NURSING DOCUMENTATION HANDBOOK

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NOTE TO THE READER: The author and publisher have diligently verified the nursing considerations discussed for accuracy and compatibility with officially accepted standards at the time of publication. With continual advancements in practice and great variety in particular patient needs, we recommend that the reader consult the latest literature and exercise professional judgment in using the guidelines in this book.

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PREFACE

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This book contains a series of documentation examples and guidelines for nurses that are easily referenced by the patient's clinical problems. As hospitals and other inpatient settings are experiencing decreasing lengths of stays and increasing patient acuity, the professional nurse must manage more responsibilities in a shortened time frame. The goal of this book is to assist the nurse in efficiently and effectively documenting patient care in the clinical record.

This book uses the nursing process to assist the nurse in achieving two objectives: meeting patient goals and simultaneously creating effective documentation. The easy-to-use format, with patient problems categorized alphabetically, will help the nurse to remember the myriad skills he or she brings to the patients bedside daily. These standards can be applied in orientation, education, and clinical case reviews, as well as at the patient's bedside. The generation of clear documentation requires a learning process. This book integrates the documentation needed for practice with actual clinical conditions.

Some special devices have been included to make this book easy to use. In the clinical material certain standard abbreviations are used throughout to simplify the written material and to allow the reader to quickly refer to needed information. If any abbreviation is unclear, check its meaning in Appendix C, Key Abbreviations. The documentation guidelines are alphabetized in all areas in Part Two on medical-surgical care, Part Three on hospice care,

and Part Four on maternal child care. These areas are cross-referenced for easy access to the information. For example, care for arthritis is actually under the heading Osteoarthritis, but it is included in the table of contents as Arthritis with the page number for Osteoarthritis. For a more detailed discussion of how to use this book for care planning and other aspects of documenting patient care, see How to Use This Handbook to Streamline Documentation.

HOW TO USE THIS HANDBOOK TO STREAMLINE DOCUMENTATION

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Nursing entries in the clinical record are valued for the wealth of patient information they contain. It is nurses who comfort and care for patients 24 hours a day. It is nurses who coordinate all activities related to the patient. These activities are multifaced and range from clinical tests to therapeutic interventions. It is to the professional nurse that patients and their families and friends look for solace and expertise.

How does documentation relate to these important nursing responsibilities? What is the role of documentation in nursing care? Is it writing a note every shift or updating the care planning record every 24 hours? Documentation includes the all-encompassing realm of *written* communication. All other communications, verbal and nonverbal, other than written, simply appear never to have occurred. As a result, the remembering and recording of what care occurred, the patient's response, and myriad other details, take on new importance in the clinical record.

The goal of this book is to facilitate succinct documentation that assists the nurse in thoroughly documenting the care given to patients while minimizing the time required for that documentation. The initial chapters (Part One) describe the clinical record. Coverage includes the formats of clinical records, common types of nursing docu-

mentation systems, and the actual creation of effective documentation. These chapters also provide general guidelines for complete and effective documentation.

In Parts Two through Four, documentation guidelines are presented for common medical diagnoses/patient problems in medical-surgical care, hospice care, and maternal/child care. The diagnoses or patient problems are listed alphabetically. Thus when caring for a patient with diabetes mellitus and an open wound, the nurse might refer to the following clinical topics: diabetes mellitus, amputation, and wound care. The documentation guidelines provided can be used throughout the clinical record, regardless of the nursing documentation system in use at the health care facility. The format of the book's documentation guidelines can assist the busy nurse in quickly identifying interventions, data, or goals/outcomes that may be appropriate for a specific patient.

The following descriptions explain numbered entries for each clinical topic.

1. Assessment of the patient problem

This assessment is the subjective data and is often the assessment of what the patient, family, or caregiver perceives to be the problem. For SOAP notes, this is the "S." This assessment is one of the most important pieces of information that a patient provides. Obtaining this data requires good listening skills, as well as respect and empathy. The patients perception of the problem is a nursing problem needing nursing management.

