



Professional Nursing Services

10615 York Road
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www.pnsnursing.com

NURSING DOCUMENTATION

Why is home health documentation so important?

Complete, accurate clinical documentation is vital for a number of reasons. It is used to communicate the following:

- patient's "medical story" to staff, families and other medical personnel , (communication vehicle)
- It's a legal document required by law and other regulatory bodies.
- Provides evidence of positive outcomes, quality care, and improvement.
- basis for which you are paid.
- It also leaves a record of the care you provided in the event you are called away for an emergency.
- **Your documentation shows the quality of care you give your patients.**
- It protects you from malpractice and minimizes your risk of takebacks and/or audits.
- Justification to payers that charges billed were for medically necessary skilled services.

*The "wasn't documented, wasn't done" motto is a common one in healthcare settings, particularly as it applies to **medical record documentation**.* Consistent and complete documentation in the medical record for every patient is an essential component of providing quality patient care.

Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice.

You Are What You Document!! Shows the quality of care you gave patient



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DOCUMENTATION CHARACTERISTICS

Standards for quality documentation are:

- Accessibility (remains in client chart)
- Accurate, relevant, and consistent
- Clear, concise, and complete
- Legible/readable
- Factual- both subjective and objective backed by supporting evidence

Subjective data is information from the client's point of view, including, (symptoms) feelings, perceptions, and concerns obtained through interviews (usually in “parenthesis”)

Objective data are observable and measurable **data** (“signs”) obtained through observation, physical examination, vital signs, equipment readings, laboratory and diagnostic testing.

- Timely, concurrent and sequential- document as performed.
- Reflective of the **five** phases of the nursing process:

Assessment- performed by the nurse

Diagnosis- 485 Physician Orders

Planning- outcomes and goals

Implementation- physician orders directed

Evaluation- nurses evidence based effectiveness of interventions



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Five Phases of the Nursing Process

Assessment: performed immediately or within the 1st hour. Collection of information both subjective-the patients symptoms, (what the patient says), and objective data- vital signs, equipment readings. Subjective findings verbalized or stated by the client ex. ("I have a headache" " I feel sick in my stomach."). Examples of objective data- vital signs, equipment readings, wound appearance- dime size yellow drainage on dressing.

Diagnosis: The diagnoses phase is a critical step as it is used to determine the course of treatment. The diagnosing phase involves a RN making an educated judgement about a potential or actual health problem with a patient. It is an interpretation and analysis of the data collected by the nurse about the patient during the assessment phase. This phase may be compared to the 485 Doctors Orders form in each clients' charts which has a list of diagnosis. Communication with the nursing supervisor is a critical part of this phase.

Planning: The nursing supervisor/primary care physician has developed a POC- plan of care (CMS 485) with goals and outcomes to address the diagnosis and plans for possible interventions. Example turn every 2hours to prevent skin breakdown.

Implementation: Interventions/procedures- these are commonly outlined as physician orders- feedings, position changes, checking feeding tube placement (air rush and gurgle), medications administered including prn-why. **The nurses role is to assess the tolerance/effectiveness of ordered procedures/medication etc.** tolerance to procedures/feedings/oxygenation increases or decreases, sleep, medications, therapies, travel, prn medications- why administered and effectiveness, vital signs changes-why- communicated to primary care giver and RN supervisor.

Evaluation: Both the patient's status and the effectiveness of the nursing interventions/care must be continuously evaluated/documented and the care plan modified as needed. This involves communication with the RN supervisor/physician orders.



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NURSING DOCUMENTATION

You should keep in mind a few core guidelines when you write notes on any patient:

Always use a consistent format: Nursing notes include your full name, title, the date (at the top) and the time of entry- not in military time, signature at the bottom with full name and title.

Keep notes timely: Write your notes as care is completed. Writing down your observations and noting care given must be done while it is fresh in your memory, so no faulty information is passed along. Never pre write your note.

Use standard abbreviations: Write out complete terms whenever possible. If you must use an abbreviation, stick to standard medical abbreviations familiar to other nurses or the attending physician. See approved list of abbreviation in the policy section on PNS's web site.

Remain objective: Write down only what you see and hear. Avoid noting subjective comments or giving your own interpretation on the patient's condition. Subjective data should be in parenthesis of comments by client or clients family. Symptoms are subjective observations- client is red faced and feels hot to touch, axillary temperature is 101 F. Never write had a good day- but notations on tolerance of interventions and evaluation of interventions is a must.

Note all communication: Jot down everything important you hear regarding a patient's health during conversations with family members, doctors and other nurses. This will ensure all available information on the patient has been charted. Always designate communication with family member/client with quotation marks.

Ignore trivial information: Everything included in your nurses notes should directly relate to your patient's health. Do not note information on your chart that does not pertain to their immediate care.

Keep it simple: Notes are not meant to be a work of art. They are designed to be quickly read, so nurses and doctors on the next shift can be caught up to speed on a patient. Focus only on specific information relevant to signs/symptoms you are charting. Do not go into depth on the patient's medical history.



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Write clearly: When you do handwritten notes, it must be clear and readable. Illegible handwriting can lead to a patient receiving the wrong medication or an incorrect dosage of the right medication. This can have serious, or even fatal, consequences. **It is considered one of the most common malpractice errors.**