NURSING PROCESS

Chapter 7
The Nursing Process:
Documenting the Nursing Process

Chapter 17
Fundamentals:
Documenting, Reporting, and Conferring

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References

- Doenges, M. E., & Moorhouse, M. F. (2003). *Application of nursing process and nursing diagnosis: An interactive text for diagnostic reasoning* (4th ed.). Philadelphia: F. A. Davis.
- Taylor, C., Lillis, C. and LeMone, P. (2005) *Fundamentals of* Nursing (5thEd.). Philadelphia: Lippincott.

Competencies for Ch 7: Documenting the Nursing Process

- By the end of this unit the student will:
  - Describe the purpose and 3 goals of documentation
  - List 7 major functions of progress notes
  - Demonstrate use of appropriate descriptive note writing
  - List 5 areas of content to include in a progress note
  - Briefly describe 5 types or formats of progress notes
  - List examples of items documented on flow sheets
  - Describe the purpose and content of reporting and conferring

Documentation

- **Written, legal record of all pertinent interactions with the patient**
- **Documentation provides a record of the use of the nursing process for the delivery of individualized client care**

Goals of documentation:

- facilitate the delivery of quality client care
- ensure documentation of progress with regard to client-focused outcomes
- facilitate interdisciplinary consistency and the communication of treatment goals and progress

Progress Notes

Progress notes should include all significant events that occur during the client's hospitalization/treatment program

7 major functions of progress notes:

- staff communication
- evaluation
- relationship monitoring
- reimbursement
- legal documentation
- accreditation
- training and supervision

Descriptive Note Writing

- **Notes should be able to form a clear picture of what occurred with the client**
- **Descriptive or observational statements (statements referring to specific observable or measurable events) ensure clarity of progress notes**
- Descriptive language:
  - measurable periods of time
  - measurable quantities
  - a basis or rationale for qualities named in the note

Descriptive Note Writing

- **Descriptive language avoids statements that are evaluative or judgmental <u>unless</u> observational evidence can be presented to back up judgment**
- **Judgmental language can lead to miscommunication**
- Judgmental statements include:
  - undefined periods of time
  - undefined quantities
  - unsupported qualities
  - objective basis for judgments
- See Nursing Process, page 138-141, & 139, Box 7-1

Content of Note/Entry

- Client's progress
- Significant observations/information
- Correct spelling and grammar
- Be brief, concise, short succinct sentences or phrases
- Consistent in style and format to comply with agency policies

Format of Note / Entry

- Block notes (single entry covering entire shift)
- Narrative timed notes (date, time, and event)
- Charting by exception
- Problem-oriented medical record (POMR)
  - Subjective/objective/analysis/plan (SOAP)
  - Subjective/objective/analysis/plan/ implementation/ evaluation/revision (SOAPIER)
  - Problem/intervention/evaluation (PIE)
- Focus charting
  - Data/action/response (DAR)
- See Nursing Process, page 148-149, Box 7-1, 7-2
- See Fundamentals, page 358, Table 17-5

Flow Sheets

- Graphic record (T,P,R,B/P, wt, etc.)
- Fluid balance record (I&O)
- Medication record
- Acuity form
- Home healthcare documentation
- Long-term care documentation (minimum data set, resident assessment instrument)

Reporting/Conferring

- Change of shift report
- Telephone reports
- Telephone orders
- Transfer and discharge reports
- Reports to family and significant others
- Incident reports
- Nursing care conference