# Nursing Documentation

Nursing documentation is a responsibility that spans across all nursing practice levels and settings. It is a crucial and fundamental skill that is necessary to deliver clear communication among interdisciplinary healthcare team members. Nursing documentation provides a full account of patient care to create record of services. These records of services are used by payors for reimbursement, to ensure quality patient care and reduce errors, by the legal system as evidence, to generate data for research and quality improvement initiatives, and to provide the basis for demonstrating nursing's contributions to patient care outcomes (ANA, 2015; Goodwin, 2019).

## Six Principles of Nursing Documentation

The American Nurses Association (ANA) has identified six principles of nursing documentation to provide guidance for producing high quality documentation (ANA, 2015).

### 1. Documentation Characteristics

- 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

### 2. Education and Training

- Technical elements of documentation
- Competence of the documentation system, use of computer and use of associated hardware
- Proficiency of any related systems that may house pertinent patient documentation or data

### 3. Policies and Procedures

- Knowledge and application of all organizational documentation policies and procedures
- Proficiency in the policies and procedures of documentation during "downtime" when electronic medical record is unavailable

### 4. Protection Systems

- Security of data
- Protection of patient identification
- Confidentiality of patient information
- Confidentiality of healthcare workers' information
- Confidentiality of organizational information

### 5. Documentation Entries

- Accurate, truthful, and comprehensive
- Dated and timed
- Legible/readable

- Utilize standardized terminology, acronyms, and symbols

### 6. Standardized Terminology

- Consistent use of standardized terminology to allow aggregation and analysis of data to function in the planning, delivery, and evaluation of nursing care

## Practical Tips for Documentation

- Be sure you are documenting in the correct patient record.
- Strive to produce documentation that reflects the nursing process and full scope of nursing practice; include actual work of nurses, including education, physical, and psychosocial support.
    - Vital signs, change in patient's condition, medications, treatments, interventions, and reassessments.
    - 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.
- Document accurate and complete descriptions.
- Provide complete medication administration documentation and patient response.
- Record details of phone calls or messages to provider and response; include date and time.
- Document preventative measures, such as falls risk identification bands and signage.
- Document patient refusal and/or compliance with medical care or medications, along with notification to provider.
- Document events/care in timely manner.
- Clearly note if documentation is post-facto with details of date and time. Never document ahead of time.
- When documenting a symptom, follow with implementation of treatment/intervention and patient response.
- When necessary to document statements that are verbalized by someone, always use quotation marks.
- Do not alter the medical record.
- Document the whole story, but in a concise manner.
- Satisfy legal requirements:
    - Each page of the medical record (electronic or written) must include the patient's name and medical record number.
    - All entries in the record must be signed, and 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.
        - Electronic health records have specific pathways for correcting errors. Be familiar with the correction procedures for each system used within your institution.

- 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.
- 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 (if consent from patient) were informed of the patient's condition, treatment, progress, and self-care recommendations.
- Avoid words such as *accidentally, assume, confusing, could be, may be, miscalculated, mistake, unintentionally, inadvertently, unexpectedly, appeared, apparently,* and *seems to be.*
- 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.
- Use quantifiable data with descriptions for wounds (measurements for depth, etc.).
- Don't document for another health care provider or sign off on another practitioner's interventions.
- Don't correct or destroy a colleague's notes.

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