Nursing Documentation

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NURSING DOCUMENTATION

UU No 28 tahun 2014 tentang Hak Cipta

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Pembatasan Pelindungan Pasal 26

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i. Penggunaan kutipan singkat Ciptaan dan/atau produk Hak Terkait untuk pelaporan peristiwa aktual yang ditujukan hanya untuk keperluan penyediaan informasi aktual;
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iii. Penggandaan Ciptaan dan/atau produk Hak Terkait hanya untuk keperluan pengajaran, kecuali pertunjukan dan Fonogram yang telah dilakukan Pengumuman sebagai bahan ajar; dan
iv. Penggunaan untuk kepentingan pendidikan dan pengembangan ilmu pengetahuan yang memungkinkan suatu Ciptaan dan/atau produk Hak Terkait dapat digunakan tanpa izin Pelaku Pertunjukan, Produser Fonogram, atau Lembaga Penyiaran.

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1. Setiap Orang yang dengan tanpa hak melakukan pelanggaran hak ekonomi sebagaimana dimaksud dalam Pasal 9 ayat (1) huruf i untuk Penggunaan Secara Komersial dipidana dengan pidana penjara paling lama 1 (satu) tahun dan/atau pidana denda paling banyak Rp100.000.000 (seratus juta rupiah).
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FOREWORD

Our foremost and utmost gratitude to God The Almighty, for His abundant grace that allowed us, Deepublish Publisher to publish this book entitled ***Nursing Documentation***.

As a publisher that–above other missions–prioritizes its role to educate and glorify mankind, as well as to utilize science and technology to its best, we do not only attend to the work of established writers, but we provide the room and facility for people who wish to express their creativity and innovation in writing and conveying ideas and values.

Our warmest gratitude and appreciation to the author, H. Amandus, S.Kep., Ns., M.P.H., who has given us trust and contribution to the perfection of this book. Hopefully, this book is useful, and educative, and contributes well in glorifying mankind and the utilization of science and technology in the country.

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INTRODUCTION

A. Subject Description

This textbook is divided into four chapters: the first chapter discusses an introduction to the concepts of nursing documentation, the second chapter explains the nursing documentation process, the third chapter explains electronic health records for nurses, and the fourth chapter explains nursing documentation in certain units. Students take this course in semester 3 with a two-credit load, one theory, and one practicum.

B. Learning Objective

After studying this textbook, students are able to:

1. Formulate the concept of documentation
2. Demonstrate documentation of nursing care.
3. Apply the concept of electronic health records in nursing.
4. Differentiate documentation in certain units.

C. Instruction

To help you study this textbook, follow these study guides:

1. Carefully read the introductory part of this textbook until you understand what it is for, what it is for, and how to study the contents of the textbook.
2. Skim through section by section and find keywords in words that you think are new. Look for and read the meaning of these keywords in the dictionary.
3. Understand the meaning of the definition of the contents of this textbook through your understanding and exchange ideas with other students or with your tutor in online tutorial activities.

4. To broaden your horizons, read and study other relevant sources. You can search for reading from various sources, including the internet.
5. Strengthen your understanding by doing the exercises in the textbook and through discussion activities with other students or colleagues.
6. Don't miss trying to answer the questions that have been provided at the end of each learning activity. It is useful to know whether you have correctly understood the contents of this textbook.

D. Glossaries

- *Antenatal care*: prenatal care is to maximally improve pregnant women's physical and emotional health so that they can deal with childbirth, postpartum, prepare for exclusive breastfeeding, and fairly return to reproductive health.
- *Assessment*: efforts to obtain data/information from processes and results.
- *Authentic*; trustworthy or legitimate, genuine.
- *Confidentiality:* only authorized individuals may access data, messages, or device systems.
- ED; emergency department.
- EHR; electronic health record.
- EHR *software*; computer software used to store nursing information or records.
- *Emergency department*: a part of the hospital that offers 24-hour emergency care to individuals who require immediate medical attention.
- *Evidence*: data and facts obtained through observation, interviews, and real experiences

- *Initial assessment*; a cycle of fast assessments followed by resuscitation techniques for the management of critically unwell individuals.
- *Intranatal care*; a process of evacuating a full-term fetus and placenta through the birth canal or other channels, with or without assistance.
- *Legal*; under statutory regulations or laws
- *Maternity nursing*: women or mothers as customers and their families receive service care during pregnancy, childbirth, and the puerperium, with the scope of nursing extending from conception to 6 weeks after the baby is born.
- *Medical record*; a file including notes and papers about the patient's identity, examination, treatment, action, and past health services received.
- *Medicolegal*; the field of medicine that provides medical services to law enforcement.
- *Nursing documentation*: a document containing the patient's condition from bio-psycho-social-spiritual and all activities or actions taken by the nurse for the patient since the patient came to the hospital until the patient returns.
- *Nursing process*: a methodical, patient-centered, and goal-oriented nursing strategy that serves as a foundation for nursing practice.
- *Pediatric nursing*: family-centered nursing care for children and initiatives to reduce childhood trauma.
- *Perioperative*: a combination of three phases, namely preoperative, intraoperative, and postoperative.
- *Postnatal care*: the period begins one hour after the delivery of the placenta up to 6 weeks after delivery.

CHAPTER I.

INTRODUCTION TO THE CONCEPT OF NURSING DOCUMENTATION

A. Learning Objective

After studying Chapter 1, students are able to.

1. General learning objective;
   - Formulate the concept of documentation
2. Part learning objective;
   a. Describe the concept of documentation
   b. Describe the legal aspects of documentation
   c. Differentiate models of nursing care documentation

B. Concept of Nursing Documentation

1. Definition of nursing documentation

   Nursing documentation is a confidential document that records all patient nursing services, the record can be interpreted as notes with various benefits and uses (American Nurses Association, 2010). Nursing documentation is a standard of professional performance whose main objective is to improve nursing care related to quality assurance, research, ethics, and nursing performance (Dehghan et al., 2013).

Source; shutterstock.com (2023)

2. The purposes of nursing documentation

Each activity should be documented properly as authentic and crucial evidence (Asmirajanti et al., 2019). The purposes of nursing documentation are.

a. to identify the status of the patient's health needs, as well as, to plan, carry out and evaluate nursing intervention;
b. to avoid errors, overlaps, and incompleteness of information in nursing care;
c. to maintain good and dynamic coordination between nurses or other parties through written communications;
d. to increase the efficiency and effectiveness of nurses' tasks;
e. to improve the quality of nursing care;
f. to provide legal protection for nurses;
g. to provide data for research, writing scientific papers, and improvement of nursing care standards;
h. to protect patients from malpractice

3. The functions of nursing documentation
   Nursing documentation has several functions, such as:
   a. A proof of the quality of nursing care
   b. Ethical and legal accountability aspects
   c. Information on individual protection
   d. Proof of application of nursing practice standards
   e. Sources of statistical, financial, educational, and nursing research information
   f. Communication of nursing intervention
   g. Data sources for future healthcare planning

4. Nursing documentation principles

   Documentation is a crucial part of nursing practice and is required by federal and state nurse practice laws, as well as by organizational policies and procedures. Therefore, the American Nurses Association offers these guidelines (American Nurses Association, 2010).

   ✓ Principle 1. Documentation Characteristics
     High-quality documentation is:
     - Accessible
     - Accurate, relevant, and consistent
     - Auditable
     - Clear, concise, and complete
     - Legible/readable (especially concerning the resolution and other characteristics of EHR content as it is shown on various devices' screens)
     - Thoughtful
     - Timely, contemporaneous, and sequential
     - Reflective of the nursing process
     - Permanently retrievable in a nursing-specific manner

- ✓ Principle 2. Education and Training
  The technical components of documentation (as described in this article) and the organization's policies and procedures relating to documentation must be thoroughly taught and trained to nurses in all settings and at all levels of service. To guarantee that each nurse can perform the following, this education and training should cover staffing issues that consider the time needed for documentation work.
  - use of a global documentation system that is both functional and skillful.
  - proficiency with a computer and its associated hardware
  - proficiency in the use of software systems used to capture documentation or other pertinent patient, nursing, and health care reports, records, and data.
- ✓ Principle 3. Policies and Procedures
  The nurse must be conversant with all organizational documentation rules and processes and apply them as part of her nursing practice. Policies or processes for preserving efficiency in the use of the "downtime" system for documentation when the available electronic systems do not function are very important.
- ✓ Principle 4. Protection Systems
  Protection systems must be established and implemented into paper-based or electronic documentation systems to offer the following as required by industry standards, legislative laws, accrediting organizations, and organizational policies and procedures:
  - Data security
  - Patient identification protection

- Patient information confidentiality
- Clinical professionals' information confidentiality
- Organizational information confidentiality

✓ Principle 5. Documentation Entries

Entries into organizational papers or the health record (including but not limited to physician orders) must include the following information:

- Authenticated; that is, the information is true, the author is identified, and nothing has been added or inserted;
- Dated and time-stamped by the people who created the entry;
- Legible/readable; and
- Created using standardized terminology, including acronyms and symbols.

✓ Principle 6. Standardized Terminologies

Because standardized terminologies allow data to be gathered and evaluated, these terminologies should contain the phrases used to describe the planning, delivery, and evaluation of patient or client nursing care in various settings.

5. The benefits of nursing documentation

Nursing documentation has several benefits in the nursing process, for patients, nurses, and institutions.

a. Benefits for patients

Patients receive quality, effective, and nursing services efficiently. The nursing care provided has been selected according to patient needs through data tracing, problem formulation, proper nursing diagnosis, targeted plans, planned nursing intervention, and continuous assessments.

b. Benefits for nurses

   The nursing process will increase nurses' independence in the implementation of nursing care and sufficient from other professions. It also provides optimum satisfaction for nurses who have successfully implemented their nursing care.

c. Benefits to Institutions

   Healthcare institutions will benefit from satisfied patients, who recover quickly, receive good quality service, and provide their first-hand experience as, promotion for the institution. Thus, profits will increase, and the image of the institution will also improve.

6. The legal aspects of nursing documentation

   Complete documentation is a legal aspect and valid proof of nursing activity (Hariyati et al., 2019). Regulations that require nurses to carry out documentation in Indonesia are Article 13 of the Constitution number 44/2009 which regulates the hospital services. It mentions that health workers who work in Hospitals work according to professional standards, hospital service standards, standard operational procedures, and professional ethics; In addition, they need to respect the patient's rights and prioritize the safety

   a. Article 66 of the Constitution number 36/2014 which regulates health workers. Health workers in carrying out their practices are obliged to comply with professional standards, professional service standards, and standard operating procedures.
   b. Article 30 of the Constitution Number 38/2014 which regulates nursing care providers. A nurse is authorized to establish a nursing diagnosis in carrying out duties as a nursing care provider.

7. The model of nursing documentation

Nursing documentation is legal documentation for the nursing profession (Hariyati et al., 2019). Therefore, nursing documentation needs to follow the standards of the Joint Commission on Accreditation of Health Service Organizations (JCAHO) that include:

a. Initial assessment and review
b. Nursing diagnosis
c. Nursing care planning
d. Implementation of nursing care provided for client response.
e. Evaluation of nursing care results and the ability for follow-up nursing care after the patient is discharged.

Several models of nursing documentation are used for nursing services in healthcare facilities, such as:

- Traditional narrative charting

  In any clinical environment, narrative charting is a plain chronological explanation of the patient's status, nursing actions undertaken, and the patient's response to those interventions. Documentation is typically provided in progress notes and reinforced with flow sheets. The Joint Commission requires all healthcare facilities to establish policies regarding how frequently patients should be evaluated. Document patient assessments as frequently as your institution mandates, and more frequently if any of the following occur:

  - change in the patient's condition
  - response of a patient to a treatment or medicine
  - Inability to improve the patient's condition
  - response of the patient or a family member to instruction

Document everything that you hear, see, inspect, do, or teach. Include as much detail and description as possible. Always keep track of how your patient reacts to care, treatments, and drugs, as well as his progress toward the desired objective. Include communication with the doctor for any modifications that have happened. Document this communication, the physician's answer, any new instructions issued, and the patient's reaction. You can organize your notes by going from top to bottom or by referring to the treatment plan and capturing the patient's progress about the plan as well as any outstanding issues. Be specific and document chronologically, documenting exact timeframes, regardless of how you structure your narrative note.