2. Associated nursing diagnoses

This section includes the nursing diagnoses approved by the North American Nursing Diagnosis Association (NANDA) that are often correlated with the clinical problem. These nursing diagnoses are the identified focus for intervention by nurses and are used in the care planning record, the problem identification list, and throughout the clinical record. All or some of the diagnoses listed may be appropriate for a specific patient.

3. Examples of objective data for documentation

This section lists measurable or observable criteria specific to the clinical problem. These objective indicators are factual and can be observed. An example might be a patient crying or a temperature of 101° F rectally.

4. Examples of the assessment of the data

This section lists likely nurses' judgments based on the objective findings listed in Section 3. For example, the temperature of 101° F indicates that the patient is febrile, and, based on this assessment, the nurse has information on which to base the next care decision.

5. Examples of potential medical problems for this patient

This section enumerates some of the pathological conditions that may occur as either part of the progression of the disease or a side effect of

treatment, or for other reasons. An example might be a fat embolism after bony trauma or a urinary tract infection in a patient with an indwelling urinary catheter.

6. Examples of the documentation of potential nursing interventions/actions

Nursing interventions or actions that may be appropriate for the patient are specified in this section. NOTE: The physician order(s) should always be checked prior to performing any intervention. Some, none, or all of the interventions/actions listed may be appropriate and must be individualized for a specific patient.

7. Examples of the evaluations of the interventions/actions

The evaluations listed in this section are the responses or outcomes of the interventions or implemented plans. For example, if the intervention is the administration of an antiemetic medication, the evaluation might be that the patient ceased vomiting or verbalized relief from nausea. The evaluation may be positive or negative, or there may be no change identified. There should be an evaluation statement for every nursing intervention.

8. Other services that may be indicated and their associated interventions and goals/outcomes

This section focuses on interdisciplinary patient care. For example, the patient who has suffered a cerebrovascular accident often needs rehabilitation services such as physical therapy (PT), occupational

therapy (OT), and speech- language pathology (SLP) services.

The services listed by discipline are not meant to be exclusive and/or all-inclusive for any diagnosis. Because this book is written primarily for nurses, the nursing interventions/actions are more extensive. However, this is not to say that other disciplines (e.g., PT, OT, chaplaincy, or SLP services) might not also address the same or similar interventions and goals. For example, respiratory therapists perform chest percussion, as do nurses and physical therapists. In addition, speech-language pathologists do swallowing evaluations at some hospitals whereas at others occupational therapists do the swallowing assessments. Our desire to create a concise, quick reference handbook precluded providing detailed listings of interventions for disciplines other than nursing. This is not meant in any way to diminish the importance or value of all of the variously skilled personnel whose services are needed by patients. On the contrary, the intent of this book is to encourage an interdisciplinary approach to patient care.

9. Nursing goals and outcomes.

These nursing goals and/or outcomes listed in this section are based on the patient's diagnoses or problem(s). They are objective and measurable goals that may be accomplished by nursing care, and they may be used in the patient care planning record, throughout the charting method the hospital uses, and in narrative entries. These guidelines will assist in the determination of goal achievement and in evaluating discharge planning processes. Usually,

where stated goals have been reached and documented, discharge is imminent.

10. Potential discharge plans for this patient.

The discharge plans listed in this section are the most common plans, based on the patient's diagnoses and problem(s). Clearly, these plans are specific to the patient's unique clinical course, prognoses, and wishes. They are listed to identify options that may be appropriate for a patient.

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To enhance the handbook's usefulness as a quick reference and to facilitate efficient and consistent documentation, three appendixes have been included that provide information the nurse may need to refer to frequently. Appendix A lists all the NANDA-approved diagnoses using the latest NANDA terminology. Appendix B described services commonly provided by other disciplines. Appendix C lists key abbreviations to promote consistent, comprehensible documentation.

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