Documentation Guidelines

Documentation is a vital nursing task. There are five primary guidelines that ensure efficient quality documentation. They include; keeping the documentation factual, accurate, current, organized, and complete. When using factual information, use descriptive, objective information, and support patient statements with objective data. Accurate documentation includes exact measurements and no unnecessary words and details. Include current data at the time of the occurrence, especially with assessments, treatments and responses, change in status, admissions, transfers, discharge, and death. Documentation should always be organized and completed.

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Factual

Objective Information

Objective-observation

Quality documentation includes objective data that a nurse obtains through continuous assessments. Vague words such as "appears," "seems," or "apparently" should be avoided because they convey opinions. Objective data is collected through direct observation, measurements, and patient behavior.

Subjective Information from Patient

Subjective-thought-bubble

Comments made by the patient are the only subjective data that should be included in documents. When recording a patient's statement, use the exact patient words in quotation marks, such as, “Patient states that she is experiencing “throbbing, sharp pain” in her head.”

Objective Supports Subjective

Objective-observation Supports Subjective-thought-bubble

When using subjective data in the documentation, use objective data to support it. Example: A patient feels nervous. Instead of just documenting "the patient feels nervous," report the patient's elevated heart rate and blood pressure noted in their vitals and the patient's statement "I am feeling so nervous" in quotations.

Accurate

Avoid Unnecessary Words and Details

Avoid-sign at the Unnecessary Words Road

Avoid irrelevant words and details in the documentation. Facts that add value and pertain to necessary collected data should be the only details charted.

Exact Measurements

Exact Ruler

Documentation should use exact measurements so that subsequent patient assessments are tracked accurately. It also allows for better care for the patient because it is more apparent when a patient's health deteriorates or improves. Example: Stating a patient "did not eat much dinner" allows for a lot of interpretation, by saying the patient "ate 1/4th of their dinner" is more accurate.

Current

Assessments

Assess-man

Assessments are important to document at the time of occurrence. They provide information that health professionals rely on for providing care. Assessments give essential information about a patient's health, if there are abnormal findings, immediate interventions are required.

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Document ASAP

Document ASAP Watch

Completed nursing tasks are to be documented at the time they occur. Timely documentation ensures that all of the collected data is current, and there is a precise timeline for any health changes.

Treatment and Response

Treats and Response

Treatments and patient responses are also to be documented immediately. Any treatments and interventions provided are charted when they occur to keep a clear timeline of the care and treatment options offered. It is equally important to follow up with the patient to assess how the treatment has helped. If the treatment is unsuccessful further assessment and interventions are required.

Change in Status

Delta-triangle and Patient

With a change in status it is essential to document the findings immediately. It is important to keep a current record of patient changes to ensure that the significant data is accurate and can be traced if needed.

Admission, Transfer, Discharge or Death

Admission-ticket, Transfer-train Discharging from Hospital and Death

Admission, transfer, discharge or death are documented immediately to keep a clear record of a patient's location. Accurate tracing ensures proper care is provided and the transfer of patient information is passed onto the appropriate recipient.

Organized

Document in a Logical Order

Document in Order

Keeping notes concise, clear and in a logical order is the most effective way to document. Using the nursing processes will help the documentation be precise and clear. First, chart the assessment, then the diagnosis, plan, implementation, and finally the evaluation.

Ensure Information Recorded is Complete

All Information is Filled in

When closing the documentation, ensure that everything is complete and contains relevant and essential information. Report any patient health problems and nursing activities provided.

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