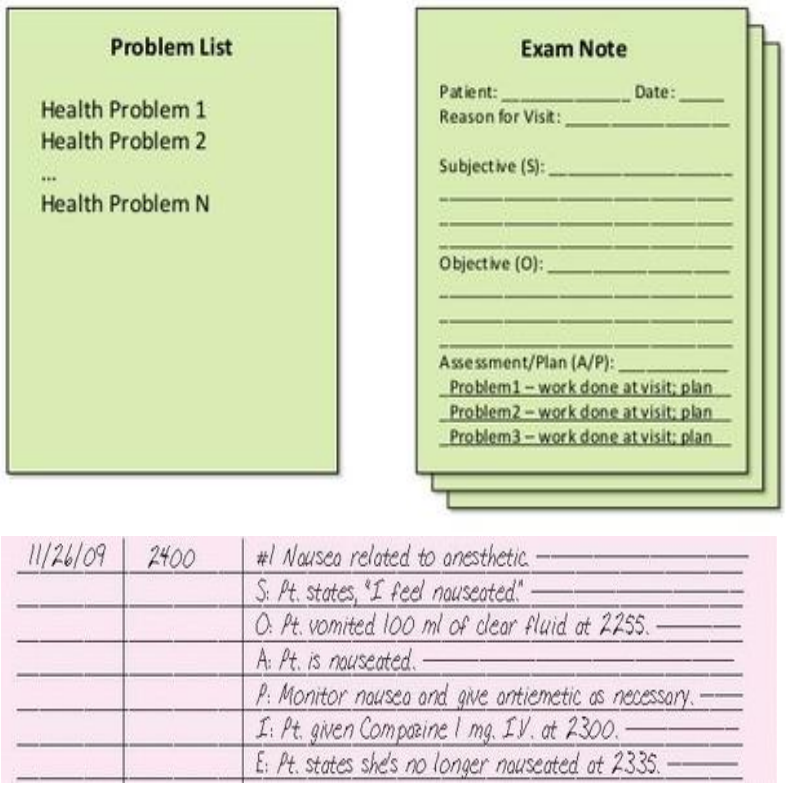
11/26/09	2255	Patient 4 hr postop, awakens easily, oriented X 3 but groggy, incision site in front of Ⓠ ear extending down and around the ear and into neck — approximately 6" in length — without dressing. No swelling or bleeding, bluish discoloration below Ⓠ ear noted, sutures intact. Jackson-Pratt drain in Ⓠ neck below ear with 20-ml bloody drainage measured. Drain remains secured in place with suture and anchored to Ⓠ anterior chest wall with tape. Pt. denied pain but stated she felt nauseated and promptly vomited 100 ml of clear fluid. Pt. attempted to get OOB to ambulate to bathroom with assistance, but felt dizzy upon standing. Assisted to lie down in bed. Voided 200 ml clear, yellow urine in bedpan. Pt. encouraged to deep breathe and cough qhr, and turn frequently in bed. Lungs sound clear bilaterally. Antiembolism stockings applied to both lower extremities. Explanations given regarding these preventive measures. Pt. verbalized understanding. ——— Bridget Smith, RN
	2300	Pt. continues to feel nauseated. Compazine 1 mg IV. ——— Bridget Smith, RN
	2335	Pt. states she's no longer nauseated. No further vomiting. Rating pain in incisional areas as 7/10, on a scale of 0 to 10. Medicated with morphine 2 mg IV. ——— Bridget Smith, RN
	2355	Pt. states pain as 1/10. Demonstrated taking deep breaths and coughing effectively. ——— Bridget Smith, RN

Source; nursekey.com (2023)

- Problem-Oriented Record

  The concept centralizes patient data, which is then documented and categorized according to the patient's situation. This form of documentation system integrates all data related to issues collected by doctors, nurses, or other health professionals involved in providing services to patients. Every 24 hours or whenever the patient's state changes, you must typically create a note for each present concern. Progress notes are structured using SOAP, SOAPIE, or SOAPIER. If there is nothing to record for a component, simply leave the letter off the note. SOAPIER's components are as follows:

  - Subjective data: chief complaint or other information the patient or family members tell you
  - Objective data: factual, measurable data, such as observable signs and symptoms, vital signs, or test values
  - Assessment data: conclusions based on subjective and objective data and formulated as patient problems or nursing diagnoses
  - Plan: a strategy for relieving the patient's problems, including short- and long-term actions
  - Interventions: measures you've taken to achieve expected outcomes
  - Evaluation: analysis of the effectiveness of your interventions
  - Revision: changes from the original care plan.

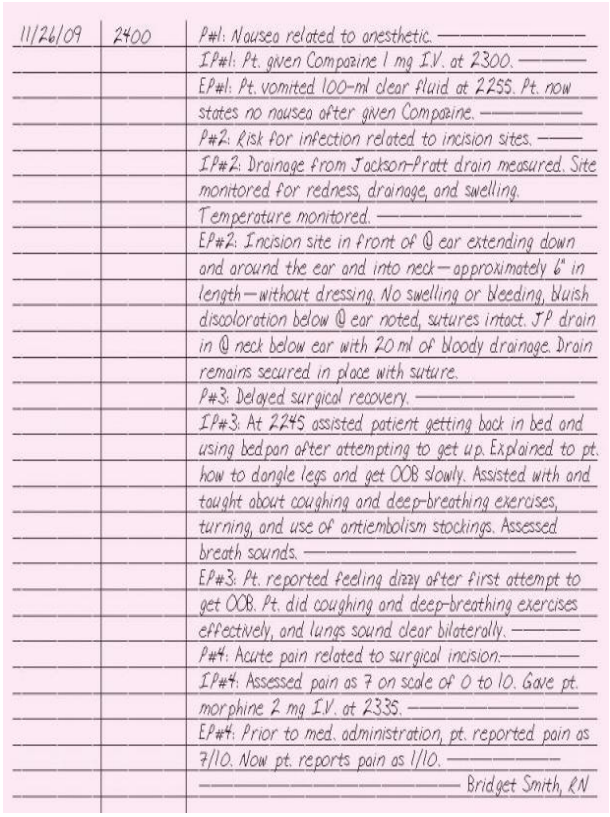


Source; nursekey.com (2023)

- Problem Intervention and Evaluation (PIE)
  The PIE model is a process-oriented approach to documentation with an emphasis on the nursing process and nursing diagnosis. Use data collected from your initial assessment to identify pertinent nursing diagnoses.
  - Problem; Use your facility's list of nursing diagnoses, which usually correlates to the diagnosis approved by the North American Nursing Diagnosis Association (NANDA). When documenting a problem in the progress notes, use

the letter P and a number, such as P#1. You can then refer to it by number without having to re-document the problem statement.

- Intervention; keep a record of the nursing actions you take for each nursing diagnosis. Label each entry with I, P, and the problem number, for example, IP#1.
- Evaluation; your assessment is based on the patient's response to treatment. For example, in EP#1, use the label E followed by P and the problem number.



11/26/09	2400	P#1: Nausea related to anesthetic. ———
		IP#1: Pt. given Compazine 1 mg I.V. at 2300. ———
		EP#1: Pt. vomited 100-ml clear fluid at 2255. Pt. now states no nausea after given Compazine. ———
		P#2: Risk for infection related to incision sites. ———
		IP#2: Drainage from Jackson-Pratt drain measured. Site monitored for redness, drainage, and swelling. Temperature monitored. ———
		EP#2: Incision site in front of @ ear extending down and around the ear and into neck—approximately 6" in length—without dressing. No swelling or bleeding, bluish discoloration below @ ear noted, sutures intact. JP drain in @ neck below ear with 20 ml of bloody drainage. Drain remains secured in place with suture.
		P#3: Delayed surgical recovery. ———
		IP#3: At 2245 assisted patient getting back in bed and using bedpan after attempting to get up. Explained to pt. how to dangle legs and get OOB slowly. Assisted with and taught about coughing and deep-breathing exercises, turning, and use of antiembolism stockings. Assessed breath sounds. ———
		EP#3: Pt. reported feeling dizzy after first attempt to get OOB. Pt. did coughing and deep-breathing exercises effectively, and lungs sound clear bilaterally. ———
		P#4: Acute pain related to surgical incision. ———
		IP#4: Assessed pain as 7 on scale of 0 to 10. Gave pt. morphine 2 mg I.V. at 2335. ———
		EP#4: Prior to med. administration, pt. reported pain as 7/10. Now pt. reports pain as 1/10. ———
		——— Bridget Smith, RN

Source; nursekey.com (2023)

- FOCUS charting

  The FOCUS charting system is divided into patient-centered subjects or focuses. It invites you to evaluate these concerns using assessment data. Make a progress sheet with columns for the date, time, concentration, and notes. Write each focus as a nursing diagnosis, a sign or symptom, a patient's behavior, a special need, an abrupt change in the patient's health, or an important event in the focus column. Organize information in the progress notes column into three categories: data (D), action (A), and response (R). Include subjective and objective information about the emphasis in the data category. Include immediate and future nursing actions based on your assessment of the patient's condition, as well as any adjustments to the care plan that you feel necessary based on your evaluation, in the action category. Describe the patient's reaction to nursing or medical care in the response category. Using all three categories ensures simple nursing process documentation. Flow sheets and checklists can be used to document all other routine nursing procedures and evaluation data.

Date	Time	Focus	Progress notes
11/26/09	2400	Nausea related to anesthetic.	D: Pt. states she's nauseated. Vomited 100-ml clear fluid at 2255. ———
			A: Given Compazine 1 mg IV. at 2300.
			R: Pt. reports no further nausea at 2335. No further vomiting. ———
		Risk for infection related to incision sites.	D: Incision site in front of Ⓠ ear extending down and around the ear and into neck—approximately 6" in length—without dressing. Jackson-Pratt drain in Ⓠ neck below ear secured in place with suture. ———
			A: Assessed site and emptied drain. Taught patient S&S of infection. ———
			R: No swelling or bleeding; bluish discoloration below Ⓠ ear noted. JP drained 20-ml bloody drainage. Pt. states understanding of teaching.——

Source; nursekey.com (2023)

8. The standards of nursing documentation

A documentation standard is essential to strengthen the pattern of recording and as a guideline for documenting practices in the nursing process. Standardized nursing terminology is a prerequisite for describing nursing care processes and generating knowledge for decision-making and management (Mykkänen et al., 2022). Information concerning nurses' abilities to document shows writing skills by documentation requirements that are consistent, effective, complete, and accurate. Nursing documentation quality, accuracy, and development require follow-up and evaluation (Mykkänen et al., 2016). Clear, accurate, and accessible documentation is an essential element of safe, qualified, evidence-based nursing practice; and it should be ensured by nurses in their practices (Secer & Karaca, 2021). The use of effective documentation standards includes:

a. Compliance with documentation rules established by profession or government.
b. The standards of the nursing profession are written into health records, data what is there describe and what nurses do.
c. The nurse has the authority to formulate a diagnosis nursing and nursing interventions on patient responses to actual health issues, risks, or health promotion.
d. Regulations on nursing practice can be seen on the notes service. The written data shows the activities of nurses which are independent and interdependent. Nursing diagnosis is not regularly specifically having permission to diagnose medical problems otherwise

diagnosis medical is not on the nursing record but the diagnosis nursing is written on the nursing records

e. Accreditation guidelines should be followed, with particular emphasis on data about observation and evaluation activities. Every stage in the nursing process is the writing of the data of each patient at the time of hospital admission until home.

9. The techniques of nursing care documentation

There are 3 techniques, namely narrative techniques, flow sheet techniques, and checklist techniques, described as follows.

a. Narrative techniques

It is a traditional recording technique. This technique can last the longest and is a flexible recording system. It is because a narrative record is formed by the source of origin documentation and is often referred to as documentation oriented to the source. The source of the documentation can be obtained from anyone, including health workers who are responsible for providing information. Each resource person provides the results of his/her observations and describes his/her unique activities and evaluations. The technique strictly follows the sequence of events or chronological order.

The advantages of narrative documentation are:

- The chronological recording makes it easy to interpret sequentially the occurrence of nursing care and intervention.
- It gives nurses the freedom to take notes in a style that they like.

- The format simplifies the process of logging problems, events changes, interventions, patient responses, and outcomes.

The weaknesses of narrative documentation.

- This type of logging tends to be a disjointed, overlapping data set, and perhaps the records are less meaningful.
- Sometimes it is difficult to find information without reading the whole note or most of those records.
- It is worth reviewing records from all sources to know a comprehensive clinical picture of the patient.
- Recording takes a lot of time due to the plain format demands careful consideration in determining information for every patient needs to note.
- The chronological sequence of events can complicate interpretation because the relevant information may not be recorded at the relevant place.
- Keeping up with patients can take a lot of time.

b. Flowsheet

Flowsheet allows nurses to record observations or unnecessarily repeated measurements written on time including the patient's clinical data on vital signs (blood pressure, pulse, breathing, temperature), weight, amount of fluid input and output within 24 hours as well as drug administration. Flowsheet is the fastest and most efficient way to take notes of information. In addition, health workers will easily find out the patient's condition just by looking at the graph in the flowsheet. Therefore, it is often used in

emergency departments, especially on physiological data. The flowsheet itself contains observations and certain actions. Various formats may be used in record keeping; however, the issue list, flowsheet, and progress notes are minimum requirements for adequate patient documentation.

c. Checklist

A checklist is a format created with a consideration that nursing documentation standards will ease nurses to fill out documentation. Nurses will fill in the appropriate items with the state of the patient by ticking. If nurses must fill in numbers, the checklist has very concise filling in vital sign data.

The advantages of using the checklist documentation format

- ✓ For nurses
  - Efficient assessment
  - Plenty of time with patients in performing nursing interventions. Thus, complete and comprehensive nursing care can be realized.
  - Anticipated risk problems or health promotion related to complications that may occur
  - Legality and accountability of nursing care can be implemented
- ✓ For patient and family
  - The cost can be estimated before the patient decides to get treatment.
  - Patients and families are satisfied with the nursing care provided during the procedure.
  - It can establish the independence of patients and families.
  - Patients get legal protection during treatment

d. Electronic nursing documentation

Electronic nursing documentation gives a development process that resulted in an easier conversion from paper-based to computerized documentation (Shafiee et al., 2022). Using electronic software to improve the standard and completeness of nursing documentation (Ranjbar et al., 2021).

C. Summary

Nursing documentation is a standard of professional performance whose main objective is to improve nursing care related to quality assurance, research, ethics, and nursing performance. Each activity should be documented properly as authentic and crucial evidence. Nursing documentation has several functions, such as proof of the quality of nursing care, ethical and legal accountability aspects, information on individual protection, proof of the application of nursing practice standards, sources of statistical, financial, educational, and nursing research information, communication of nursing interventions, and data sources for future healthcare planning. Nursing documentation has several benefits in the nursing process for patients, nurses, and institutions. Documentation is a crucial part of nursing practice and is required by federal and state nurse practice laws as well as organizational policies and procedures. Nursing documentation needs to follow the standards and several models of nursing documentation used for nursing services in healthcare facilities. The completeness of documentation is a legal aspect and valid evidence of nursing activities.

D. Exercise

Task 1. Read and answer the following questions!

1. Describe the purpose of nursing documentation!
   Answer.

2. Describe the function of nursing documentation!
   Answer.

3. Describe the legality of nursing documentation!
   Answer.

4. Describe the model of nursing documentation!
   Answer.

Task 2. Match the words in the following boxes.

