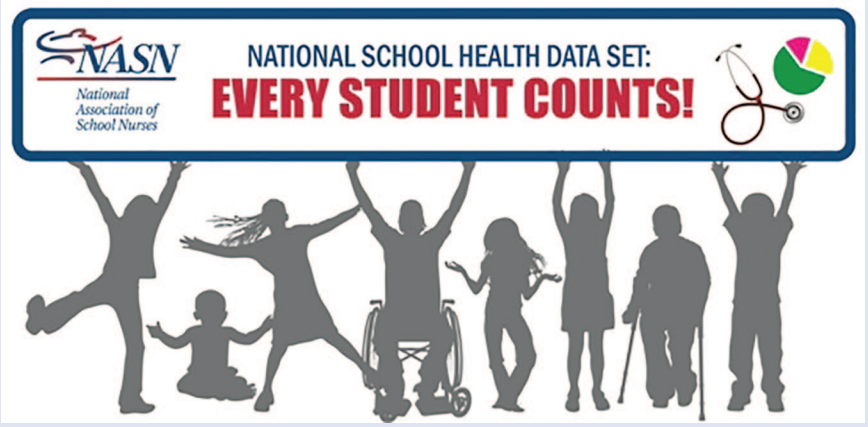
6/2/19 0900 Nosebleed	
S	Denies injury; reports started while "sitting in class."
O	No observable external bleeding. Small amount of blood at end of nares.
A	Nosebleed, not related to injury.
P	Goal: stop bleeding. Self-care: apply pressure to bleeding site to induce clotting.
I	Instructed to tilt head forward, pinch nose with tissue.
E	Bleeding resolved. Student returned to class.

Table 7. Answer Table–DAR Format (D: Data; A: Action; R: Results)

6/2/19 0900 Nosebleed	
D	Started while "sitting in class." No external bleeding observed, small amount of blood at end of nares.
A	Student self-managed, instructed to tilt head forward and pinch nose with tissue.
R	Bleeding resolved, and student returned back to class.

National School Health Data Set: Every Student Counts! (NASN, n.d.; see Figure 1). Make sure that the students you serve and the care you provide *Counts!* by using the nursing process to document that care. For more information on *Every Student Counts!* see https://www.nasn.org/nasn/research/everystudentcounts. ■

Figure 1. Logo for the *National School Health Data Set: Every Student Counts!*



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