1. Problem-Oriented Record
2. Charting-By Exception
3. Process-Oriented System
4. Progress-Oriented Record
5. Problem Intervention and Evaluation
6. Source-Oriented Record

No	Questions	Answer
1	The reception department has a fill-in sheet of its own, Doctors use it to record instructions, history, and progression of the disease, and nurses use notes on patient progress. Similarly, other disciplines have their records.	
2	This form of documentation system integrates all data related to issues collected by doctors, nurses, or other health professionals involved in providing services to patients.	
3	The model typically uses three types of progress records: nurse records, flowsheets, and discharge notes or reference summaries.	
4	The model is a documentation system that only records narrative results or monitoring that deviate from normal standards.	
5	The model is a process-oriented approach to documentation with an emphasis on the nursing process and nursing diagnosis.	
6	The model emphasizes a patient-focused orientation process.	

E. Reference

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CHAPTER II.

NURSING DOCUMENTATION PROCESS

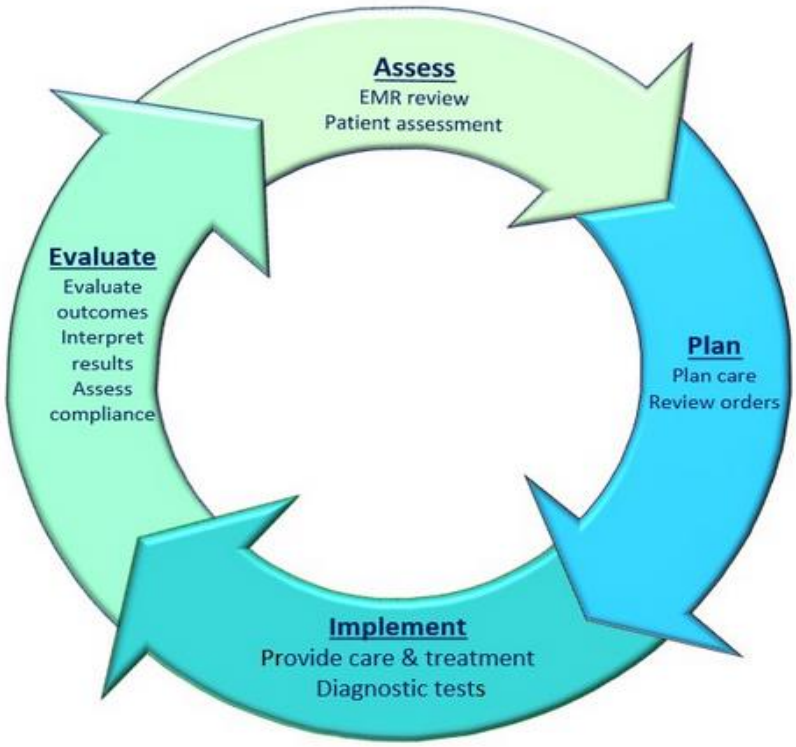
A. Learning Objective

After studying Chapter 2, students are able to:

1. General learning objective;
   - Demonstrate documentation of nursing care.
2. Part learning objective;
   a. Describe the system and documentation of nursing care.
   b. Properly perform documentation and reporting techniques in clinical settings.

B. Nursing Documentation Process

Nursing documentation adheres to the ‘nursing process’ and incorporates the concepts of assessment, planning, execution, and evaluation. It is ongoing, and nursing records ought to reflect this.



Nursing Process; Source; rch.org.au (2023)

1. Nursing assessment documentation
   a. Definition

      The documentation of nursing assessment is a record of outcomes assessments carried out to collect information from patients, create basic data about patients, and make notes on responses to patients' health (Secer & Karaca, 2021). Thorough and systematic assessment will logically lead and support the identification of problems in the patient. These problems use assessment data as a basis for formulations expressed as nursing diagnoses.

   b. Purpose

Nursing assessment purposes are:

- to collect, organize, and record data that describe responses of humans who influence patients' health patterns.
- to record the results of the assessment document as the basis for writing a nursing care plan
- to provide confidence about basic information on the patient's health to be used as a reference for his current or past health status.
- to provide sufficient data in determining a treatment strategy according to the patient's need

c. Types of assessment documentation

Types of nursing documentation used in nursing assessments are:

- Initial assessment

  Documentation is created when the patient first enters the hospital. Data is studied on patients in the form of initial data and used as a basis for nursing care.
- Ongoing assessment

  The data in this documentation is the basic development carried out to complete the initial assessment. All of the data will support information on the health problems of the patient. The results of this assessment are included in an integrated progress log or on supporting data sheets.
- Reassessment

  It is a record of the results of the assessment obtained from information during the evaluation.

d. Types of assessment data

There are types of data obtained through nursing assessments, such as:

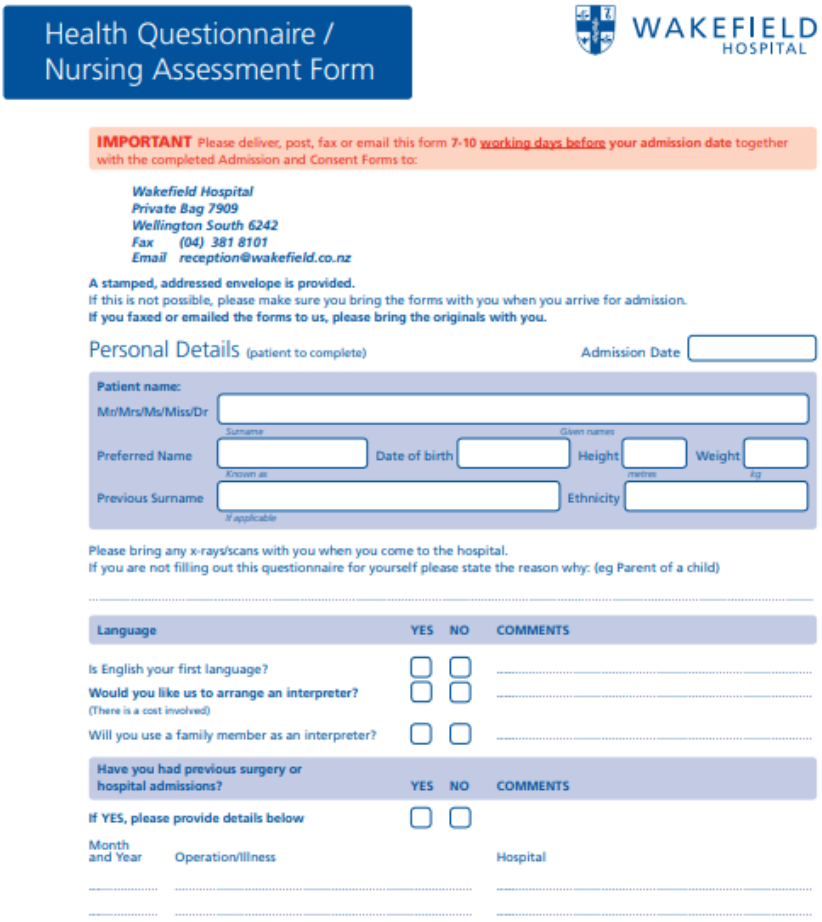
- Subjective data
  Subjective data are obtained from the results of the patient's assessment with several techniques, for example, interviews, family, consultants, and other health professionals. These data are subjective complaints of the patients on their health status.
- Objective data
  Objective data information is obtained from observations, physical examinations, results supporting examinations, and laboratory check-ups.

e. Methods of collecting assessment data
   Nurses can obtain assessment data by:
   - Effective communication
     Communication in nursing studies is known as therapeutic communication. It is an effort to invite patients and families to exchange thoughts and feelings. Nurses need to be active listeners of patient complaints. The elements of an active listener are reducing inhibitions in communicating, paying attention to complaints submitted by patients and relating them to the complaints experienced by the patient, listening attentively to what is complained, giving the patient a chance to finish his/her words, being empathetic and avoiding interruptions, and giving full attention to the moment with the patient.
   - Observation
     Observation is the second stage of data collection. Nurses observe behavior and make developmental observations of patients' state of health. Observation activities include sight, smell, hearing,

feeling, and taste. These activities include physical, mental, social, and spiritual observations.

- Physical assessment

  Physical assessment is carried out simultaneously with the interview. Nurses focus on the functional ability of the patient. The purpose of the physical assessment is to determine the health status of patients, identify health problems, and obtain basic data to create action plans.



Health Questionnaire / Nursing Assessment Form

WAKEFIELD HOSPITAL

IMPORTANT Please deliver, post, fax or email this form **7-10 working days before your admission date** together with the completed Admission and Consent Forms to:

Wakefield Hospital
Private Bag 7909
Wellington South 6242
Fax (04) 381 8101
Email reception@wakefield.co.nz

A stamped, addressed envelope is provided.
If this is not possible, please make sure you bring the forms with you when you arrive for admission.
If you faxed or emailed the forms to us, please bring the originals with you.

Personal Details (patient to complete) Admission Date

Patient name:
Mr/Mrs/Ms/Miss/Dr (Surname / Given names)
Preferred Name (Known as) Date of birth Height (metres) Weight (kg)
Previous Surname (If applicable) Ethnicity

Please bring any x-rays/scans with you when you come to the hospital.
If you are not filling out this questionnaire for yourself please state the reason why: (eg Parent of a child)

Language	YES	NO	COMMENTS
Is English your first language?	☐	☐	
Would you like us to arrange an interpreter? (There is a cost involved)	☐	☐	
Will you use a family member as an interpreter?	☐	☐	

Have you had previous surgery or hospital admissions?	YES	NO	COMMENTS
If YES, please provide details below	☐	☐	

Month and Year	Operation/Illness	Hospital

Do you have or have you ever had	YES	NO	COMMENTS
High blood pressure	☐	☐	
Chest pain / angina	☐	☐	
Heart attack	☐	☐	
Chest palpitations or irregular heartbeat	☐	☐	
Heart pacemaker	☐	☐	
Artificial heart valves or other heart surgery	☐	☐	
Rheumatic heart disease	☐	☐	
Stroke	☐	☐	
TIAs (mini strokes)	☐	☐	
Shortness of breath	☐	☐	
Breathlessness on exertion	☐	☐	
Swollen ankles	☐	☐	
Asthma or lung problems	☐	☐	If yes, how often do you use your inhaler?
Tuberculosis	☐	☐	
Diabetes	☐	☐	Which type
Jaundice / Liver Disease	☐	☐	
Kidney problems	☐	☐	
CJD or any neurological disease currently under investigation	☐	☐	
A dura mater graft / corneal surgery prior to 1990	☐	☐	
Human pituitary derived gonadotrophin or growth hormone prior to 1990	☐	☐	
Blood clots in the legs or lungs	☐	☐	
Bleeding or bruising problems	☐	☐	
Anaemia	☐	☐	
Blackouts or fainting	☐	☐	
Migraines	☐	☐	
Epilepsy / fits / seizures	☐	☐	
A head injury	☐	☐	
A psychiatric illness	☐	☐	
Memory loss and/or confusion	☐	☐	
Arthritis / jaw, neck or back problems	☐	☐	
Joint replacement surgery	☐	☐	
Muscle or nerve disease	☐	☐	
Severe snoring / sleep apnoea	☐	☐	
Severe motion sickness	☐	☐	
Gastric reflux / stomach ulcer	☐	☐	
HIV / AIDS / Hepatitis	☐	☐	
Thyroid disease	☐	☐	
Pituitary problems	☐	☐	
Treatment for cancer	☐	☐	
History of eczema, skin conditions	☐	☐	
MRSA / VRE ESBL	☐	☐	
Employment in a health facility within the last 6 months	☐	☐	

General Anaesthetics	YES	NO	COMMENTS
Have you ever had a general anaesthetic?	☐	☐	
Any problems / side effects, complications following a general anaesthetic?	☐	☐	If yes please explain
Do you have any concerns about your anaesthetic that you would like to discuss with your Anaesthetist?	☐	☐	

If you need more space please attach the additional information on a separate piece of paper

Medications

It is important that you list **all medications** you are taking, including natural (alternative) and complementary medications. **Please bring all medications into hospital in the original containers. If your medicines are in "Blister Packs", please provide a medicine list from your pharmacist or General Practitioner.**

Medication (drug name on packet)	Dose or strength	Number of times taken each day	Reason for medication (if known)

Allergies and Sensitivities	YES	NO	COMMENTS
Are you allergic / sensitive to any:			*If YES, please name the item and describe the reaction*
Medications	☐	☐	
Foods	☐	☐	
Plasters and tape	☐	☐	
Latex	☐	☐	
Other	☐	☐	

General Questions	YES	NO	COMMENTS
Do you smoke?	☐	☐	If yes, how many per day?
Did you ever smoke?	☐	☐	If yes, what year did you stop?
Do you drink alcohol?	☐	☐	Average weekly intake
Females: is there a possibility you might be pregnant? (X-rays during surgery or anaesthetic drugs may cause harm to your baby)	☐	☐	
Do you presently have any cuts, scratches, sores or abrasions on your skin?	☐	☐	Location
Do you have a family history of:			
– **Anaesthetic reactions**	☐	☐	
– **Bleeding disorders**	☐	☐	
– Other neurological illness currently under investigation	☐	☐	
Do you have any concerns about your hospital stay that you would like to discuss with us?	☐	☐	

Dietary Needs	YES	NO	COMMENTS
Do you have special dietary needs?	☐	☐	

Cultural Care	YES	NO	COMMENTS
Do you have any cultural needs we should be aware of?	☐	☐	.....
Would you like us to return any surgically removed body parts or metalware?	☐	☐	.....

Spiritual Care	YES	NO	COMMENTS
The inter-denominational hospital chaplain visits as part of Wakefield's spiritual care			
Would you like to be visited by the hospital chaplain?	☐	☐	.....
Would you like a visit from a minister/priest of your own faith?	☐	☐	.....

Activities of Daily Living	YES	NO	COMMENTS
Do you have any restrictions with mobility?	☐	☐	.....
Have you had any falls in the last 6 months?	☐	☐	.....
Do you use any mobility aids eg crutches?	☐	☐	.....
Do you have any stairs at home?	☐	☐	.....
Do you have any problems with speech?	☐	☐	.....
Do you have any problems with vision?	☐	☐	.....
Do you have any problems with hearing?	☐	☐	.....
Do you need assistance with toileting?	☐	☐	.....
Do you need assistance with showering?	☐	☐	.....
Do you need assistance with dressing?	☐	☐	.....

Discharge arrangements you have made	YES	NO	COMMENTS
Are you going to your own home on discharge?	☐	☐	.....
Someone to stay with you on the night of discharge?	☐	☐	.....
Someone to drive you home?	☐	☐	.....
Do you have dependants at home?	☐	☐	.....
Do you anticipate any problems on discharge? If yes, please explain	☐	☐	.....

Do you currently receive assistance or have you arranged any Community Services?	YES	NO	COMMENTS
ACC Home Care	☐	☐	.....
Home Help services	☐	☐	.....
District Nurses	☐	☐	.....
Other	☐	☐	.....

Is there anything else you wish to add that could assist us with your care?

.....

.....

Do you wish to proceed with the surgery your surgeon has discussed with you? YES ☐ NO ☐

Would you like us to phone you after discharge? YES ☐ NO ☐

Patient/Guardian Signature ..... Date ... / ... / ...

NOTE: If within 7 days prior to your admission you have any of the following: flu, cold, broken or infected areas of the skin, vomiting/diarrhoea – **please contact your surgeon.**

FOR HOSPITAL USE ONLY (prior to admission)

Phone Pre-assessment

YES ☐ NO ☐ Date Pre-assessed / /

Anaesthetic Issues:

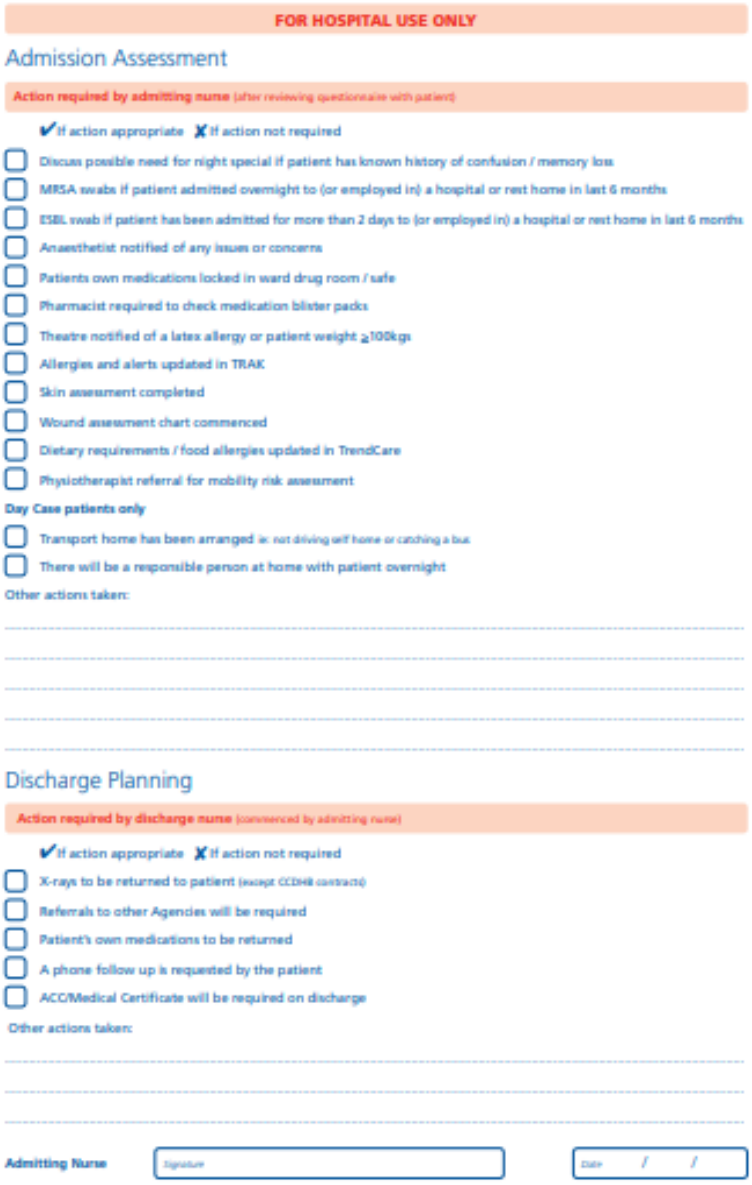
Medical History:

Medications:

Other:

	YES	NO	COMMENTS
Sensitivites: on TRAK	☐	☐	
Allergies: On TRAK	☐	☐	
Needs confirmation with patient	☐	☐	
Alerts: On TRAK	☐	☐	
Medical staff informed	☐	☐	
Request for information from other Health Providers	☐	☐	From:

Pre-assessment Nurse Signature Date / /



FOR HOSPITAL USE ONLY

Admission Assessment

Action required by admitting nurse (after reviewing questionnaire with patient)

✔ If action appropriate ✘ If action not required

- ☐ Discuss possible need for night special if patient has known history of confusion / memory loss
- ☐ MRSA swabs if patient admitted overnight to (or employed in) a hospital or rest home in last 6 months
- ☐ ESBL swab if patient has been admitted for more than 2 days to (or employed in) a hospital or rest home in last 6 months
- ☐ Anaesthetist notified of any issues or concerns
- ☐ Patients own medications locked in ward drug room / safe
- ☐ Pharmacist required to check medication blister packs
- ☐ Theatre notified of a latex allergy or patient weight ≥100kgs
- ☐ Allergies and alerts updated in TRAK
- ☐ Skin assessment completed
- ☐ Wound assessment chart commenced
- ☐ Dietary requirements / food allergies updated in TrendCare
- ☐ Physiotherapist referral for mobility risk assessment

Day Case patients only

- ☐ Transport home has been arranged ie: not driving self home or catching a bus
- ☐ There will be a responsible person at home with patient overnight

Other actions taken:

Discharge Planning

Action required by discharge nurse (commenced by admitting nurse)

✔ If action appropriate ✘ If action not required

- ☐ X-rays to be returned to patient (except CCDHB contracts)
- ☐ Referrals to other Agencies will be required
- ☐ Patient's own medications to be returned
- ☐ A phone follow up is requested by the patient
- ☐ ACC/Medical Certificate will be required on discharge

Other actions taken:

Admitting Nurse Signature Date / /

Sample nursing assessment forms. Source: www.templet.net (2023)

Holistic Nursing Assessment Form

Adapted from Seeds & Bridges Holistic Nurse Access Tool (1996)
and Bodymind Systems Self Assessment tools (1987)
A service of Holistic Nursing Consultants - Barbara Denison MSN, ARNP, AHN-BC

Name: _____**DOB:** _____ **Age:** ____
Gender: __ **Address:** _____ **Phone:** _____
Email: _____**Marital Status:** _____ **Children:**
_____
Occupation/Profession: _____

Formal education completed: _____

Family of Origin: (who raised you, still living? siblings?)
_____
Medical Diagnosis: (if appropriate)
_____
_____
_____
_____
Hospitalizations: (when & for what, include surgeries):
_____
_____
_____
_____
Healthcare Provider(s):
_____
_____
Allergies: (known) _____
Food sensitivities: (known)_____
(suspected) _____
Medications:
_____
_____
_____
_____
Supplements: (herbs/botanicals/vitamins/minerals/nutrients)
_____
_____

Current health problem(s) leading you to seek consultation:

_____
_____
_____
_____
_____
_____

Physical Health Patterns:

1. How many glasses of water do you drink a day on average? _____
2. How many servings of fruits do you eat a day? _____
3. How many servings of vegetables do you eat a day? _____
4. How many servings of meat and/or fish do you eat a day? _____
5. What do you eat as your sources of protein? _____
6. How many servings of dairy products (cheese, milk, yogurt) do you eat a day? ___
7. How many servings of grains (bread, pasta, rice) do you eat a day? ____
8. How many sweets/sugar containing foods/beverages do you consume daily? ____
9. How many caffeine beverages do you consume daily? (list coffee separate) ____
10. How many servings of fried food do you consume daily? _____
11. Do you routinely salt your food? _____
12. Do you buy organic food whenever possible? _____
13. How many hours do you sleep a night on average? _____
14. Do you tend to sleep more on your right or left side? ____
15. Do you have difficulty getting to sleep or wake up during the night? _____
16. If yes to #15, what do you use as or do for sleep aids? _____
17. Do you wake up refreshed or tired? (please circle)
18. Do you remember your dreams? ____
19. Do you have enough energy to work and do household chores? ____
20. Do you smoke? ____ If yes, how much? ____
21. Do you drink alcoholic beverages? _____ If so, how much on the average per week and what? _____
22. How much exercise do you get a week (frequency & how long)? _____
23. Describe what type of exercise you do? _____
24. Do you routinely incorporate relaxation? ____
25. What frequency and type? _____
26. What do you do for your health maintenance? _____ _
27. Can you perform all your personal self care activities? (bathing, etc.) ___
28. What do you do for fun/pleasure? (hobbies, social activities, play)

    _____
29. How much sunlight do you get a day? ____
30. What condition are your nails? ___ Circle if you have white spots, ridges, weak or peeling nails.

31. How well do you eliminate? ____
32. How many bowel movements a day? ____ Circle if you tend to be constipated or have loose/diarrhea stools.
33. How often do you urinate? ___ Do you get up at night to urinate? ____
34. What color is your urine? _____ Circle if it's clear or cloudy.
35. Do you perspire with exercise? ____ Does it have a bad odor? ____
36. Circle any skin problems, eruptions, discoloration, dry, flaky, other
37. Do you bruise easily? ____
38. Do your gums bleed easily? ____
39. Circle if you have a problem with your hearing, ringing in ears, drainage.
40. Circle if you have problems seeing, wear glasses for reading or distance, blurry vision, double vision, see spots or unable to see in some of your field of vision.
41. Circle if you have a problem with drainage from nose, sinuses. What color is it? _____
42. Circle if you have a problem with your breathing, short of breath, hard to get breath, wheezing, cough up mucus regularly. What color is it? _____
43. Describe any persistent pain you may have, its location, duration, severity (using a scale of 1-10, with 10 being worst).

    _____
    _____
    _____
44. How many colds a year do you tend to get? ____ How long do they last? _____
45. When you get sick, what part of your body is usually affected? ___ How long do you take to recuperate? _____
46. Rate your ability to heal from cuts (1-10, with 10 healing fastest) ____
47. Circle if your feet, hands or ankles swell. When does it happen? ____
48. Are you aware of any swelling or tenderness in your lymph nodes? ____ (neck, groin, under arms)

motional Health Patterns:

1. How would you describe your emotional response to stress? ____
2. Are you aware of your feelings when involved in a difficult situation? _____
3. Would you say you tend to spend more time being (please circle) angry, lonely, depressed, sad, agitated, calm, at peace, loving, happy, joyful, fearful, anxious, nervous, numb to feelings? Or write in your predominate feelings _____
4. Describe how you feel when you perceive an injustice has been done or a situation has turned out unfair? _____
5. Do you tend to have a judgmental or nonjudgmental attitude? (circle)
6. Rate your ability to express your feelings (1-10, with 10 most able)____
7. Are you able to share your feelings without seeking the approval of others or fearing the outcomes? _____

8. Circle if you view feelings as guides, barometer, interference, none of these.
9. Are you satisfied with how you handle your feelings (rate 1-10) ____
10. Circle your response to illness or pain-
    acceptance, ally, enemy, anger, separate, connection, ignore, other
11. Do you tend to avoid situations or conversations that will stir up your emotions? ___
12. Please circle, do you tend to be a good listener or do you find yourself thinking of other things when someone is sharing feelings or thoughts? Other _____
13. Can you respect others feelings even if you don't agree with them?_____
14. Please circle if family/friends lifestyle is healthy or unhealthy.
15. Rate your satisfaction with the amount of social contacts you have (1-10, with 10 most satisfied) ____
16. Are you in an intimate relationship? _____
17. Rate your satisfaction with sexuality as part of this, or other, relationship (1-10) ____
18. Rate how you feel about yourself (1-10, with 10 most content) ____
19. Rate your body image satisfaction (1-10, with 10 most satisfied)____

Mental Health Patterns:

1. On a scale of 1-10, with 10 being most and 1 being least. Rate your perception of ability to move about doing activities of daily living. ____
2. Rate your perception of your flexibility ___
3. Rate your perception of your strength ___
4. Rate your perception of how much endurance you have with activities ___
5. Rate your perception of how much energy you have ___
6. Rate your perception of your dietary habits ___ (10 most satisfied, 1 least)
7. Rate your perception of your exercise habits ___
8. Rate the amount of stress in your life (1-10, with 10 most stress) __
9. Rate your ability to cope with stress (1-10, with 10 most able) ___
10. Rate the amount of change currently in your life (1-10, with 10 most)___
11. Rate your willingness to grow/learn from stress (1-10) ___
12. Rate your openness to considering new ideas (1-10) ___
13. Circle how you prefer to learn-auditory, visual, doing
14. What subjects do you like to read/learn about?

    _____
15. Do you tend to have interest and knowledge in many topics? ____
16. Rate your ability to complete new tasks that you begin (1-10) ____
17. Do you like to prioritize your work and set goals to accomplish them? ____
18. Are you willing to ask for help or suggestions when doing/learning something that you are unfamiliar with? ___
19. Are you able to follow through with tasks or plans you start? ___
20. Do you tend to procrastinate? ___
21. Circle if you enjoy or resist developing new skills and talents.
22. Do you believe that you have choices to change/improve your health or lifestyle? ___

23. Circle if you tend to be set in your ways of thinking/believing or are willing to use your imagination/creativity to consider new possibilities.
24. Rate your memory of recent events (1-10, with 10 best memory) ___
25. Rate your memory of events in the past (1-10) ___
26. Circle if your thought processes are clear or foggy.
27. Do you tend to be forgetful? ___
28. Rate whether you recognize your intuition (1-10) ___
29. Rate whether you tend to be a worrier (1-10, with 10 worry a lot) ___
30. Rate how much you use humor in interactions (1-10) ___
31. Do you think people are basically good? ___
32. Do you tend to be hurtful when you are angry at someone? ___
33. Circle if you see challenges as opportunities or obstacles.
34. Are you willing to say "no" when your plate is too full? ___
35. Are you able to say "no" when your plate is too full? ___
36. Are you able to make requests for what you need? ___
37. Are you able to share your opinions honestly without seeking approval of others or concern for the consequences? ____
38. Describe how you make decisions. _____
39. Rate your willingness to take risks to learn and grow (1-10) ____
40. Are you politically active (willing to accomplish something you believe in or are passionate about) ____
41. Do you recognize when circumstances are out of your control? ____

Spiritual Health Patterns:

1. Do you have a formal religion? ___ List if desired _____
2. Do you believe in a power higher than yourself? ____
3. Circle if you believe this power is good/benevolent or something to be feared.
4. Rate whether you perceive that all life has meaning. (1-10) ___
5. Circle if you believe in an underlying order within the universe or that events occur randomly without purpose.
6. What do you value in life?

   _____
7. What are your most valuable qualities when you are in touch with your Inner Self (feel most whole)? _____
8. What circumstances would be most helpful to allow these qualities to unfold?

   _____
9. What do you need to bring about these circumstances or best conditions into your lifestyle? _____
10. Are you aware at some level of a connection with the universe? ____
11. Circle if you are motivated by faith, love, fear.
12. Rate the importance of hope in your life (1-10) ____

13. Do you consider and/or value your intuition when making important life decisions? __
14. What practices or rituals do you perform to connect with your spirituality?

_____

15. One definition of spirituality is the "personal experience of the divine". Have you experienced spirituality by this definition? ____
16. Do you feel your actions are congruent with values/beliefs? _____
17. Describe how your values/beliefs affect your health/health care.

_____

_____

18. What are your thoughts about death?

_____

19. Would you consider yourself superstitious? ___
20. Are you involved in activity (ies) you feel contribute(s) to the betterment of humanity and/or world peace? _____ Describe if desired

_____

_____

Sample of holistic nursing assessment form.
Source: www.templet.net (2023)

2. Nursing diagnostic documentation
   a. Definition

      Nursing diagnosis is a clinical decision regarding a person, family, or community because of a health problem or actual or potential life processes. Nursing diagnosis is the basis for preparing a nursing care action plan (Park & Jeong, 2022). Nursing diagnosis provides a premise for the selection of nursing interventions to achieve optimal results.

   b. Purpose

      The purpose of nursing diagnosis documentation is:

      - to convey the patient's health problems which can be understood by the nurse.
      - to recognize the main problems of patients during the assessment
      - to know the progress of the treatment

- to convey patients' response to the status of their health or disease
- to convey factors that support or cause a problem.
- to inform the patient's ability to prevent or resolve problems

c. Nursing diagnosis documentation methods

Nursing diagnostic documentation includes:

- writing down the patient's problem or changes in the patient's health status
- Noting down a problem preceded by a cause associated with the word "related to".
- Following up with the signs and symptoms associated with the word "marked with" after finding the problem and cause.
- Writing commonly used terms or words
- Using non-punitive language

d. Developing a nursing diagnosis with the formula P + E + S

The steps in writing a nursing diagnosis consist of:

- Data grouping and analysis

  There are two steps performed in data analysis: (1) compare the data with normal values and (2) group the data.

  - Subjective

    For example.

    - ✓ Patient says swallowing is painful due to the presence of tumors in his neck.
    - ✓ The patient says he loses more than 10 kg in the last 12 months.
  - Objective

    For example.

    - ✓ Height 170 cm
    - ✓ Weight 50 kg

- Interpretation
  For example, there is a nutritional imbalance as the intake is less than the body needs.
- Validation
  Validation ensures the accuracy of nursing diagnosis. The patient agrees with the concluded problems and the factors supporting them.
  For example, A nurse measures a patient's weight due to the presence of a tumor based on P = Problem, E = Etiology, and S = Symptom.

Such as diagnosis;

Nutritional imbalance: Less than the body needs to be related to inadequate intake marked patient says his weight lost more than 10 kg in the last 12 months, his height is 170 cm, his and weight is 50 kg.

No	Data	Problem	Etiology
1	Subjective. ✓ Patient says swallowing is painful due to the presence of tumors in his neck. ✓ Patient says he lost more than 10 kg in 12 months. Objective. ✓ Height 170 cm ✓ Weight 50 kg.	Nutritional imbalance: Less than the body needs	inadequate intakes

Name :
Register :
Bedroom number :

No Dx	Nursing Diagnosis (by priority)	Occurring date	Resolving date	Signature
1				
2				
3				
4				

Figure 4. Form for nursing diagnosis

3. Nursing planning documentation
    a. Definition
    Nursing planning is a set of activities that identify the phases of issue-solving and formulation, its priorities, and the implementation of nursing action plans in patients based on data analysis and nursing diagnosis (Toney-Butler & Thayer, 2022).
    b. Purpose
    The planning has several objectives:
        - to represent the priority set of diagnoses (collaborative problems or nursing diagnoses) for a patient.
        - to provide a “blueprint” to direct charting.
        - to communicate with the nursing staff on what to teach, observe, and implement.
        - to provide goals or outcome criteria for reviewing and evaluating care.
        - to direct specific interventions for the client, family, and other nursing staff members to implement
    c. Steps in nursing planning
    To direct and evaluate nursing care effectively, the plan should include the following:
        - Diagnostic statements (collaborative problems or nursing diagnoses)
        Diagnostic statements can be either collaborative problems or nursing diagnoses. Prioritizing the problems is the nurse’s attempt to identify a response to patients on their health problems, both actual and potential problems. It can be determined by having a hierarchy of basic human needs.
        - Goals (outcome criteria) or nursing goals
        Client goals, or outcome criteria, are statements that describe a measurable behavior of the patient or

family, denoting a favorable status (changed or maintained) after delivering the nursing care. They serve as standards for measuring the effectiveness of care plans. Making a goal means creating a standard to evaluate patient development and skills in treating patients. A good goal is a statement that describes an action that can be measured by the ability and nurse authority. The characteristics of the outcome criteria are:

- Related to some established treatment goals.
- Achievable
- Specific, tangible, and measurable
- In positive words
- time-specific
- Verb-based statements
- Without the words “normal”, and “good”. Use written results with a set size limit.

Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum. Goals should be specific, measurable, meaningful, attainable or action-oriented, realistic or results-oriented, and timely or time-oriented.

- Nursing orders or interventions

  The action plan given to the patient is written specifically, clearly, and measurably. Treatment plans are in-line with medical plans, and they complement each other in improving the health status of the patient.

  Formulating an action plan needs to consider:

  - a specific design of intervention helps the patients achieve the outcome criteria.

- documentation of the implemented action plan must be written in a format to help nurses process the information from the beginning of the assessment and nursing diagnosis.
- Nurses work with patients in planning intervention

- Evaluation form (status of diagnosis and client progress)

No	Nursing Diagnosis	Outcome	Nursing Intervention	Signature
1	Nutritional imbalance: Less than the body needs to be related to inadequate intakes	After nursing actions for 7 x 24 hours, nutrition is poorly resolved with the indicators: 1. Weight increases 2. Able to identify nutritional needs 3. No signs of malnutrition	1. Assess for food allergies. 2. Collaborate with nutritionists to determine the number of calories and nutrients needed. 3. Encourage patients to increase protein and vitamin C. 4. Make sure the diet intake contains high fiber to prevent constipation 5. Give selected food (already consulted with a nutritionist) 6. Provide information about nutritional needs 7. Monitor the presence of weight loss 8. Monitor the amount of nutrients and caloric content	 Toe

Figure 5. Sample form nursing intervention documentation

4. Nursing implementation documentation
    a. Definition

        Nursing implementation is a series of nurses' activities to help patients with health status problems. health status describing the criteria for which the outcome is expected. The implementation process must be patient-oriented, including factors affecting nursing needs, strategies for nursing implementation, and communication activities. The accuracy of the nursing care process describes the quality and patient safety; also, it is useful for patients, nurses, and the health team (Secer & Karaca, 2021). Nursing intervention is treatments done by nurses based on knowledge and clinical judgment to achieve the expected outcomes.
    b. Types of nursing implementation

        There are three types of nursing implementation.
        - Independent Implementation

            Any intervention that a nurse can independently provide without obtaining a prescription is considered an independent nursing intervention. An example of an independent nursing intervention is during the g monitoring of a patient's 24-hour intake/output record for trends because of a risk of imbalanced fluid volume. Another example of independent nursing intervention is the therapeutic communication that a nurse uses to assist patients to cope with a new medical diagnosis.

            For example, Ms. J. was diagnosed with Fluid Volume Excess. An example of an evidence-based independent nursing intervention is, "The nurse will provide the patient with dependent edema frequently and appropriately. The nurse would

individualize this evidence-based intervention to the patient and agency policy by stating, ”The nurse will check the patient’s condition every 2 hours.”

- Dependent Implementations
  Dependent implementation is a nursing action based on referrals from other professions, such as nutritionists, physiotherapies, psychologists, and so on. For instance, the provision of nutrition to patients following the diet made by a nutritionist and physical exercise (physical mobilization) recommended by the section physiotherapy.
- Interdependent Implementations
  Interdependent implementation is a nursing action based on teamwork nursing or other health teams, like, doctors. Some examples of interdependent implementation occur in the case of oral administration of drugs, injection drugs, infusions, urinary catheters, and nasogastric tubes (NGT).

c. Principles of nursing implementation
   Some principles in nursing care implementation cover the following items (American Nurses Association, 2010);
   - Documentation has several characteristics, such as:
     - Accessible
     - Accurate, relevant, consistent
     - Auditable
     - Clear, concise, and complete
     - Legible
     - Thoughtful
     - Timely, contemporaneous, and sequential
     - Reflective on the nursing process

- Retrievable permanently in a nursing-specific manner

- Education and training

  Nurses, in all settings and all levels of service, should provide comprehensive education and training in the technical elements of documentation, as well as the organization's policies and procedures that are related to documentation. The education and training should include staffing issues, including the time needed for documentation work to ensure that each nurse is capable of the following.

- Functional and skillful use of the global documentation system
- Competence in the use of computers and their supporting hardware
- Proficiency in the use of software systems in which documentation or other relevant patient, nursing, and healthcare reports, documents, and data are stored.
- Policies and procedures

  Nurses should be familiar with organizational policies and procedures related to documentation and apply these policies and procedures as a part of nursing practices.

- Protection systems

  Protection systems must be designed and built into documentation systems, both paper-based and electronic ones, as prescribed by industry standards, governmental mandates, accrediting agencies, and organizational policies and procedures. The protection systems provide:

- Security of data
- Protection of patient identification
- Confidentiality of patient information
- Confidentiality of clinical professional information
- Confidentiality of organizational information

- Documentation entries

  Entries into organization documents or health records must be:
  - Accurate, valid, and complete
  - Authentic; as the information is truthful, the author is identified. and nothing has been added or inserted.
  - Dated and time-stamped by the person who writes the entry.
  - Legible/readable
  - Use standardized terminology, including acronyms and symbols
- Standardized terminologies

  Standardized terminologies permit data to be aggregated and analyzed. Thus, some terminologies should include terms used to describe the planning, delivery, and evaluation of nursing care in diverse settings.

Times and Date	Nursing Diagnosis	Implementation	Signature
Monday, 8 May 2023	Nutritional imbalance: Less than the body needs to be related to inadequate intakes	1. Perform a food allergy assessment. 2. Determine the number of calories and nutrients needed by the patient with a nutritionist. 3. Advise patients to increase protein and vitamin C by eating lots of fruits 4. Give foods that contain high fiber to prevent constipation 5. Monitor weight loss 6. Give the selected food according to the advice of a nutritionist	 Toe

Sample form nursing implementation documentation

5. Nursing evaluation documentation
   a. Definition

      Evaluation is the final stage of the nursing process which is a systematic and planned comparison of observed results and objectives, or outcome criteria created at the planning stage. Evaluation is carried out on an ongoing basis by involving patients and personnel. If the evaluation results show the achievement of goals or outcome criteria, the patients can leave the nursing process cycle. Otherwise, the patients will re-enter the cycle starting from the repeated review (Secer & Karaca, 2021). The evaluation consists of formative evaluation and summative evaluation. Formative evaluation focuses on nursing process activities and outcomes of nursing

measures. The evaluation is done immediately after the nurse implements a nursing plan to assess the effectiveness of the implemented nursing actions. The formative evaluation covers four components known as SOAP: Subjective (data in the form of client complaints), Objective (data on examination results), Data Analysis (benchmarking the data with a particular theory), and Planning. Evaluation is the final stage that aims to assess whether the performed nursing actions are achieved or solve a problem. Although the evaluation stage is put at the end of the treatment process stage, it is an integral part of every phase of the nursing process> Additionally, all levels of healthcare personnel need to understand the purpose and importance of nursing documentation (Cilović-Lagarija et al., 2020).

b. The elements of formative evaluation

The elements of formative evaluation using SOAP covers:

- Subjective
  Expressions of feelings or complaints from a patient or his/her family after being given the implementation of nursing care.
- objective
  Objectives that can be identified by nurses using objective observation
- analysis
  Nurse analysis after knowing the subjective and objective responses
- Planning
  Further planning after the nurse has done the analysis. The task is to evaluate and interpret the

data according to evaluation criteria, as well as to use the findings from the evaluation to make decisions in providing nursing care.

C. Summary

A thorough systematic assessment will logically lead to and support the identification of problems in the patient. These problems use assessment data as a basis for formulations expressed as nursing diagnoses. Nursing diagnosis provides a premise for the selection of nursing interventions to achieve optimal results. Nursing planning is a set of activities that identify the phases of issue-solving and formulation, their priorities, and the implementation of nursing action plans in patients based on data analysis and nursing diagnosis. To direct and evaluate nursing care effectively, the plan should include the following: a nursing diagnostic statement, outcome criteria, a nursing goal, and a nursing intervention. Nursing intervention is the treatment done by nurses based on knowledge and clinical judgment to achieve the expected outcomes. Evaluation is the final stage of the nursing process, which is a systematic and planned comparison of observed results with objectives or outcome criteria created at the planning stage.

D. Exercise

Task 1. Work with a group, then discuss with your group what components must be included in nursing documentation

No	Nursing process	Answer
1	Nursing assessment	1. 2.
2	Nursing Diagnosis	1. 2.
3	Nursing planning	1. 2.
4	Nursing implementation	1. 2.
5	Nursing evaluation	1. 2.

Task 2. Work in pairs and do a role play on how to fill out the nursing documentation form. one student becomes a nurse, and one student becomes a patient

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_____https://www.template.net/business/forms/nursing-assessment-form/

CHAPTER III.

ELECTRONIC HEALTH RECORDS (EHR) FOR NURSING

A. Learning Objective

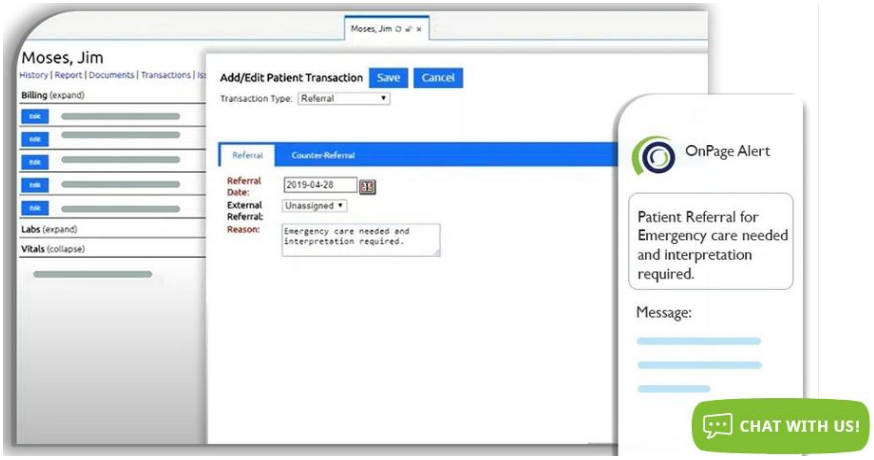
After studying Chapter 3, students are able to.

1. General learning objective.
   - Apply the concept of electronic health records in nursing
2. Part learning objective.
   a. Describe the concept of an electronic health record.
   b. Describe the benefits of electronic health records.
   c. Describe key components of the electronic health record.

B. EHR for Nursing

1. Definition

   An electronic health record (EHR) is a digital version of a patient's paper chart. Electronic healthcare records, commonly referred to as electronic medical records, serve as central data warehouses for healthcare information. EHR is patient-centered, real-time records that make information instantaneously and securely available to authorized users (Health, 2023).



Source: onpage.com (2022)

2. Benefits of EHRs

A more flexible flow of information within a digital healthcare infrastructure established by electronic health records (EHR) embraces and leverages digital progress and has the potential to alter the way treatment is delivered and compensated. Nurses primarily use electronic health records to receive medication reminders, prevent drug interactions, gain fast access to patient medical information, and document clinical treatment. Nurses must regularly monitor patients and document assessments, care plans, changes in clinical status, treatment provided, and essential patient information to assist multidisciplinary teams in providing excellent care.

Benefits of electronic health records for nurses, such as

- Improved nurse satisfaction
- Reduced time in documentation
- Reduced errors

Source: Study.com (2023)

Nursing documentation using the EHR is crucial because it ensures that patients receive the necessary care at the appropriate time. It is difficult for any nurse to remember everything that happened during a shift. If each patient's nursing records are not clear and accurate, the handover to the next team of nurses will be incomplete. The finest records include essential facts about the patient's current status as well as the activities taken by the nurse to address the patient's needs. Electronic software can improve the quality, thoroughness, and satisfaction of nursing documentation (Ranjbar et al., 2021). Overall, the hospital's nursing staff profited from EHR implementation.

3. Some advantages of using EHR

Clinical recording improves clinical outcomes and facilitates interprofessional collaboration. Nursing practice standards, organizational rules, meaningful use instructions, and a range of quality criteria are used to

document your assessments, goals, and activities. Electronic health records (EHR) support paperwork with data that can be used to improve patient safety, evaluate service quality, maximize efficiency, and determine staffing requirements. They also serve as a standard type of documentation that everyone on the healthcare team can use. However, if not used properly, EHR can diminish nurses' critical thinking abilities, increase reliance on workarounds to avoid forms and result in errors and missing documentation. Advantages of using an EHR for the nursing process (Pagulayan et al., 2018);

- When used incorrectly, the electronic health record (EHR) can lead to communication breakdowns.
- To eliminate workarounds and close communication gaps, the nursing process can be used for electronic documentation.
- EHR use that is effective can increase patient safety and care results.

4. Key component of EHR

When adopting EHR software, it is important to keep in mind the key elements that will help providers manage their workflows and improve patient care. In some cases, it can increase clinic revenue by up to 11 percent while reducing hospital admission rates by 20 percent. The following are some of the most essential characteristics of EHR software.

a. Patient management

The patient management component facilitates the collection, storage, and retrieval of up-to-date information about new patients. A new patient would be welcomed by the physician or the admissions

desk, who would ask for extensive information about their insurance, past health records, emergency contact information, and demographics. Each patient is given a unique ID, often known as a medical record number, by the system. The EHR uses this number to monitor any subsequent contacts with the patient, including lab results, diagnoses, medications, visits, and so on.

b. Clinical component

The clinical component enhances patient management by offering decision-support tools to care, teams, to provide high-quality treatment. This component enables clinicians to collect and document patient contacts, such as their history and physical, as well as operation notes. Clinical decision support components may include nursing and pharmacy services in addition to electronic recording. The nursing component simplifies the documentation of crucial health information such as patient vitals. Because of the pharmacy component, prescribers may provide safer, higher-quality care by placing pharmaceutical orders directly through their EHR systems.

c. Secure messaging and alert

As healthcare moves toward coordinated care, health IT executives must actively seek solutions to free healthcare data from the restrictions of siloed systems. When EHR systems are integrated with secure messaging and alerting technology, a centralized method for speeding up urgent communication flows is created. The integration democratizes information by liberating it from the

confines of a gated system and allowing physicians to freely access and engage with it on their phones. Time-critical EHR alerts that require immediate action can be securely conveyed to the appropriate on-call medical teams via OnPage. This data can be used by teams to provide immediate patient care or to seek guidance from other on-call clinicians. Hospitals that employ an EHR in conjunction with encrypted messaging technologies have nearly flawless alarm response rates.

d. Financial dashboards

    EHR software delivers vital financial data to healthcare providers in addition to its impact on patient care. An electronic health record software provides capabilities that allow all users, not just finance professionals, to evaluate a company's overall operations through simple and transparent dashboards. With the ability to provide reports on clinical and financial indicators for users of all levels, these applications have proven to be a valuable resource in today's competitive market, when margins are tight due to cost constraints.

e. Revenue cycle management

    Data show that practices that utilize an EHR with integrated RCM systems collect 29% more on invoiced charges than practices that do not. With a centralized dashboard for real-time data, your company can make informed financial decisions while still providing excellent patient care.

(*The Five Main Components of a Fully Developed EHR System*, 2022)

C. Summary

EHR is patient-centered, real-time records that make information instantaneously and securely available to authorized users. Nursing documentation utilizing an EHR is critical because complete, timely, and accurate medical record-keeping ensures that patients receive the appropriate care at the appropriate time. Some of the most important characteristics of EHR software are as follows: patient management, clinical components, secure messaging and alerts, financial dashboards, and revenue cycle management.

D. Exercise

Task 1. Read and answer the following questions!

1. Describe the advantages and benefits of using an EHR in nursing documentation!
   Answer.

2. Describe key components of EHR!
   Answer.

Task 2. Watch the following video using the link below, then make a summary of the material conveyed through the video.

https://study.com/academy/lesson/electronic-health-records-types-components.html

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CHAPTER IV.

DOCUMENTATION IN CERTAIN UNITS

A. Learning Objective

After studying Chapter 4, students are able to.

1. General learning objective.
   Differentiate documentation in certain units
2. Part learning objective.
   a. Describe documentation in the emergency department
   b. Describe documentation in the maternity department
   c. Describe documentation in the pediatric department
   d. Describe documentation in the perioperative department

B. Documentation in a Certain Room

1. Emergency Department (ED)
   The emergency department of records' objectives are (Guth, 2023);
   - **Communication**
     An ED encounter is rarely so private that no one else needs to be aware of it. About what transpired in the ED (such as diagnoses, treatments, our thoughts, conversations with patients and families about their concerns and desires, and discussions with consultants about their recommendations and patient care plans), our chart is the primary means by which we communicate with other health care clinicians (and even with patients).
   - Billing
     The main instrument for coding and paying for patient care services offered in the ED is medical documentation.

- **Medicolegal Protection**
  The medical record serves as a journal of the actions and ideas that were considered during the ED visit. The chart serves as the definitive (and frequently the only) record of what happened during the patient visit in the event of a subpar clinical outcome, a patient complaint, or legal action. The proverb “if it wasn’t written down, it didn’t happen” has plagued many an experienced and well-intentioned doctor. In these cases, the ED record must be able to support our defense.
- **Quality Improvement Reviews**
  One of the primary strategies used by health systems to enhance patient care in the future is chart review. Reviewers interested in quality or process improvement may place a high value on details that don’t seem significant to you (or your patient or consultant).
- **Research**
  When formulating a clinical research question, retrospective chart reviews are frequently the place to start. Clear documentation aids researchers in collecting data to plan future studies to enhance patient care.
- **Risk Management**
  Medical data are examined by hospital management to determine deadlines and areas of delay. They can get the resources they need to address these delays thanks to your charting (for instance, time documentation).

Between records kept by other clinicians and those kept by the emergency department, there are some distinct differences (Guth, 2023);

- **Time** p**ressures**
  Clinicians in the ED frequently have more time constraints than those in other care settings, which limits the amount of documentation time available and emphasizes the importance of effective charting (a compromise between thoroughness and brevity: include everything you need to know, but nothing you don't). It might be challenging to recall precisely what happened and when in the ED, thus quick completion of charting is essential for accuracy. The time of final disposal should ideally mark the completion of paperwork.
- **A note must stand alone**
  As opposed to the chapter-like inpatient progress note or clinic note, each ED note is a separate document. We reflect on data from the patient encounter and diagnostics, how we handled the urgent situation at hand, any changes in clinical state, and plans for follow-up treatment (such as hospital admission or outpatient monitoring) in ED documentation.
- **Billing mechanics**
  Compared to most other encounters, ED visits are billed differently. Based on the description of our medical decision-making (such as the complexity of problems addressed and of data evaluation), our charts are rated on a scale of 1 to 5 for complexity. The chart gets considerably down-coded if our medical decision-making isn't thoroughly documented.

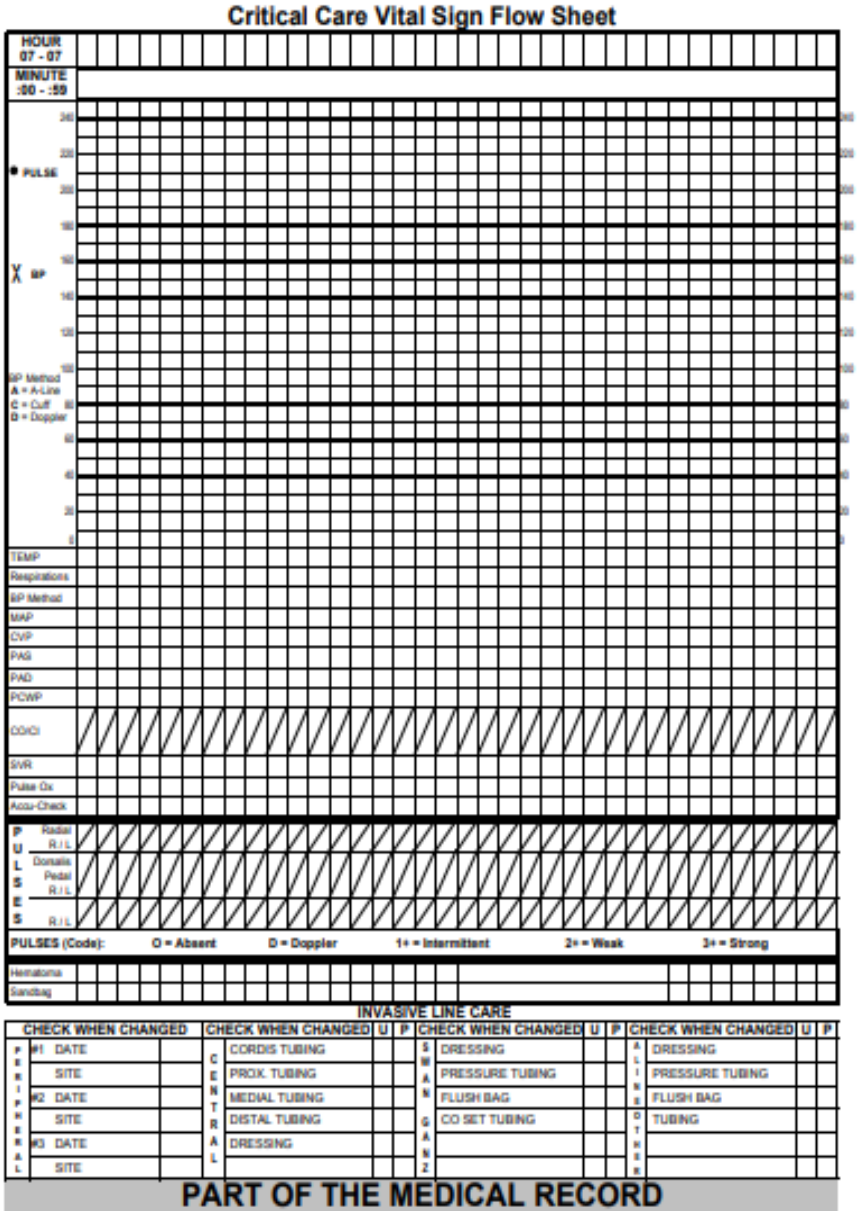
To bill for the operations they perform, emergency doctors (EPs) must properly record them.

- **Different goals of EPs vs. admitting or clinic clinicians**

  The ED's role is assessment, stabilization, and proper disposition as opposed to comprehensive treatment. Instead of always establishing a single, conclusive diagnosis, the differential diagnosis (DDx) must take a "worst-first" strategy. The concerns that are being treated during the ED visit must be documented, along with our clinical justification for each one. One of the most crucial purposes of ED notes is to clarify your thought processes regarding the patient's care.

- **Medical scribes**

  Medical scribes are showing up more frequently in EDs as a result of the time constraints associated with diagnosing and treating patients as well as maintaining documentation. Additionally, scribes need to be aware of how the ED differs from other areas of the healthcare system in terms of documentation. Since you are ultimately responsible for what the scribes document, the scribe charting needs to be carefully examined.



Sample of critical care vital sign form. Source: www.templet.net (2023)

The use of medical records as the main tool for assessing healthcare functions and getting the proper credit points for medical centers has been made possible by the standardization of documentation. The proper procedures for enhancing emergency department nurse care documentation are employee participation, managerial accountability, nurses' adherence to documentation standards, improved leadership style, and continuous monitoring and control (Vafaei et al., 2018). The ED has department-specific documentation tools, although progress notes should adhere to the framework outlined above, and in these clinical domains, the patient assessment and plan of care should be included in the progress notes at the start of each shift. Real-time progress notes are either recorded in the clinical comments part of the observation charts or in the in-progress notes. (Fernandes, 2017).

2. Maternity department

   Making a maternity document (L Moss, 2016);

   a. Antenatal care
      - Any past pregnancy-related information is kept in a marked section at the back of the current hospital record.
      - Both the handheld device and the hospital records should be used to store all antenatal screening findings that are provided to the UHL in paper copy format, as well as all UHL ultrasound reports. Additionally, outcomes are captured in the electronic patient records and on the pertinent page of the portable records.
      - Document the name of the team's contacts.

- To be noted upon registration are the following: height, weight, and BMI
- Measured uterus height in centimeters (cm), correctly plotted on the woman's customized GROW chart and recorded in notes.
- Completed in the prenatal portion were all gestation-related observations.
- Record discussions about health promotion issues and the distribution of leaflets or website links.
- If the woman doesn't want her requests recorded on the individualized care plan, it will be done.

b. Intrapartum care
   - The risk assessment for intrapartum HIE must be finished at the time of labor admission and then every two hours after that.
   - The PPH risk assessment must be finished at admission for IOL or in spontaneous labor, and it must be updated every four hours while the patient is in labor.
   - Within six hours of admission, Nerve Center should do the following risk assessments:
     - ✓ Best shot
     - ✓ Infection prevention A-F
     - ✓ Maternity nutrition
     - ✓ Patient handling risk assessment
     - ✓ Repositioning and skin monitoring
     - ✓ Screening for falls
     - ✓ Skin
     - ✓ VTE
     - ✓ Waterlow
   - As stated in the guideline "Intrapartum Care: Healthy Women and Their Babies," there should be

a proper record of intrapartum care. including the conclusion of partograms in the first and second stages.

- Keep a record of the justifications for performing vaginal exams.
- Record when the lady is informed of the indications for intervention.
- Record when the urinary catheter is placed.
- Record using the green sticker from the daily catheter care pathway.
- Absence or presence of meconium, including amount, consistency, color, or grade,
- Recording insertion of an IV cannula using a grey sticker from the BD PVAD care bundle.
- Documentation of all findings under the Intrapartum Care: Healthy Women and their Babies Guideline (both maternal and fetal)
- Documentation should follow the Fetal Heart Rate Monitoring in Labor guideline when continuous electronic fetal heart rate monitoring is indicated. CTG traces need to be properly labeled and kept in an envelope in the current pregnancy section of the maternal hospital notes.
- Verification of fetal heart rate using Pinard or Sonicaid auscultation
- In cases where an operation was performed to deliver the baby, the health records should note the circumstances, including informed consent.
- Where paired cord blood gas results are available, they should be recorded in the medical records and kept in an envelope in the current pregnancy section of the maternal hospital notes. In cases

where anesthesia has been administered, including epidural analgesia, the pertinent paperwork must be kept in the patient's medical file. This also applies to fetal blood sampling (FBS).

- The pertinent documentation must be kept in the patient's medical file whenever an anesthetic, including epidural analgesia, has been administered.

c. Postnatal care

- When leaving hospital maternity services, the Maternity Community Transfer form must be filled out completely, including the name and signature of the professional performing the discharge. One copy of the form must be kept in the maternity hospital records, and the other in the postnatal notes.
- All discharge information should be recorded electronically.

3. Pediatric department

Whether in a hospital or another healthcare facility, it is critical to acquire information about the child's history and current condition (Belleza, 2017).

a. Collecting subjective data

- Conducting the client interview

  The majority of subjective data is gathered through interviews with the family caregiver and the youngster.

  - Why do an interview? The interview aids in the formation of relationships between the nurse, the child, and the family.
  - Listening and communicating are essential. Listening and utilizing suitable communication

strategies can contribute to a successful interview.

- Introduce yourself and describe your goal. The nurse should identify herself to the kid and caregiver, and the goal of the interview should be explained.
- Create a rapport. Establishing trust and comfort requires a calm, soothing demeanor; the caregiver and nurse should be comfortably seated, and the kid should be included in the questioning process.

- Interviewing family caregivers

  The majority of the information required in caring for the kid, particularly the newborn or toddler, is provided by the family caregiver.

  - **Ask questions and note them**. Rather than just asking the caregiver to fill out a form, the nurse may ask the questions and record the answers; this procedure allows the nurse to witness the child's and caregiver's reactions as they engage with each other and answer the questions.
  - **Avoid being judgmental.** The nurse must be nonjudgmental, taking care not to show disapproval through vocal or nonverbal replies.

- Interviewing the child

  Both the preschoolers and the older children must participate in the interview.

  - Be age-appropriate. When conversing with the child, use age-appropriate objects and questions.
  - Establish a rapport. Showing interest in the child and what he or she says makes both the child and caregiver feel more comfortable; the nurse

creates trust with the child by being honest when solving the child's inquiries.

- Listen. The child's views should be carefully considered, and he or she should be made to feel valued during the interview.

- Interviewing the adolescent
  Adolescents can convey information about themselves. Private interview. When they are interviewed in privacy, they are more likely to divulge information that they would not share in front of their careers.
- Obtaining a client history
  When a child is taken to a health care facility, it is critical to collect information on the child's current state as well as medical history such as:
  - **Biographical data**
  - **Chief Complaint**
  - **History of present health concern**
  - **Health history**
  - **Family health history**
  - **Review of systems for** a **current health problem**
  - **Allergies, medications, and substance abuse**
  - **Lifestyle**
  - **Developmental level**

b. Collecting objective data

- General status
  The nurse uses her knowledge of average development and growth to determine whether the child looks to be of the claimed age.

- Observing general appearance
  The infant or child's face should be symmetrical; evaluate the skin for color, lesions, bruises, scars, and birthmarks; and examine hair texture, thickness, and distribution.
- Noting psychological status and behavior
  Physical behavior, as well as emotional and intellectual responses, should be observed during observation of conduct. Consider the child's age and developmental level, the unusual atmosphere of the healthcare institution, and whether or not the child has previously been hospitalized or otherwise isolated from family caregivers.

- Measuring height and weight
  The height and weight of the child are useful measures of growth and development.
  - When to measure
    Both weight and height should be measured and recorded during each routine physical examination for the kid, as well as at subsequent health care appointments.
  - How to measure weight
    In a healthcare facility, the infant or child should be weighed concurrently each day on the precise same scales while wearing the identical amount of clothing; the child is weighed naked, laying on an infant scale, or the child can be measured while sitting when the child is old enough.

- How to measure the height

  To measure the height of a child who is not able to stand alone steadily, usually under the age of two, place the child flat, with knees held flat, on an examining table; measure the child's height by straightening the child's body and measuring from the top of the head to the bottom of the foot.

- Measuring head circumference

  The head circumference is frequently assessed in children as young as 2 or 3 years old, as well as in any youngster with a neurologic problem.

- Vital sign

  At each visit, vital signs such as temperature, pulse, respiration, and blood pressure are obtained and compared to normal values for children of the same age.

  - Temperature
  - Pulse
  - Respirations
  - Blood pressure

- Physical examination

  Data is obtained as well through analyzing the child's body systems.

  - Head and neck
    - ✓ **Assess the range of motion**
    - ✓ **Assess the fontanels**
    - ✓ **Assess the eyes**
    - ✓ **Assess the ears**
    - ✓ **Assess the nose, mouth**, **and throat**

- Chest and lung

  Chest measurements are done on infants and children to determine normal growth rates.

  - ✓ **How to measure the chest**
  - ✓ **Adolescents**

    Take notice of indicators of breast development in older school-age children or adolescents.
  - ✓ **Assess respiratory characteristics**
  - ✓ **How to assess breath sounds**

    The nurse listens to breath sounds in each lobe of the lung, anterior and posterior, with a stethoscope as the kid inhales and exhales; describes, documents, and reports absent or attenuated breath sounds, as well as odd noises such as crackling or wheezing.
- Heart

  In some newborns and children, pulsing in the chest suggests a heartbeat, which is known as the point of maximal impulse.

  - ✓ **Assessing heart rate and rhythm**
  - ✓ **Assessing for heart abnormalities**
  - ✓ **Assess the heart function's effectiveness**
- Abdomen

  In infants and little toddlers, the abdomen may protrude slightly.

  - ✓ **Dividing the abdomen**
  - ✓ **Assess bowel sounds**
- Genitalia and rectum

  When evaluating the genitalia and rectum, it is critical to respect the child's privacy and consider the child's age and stage of development.

- ✓ **Inspect the genitalia and rectum**
- ✓ **Assess the testes**

➢ Back and extremities

Abnormalities in the back and extremities should also be evaluated.

- ✓ Assess the back
- ✓ Assess gait and posture
- ✓ Assess the extremities

➢ Neurologic

The most difficult component of the physical exam is determining the infant's and child's neurologic condition.

- ✓ Neurologic exam

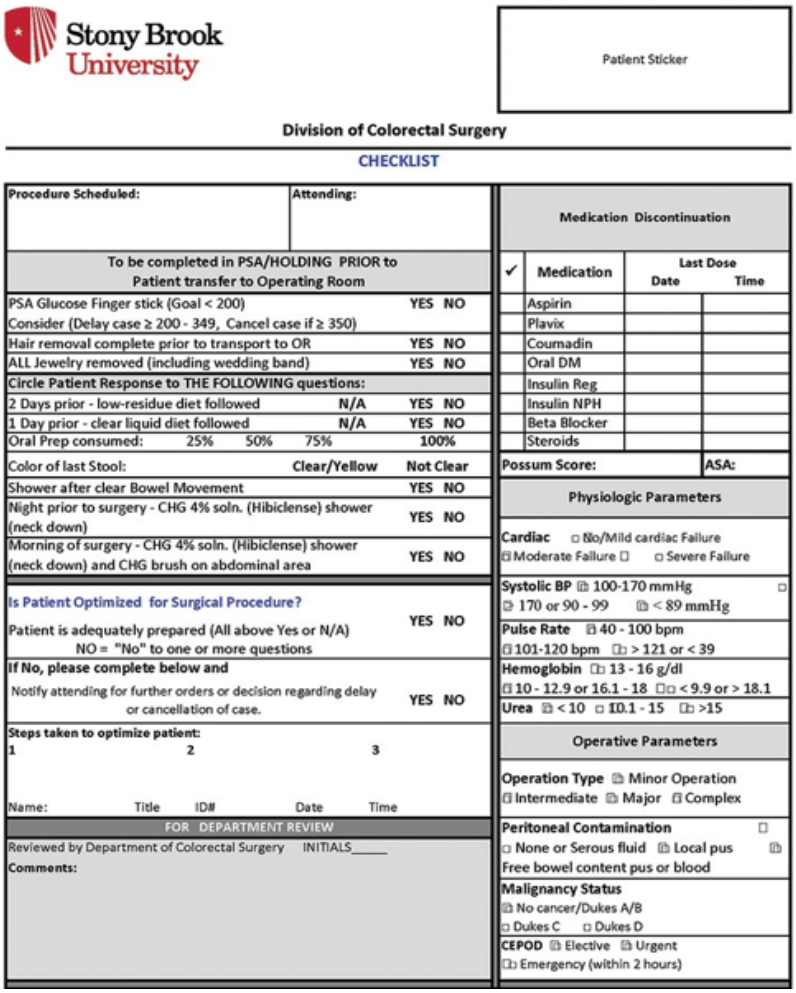
  A full neurologic exam is performed by the practitioner in the health care context to examine the child's neurologic status; this exam includes a detailed assessment of the reflex responses as well as the functioning of each of the cranial nerves.
- ✓ Neurologic assessment tool

  The nurse employs a neurologic assessment tool, such as the Glasgow coma scale; the use of a standard scale for monitoring allows for the comparison of results from one time to another and from one examiner to another; the nurse employs this tool to monitor various aspects of the child's neurologic functioning.

4. Perioperative department

These suggested practices offer perioperative nurses criteria for documenting nursing care in the perioperative practice context. Each surgical and other invasive

procedure should be documented utilizing the nursing process. The nursing process is a standardized system for providing and recording patient care. The perioperative recording is critical for maintaining goal-directed treatment and comparing achieved to projected patient outcomes (Staff.washington.edu, 2006).



Stony Brook University

Patient Sticker

Division of Colorectal Surgery

CHECKLIST

Procedure Scheduled:	Attending:

To be completed in PSA/HOLDING PRIOR to Patient transfer to Operating Room		
PSA Glucose Finger stick (Goal < 200) Consider (Delay case ≥ 200 - 349, Cancel case if ≥ 350)	YES	NO
Hair removal complete prior to transport to OR	YES	NO
ALL Jewelry removed (including wedding band)	YES	NO
Circle Patient Response to THE FOLLOWING questions:		
2 Days prior - low-residue diet followed	N/A YES	NO
1 Day prior - clear liquid diet followed	N/A YES	NO
Oral Prep consumed: 25% 50% 75% 100%		
Color of last Stool: Clear/Yellow Not Clear		
Shower after clear Bowel Movement	YES	NO
Night prior to surgery - CHG 4% soln. (Hibiclense) shower (neck down)	YES	NO
Morning of surgery - CHG 4% soln. (Hibiclense) shower (neck down) and CHG brush on abdominal area	YES	NO

Is Patient Optimized for Surgical Procedure?		
Patient is adequately prepared (All above Yes or N/A) NO = "No" to one or more questions	YES	NO
If No, please complete below and Notify attending for further orders or decision regarding delay or cancellation of case.	YES	NO

Steps taken to optimize patient:
1 2 3

Name: Title ID# Date Time

FOR DEPARTMENT REVIEW

Reviewed by Department of Colorectal Surgery INITIALS____

Comments:

Medication Discontinuation

✓	Medication	Last Dose Date	Last Dose Time
	Aspirin		
	Plavix		
	Coumadin		
	Oral DM		
	Insulin Reg		
	Insulin NPH		
	Beta Blocker		
	Steroids		

Possum Score: **ASA:**

Physiologic Parameters

Cardiac ☐ No/Mild cardiac Failure ☐ Moderate Failure ☐ ☐ Severe Failure

Systolic BP ☐ 100-170 mmHg ☐ ☐ 170 or 90 - 99 ☐ < 89 mmHg

Pulse Rate ☐ 40 - 100 bpm ☐ 101-120 bpm ☐ > 121 or < 39

Hemoglobin ☐ 13 - 16 g/dl ☐ 10 - 12.9 or 16.1 - 18 ☐☐ < 9.9 or > 18.1

Urea ☐ < 10 ☐ 10.1 - 15 ☐ >15

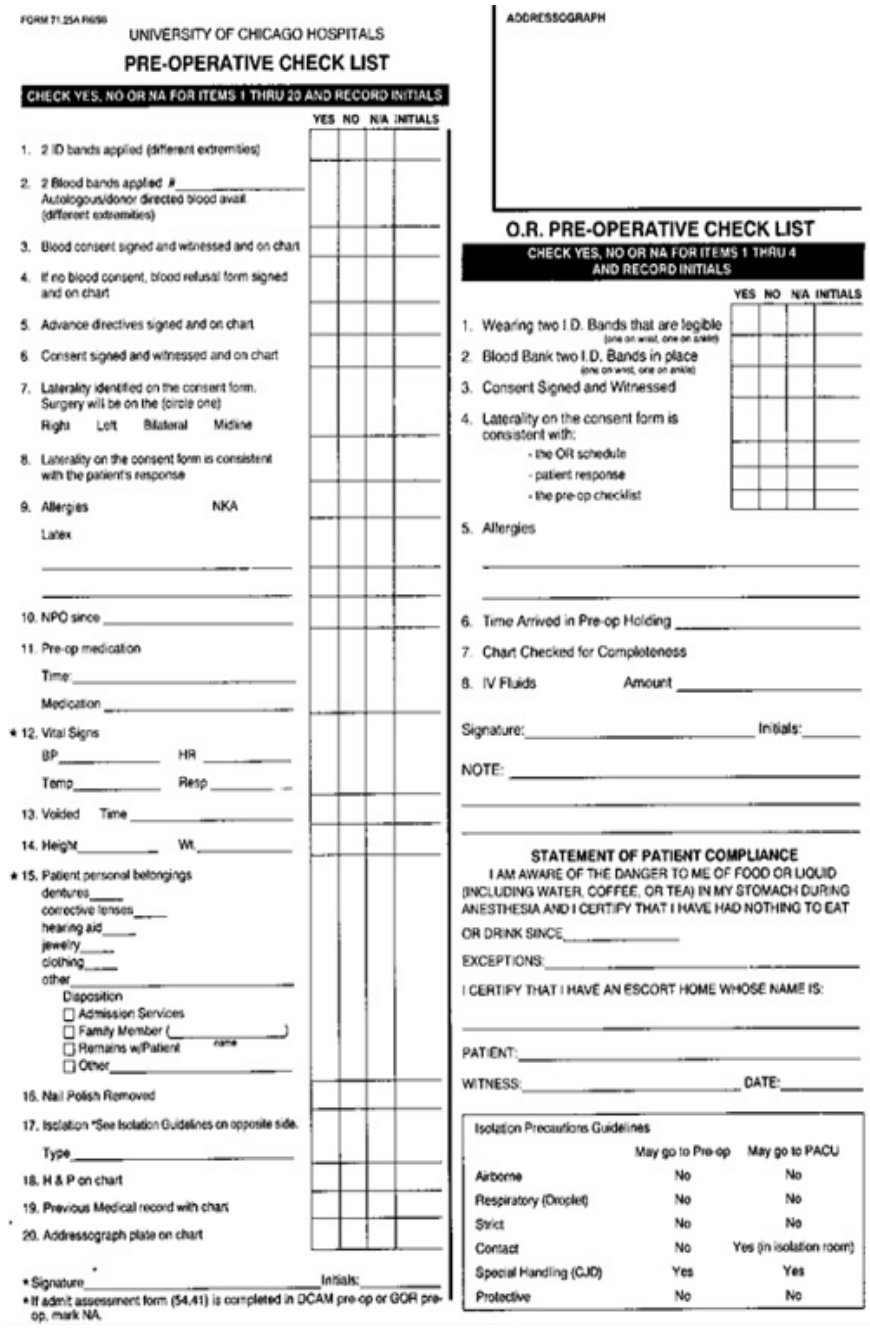
Operative Parameters

Operation Type ☐ Minor Operation ☐ Intermediate ☐ Major ☐ Complex

Peritoneal Contamination ☐ ☐ None or Serous fluid ☐ Local pus ☐ Free bowel content pus or blood

Malignancy Status ☐ No cancer/Dukes A/B ☐ Dukes C ☐ Dukes D

CEPOD ☐ Elective ☐ Urgent ☐ Emergency (within 2 hours)



FORM 71.25A R6/98

UNIVERSITY OF CHICAGO HOSPITALS

PRE-OPERATIVE CHECK LIST

CHECK YES, NO OR NA FOR ITEMS 1 THRU 20 AND RECORD INITIALS

	YES	NO	N/A	INITIALS
1. 2 ID bands applied (different extremities)				
2. 2 Blood bands applied #_____ Autologous/donor directed blood avail (different extremities)				
3. Blood consent signed and witnessed and on chart				
4. If no blood consent, blood refusal form signed and on chart				
5. Advance directives signed and on chart				
6. Consent signed and witnessed and on chart				
7. Laterality identified on the consent form. Surgery will be on the (circle one) Right Left Bilateral Midline				
8. Laterality on the consent form is consistent with the patient's response				
9. Allergies NKA Latex _____ _____				
10. NPO since _____				
11. Pre-op medication Time:_____ Medication _____				
* 12. Vital Signs BP_____ HR _____ Temp_____ Resp _____				
13. Voided Time _____				
14. Height_____ Wt._____				
* 15. Patient personal belongings dentures____ corrective lenses____ hearing aid____ jewelry____ clothing____ other_____ Disposition ☐ Admission Services ☐ Family Member (_____ name) ☐ Remains w/Patient ☐ Other_____				
16. Nail Polish Removed				
17. Isolation *See Isolation Guidelines on opposite side. Type_____				
18. H & P on chart				
19. Previous Medical record with chart				
20. Addressograph plate on chart				

* Signature_____ Initials:_____

* If admit assessment form (54.41) is completed in DCAM pre-op or GOR pre-op, mark NA.

ADDRESSOGRAPH

O.R. PRE-OPERATIVE CHECK LIST

CHECK YES, NO OR NA FOR ITEMS 1 THRU 4 AND RECORD INITIALS

	YES	NO	N/A	INITIALS
1. Wearing two I.D. Bands that are legible (one on wrist, one on ankle)				
2. Blood Bank two I.D. Bands in place (one on wrist, one on ankle)				
3. Consent Signed and Witnessed				
4. Laterality on the consent form is consistent with: - the OR schedule - patient response - the pre-op checklist				

5. Allergies _____ _____

6. Time Arrived in Pre-op Holding _____

7. Chart Checked for Completeness

8. IV Fluids Amount _____

Signature:_____ Initials:_____

NOTE: _____ _____ _____

STATEMENT OF PATIENT COMPLIANCE

I AM AWARE OF THE DANGER TO ME OF FOOD OR LIQUID (INCLUDING WATER, COFFEE, OR TEA) IN MY STOMACH DURING ANESTHESIA AND I CERTIFY THAT I HAVE HAD NOTHING TO EAT OR DRINK SINCE_____

EXCEPTIONS:_____

I CERTIFY THAT I HAVE AN ESCORT HOME WHOSE NAME IS: _____

PATIENT:_____

WITNESS:_____ DATE:_____

Isolation Precautions Guidelines	May go to Pre-op	May go to PACU
Airborne	No	No
Respiratory (Droplet)	No	No
Strict	No	No
Contact	No	Yes (in isolation room)
Special Handling (CJD)	Yes	Yes
Protective	No	No

Sample of perioperative form. Source; www.templet.net (2023)

The perioperative patient's plan of care, including assessment, diagnosis, outcome identification, planning, implementation, and evaluation, should be reflected in the patient's record.

a. Documentation should include information about the patient's condition, nursing diagnoses and actions, anticipated patient outcomes, and an assessment of the patient's reaction to perioperative nursing care. The nursing process serves as the controlling framework for perioperative nursing care documentation. When the nursing process is employed in perioperative practice settings, it exhibits the nurse's critical-thinking skills in caring for the postoperative patient.
b. Before surgical or other invasive procedures, the patient's record should contain an assessment (physical, psychological, cultural, and spiritual) completed by the perioperative nurse. A documented assessment serves as a foundation for nursing diagnoses and patient care planning. Continuity of care is improved by continuing this assessment throughout each successive phase of the patient's treatment (i.e., intraoperative, postoperative).
c. The plan of care should be documented in the patient's record. When the perioperative nurse identifies nursing interventions that will address the patient's actual or projected risk for health concerns (i.e., nursing diagnoses), the planning phase begins. Documentation improves communication among members of the health care team, promotes continuity of treatment, and serves as a legal record of the care provided. Identifying intended patient outcomes that

are individualized, prioritized, measurable, reasonable, and attainable aids in the development of a care plan.

d. During each phase of perioperative care, the patient's record should specify what nurse interventions were performed and when, where, and by whom. Assessment and planning employing nursing judgment and critical thinking skills culminate in the implementation process. Nursing interventions aim to avoid prospective patient damage or complications as well as intervene and treat actual patient problems. Documenting nurse interventions increases continuity of care for patients and improves communication among members of the health care team.
e. A continuous evaluation of perioperative nursing care and the patient's response to applied nursing interventions should be documented in the patient's record. The nursing process instructs perioperative nurses to assess the efficacy of nursing interventions in achieving intended patient outcomes. The evaluation method provides data for perioperative nursing research, risk management, and continuity of care. Documentation allows you to compare actual versus projected results.
f. Perioperative documentation should include, but is not limited to, the following items:
    - Identification of those providing perioperative patient care (i.e., name, title, and signature of the person in charge of the care);
    - Description of the patient's overall skin state upon admission and discharge from the operating room;

- Patient care planning during surgery, including baseline physical, emotional, psychological, and cultural data;
- Sensory aids and prosthetic devices (e.g., spectacles, hearing aids, dentures, artificial limbs) are present and/or in use;
- Electrosurgical unit (ESU) dispersive pad placement, as well as identification of the ESU and setting used throughout the surgical operation;
- Temperature-regulating device use, including identification of the unit and documentation of the patient's body temperature before and after perioperative suite discharge;
- Electrocardiogram electrode installation, blood pressure cuff, oximetry and temperature probe placement, and other invasive and monitoring devices;
- Devices and supports for patient positioning and/or repositioning, including immobilization devices used during the surgical operation;
- Tourniquet cuff placement, including unit identification, pressure settings, and inflation and deflation times;
- Skin preparation, including the application of a prep solution;
- Identification of the unit, name of surgeon and support staff members, type of laser utilized, surgical process, lens used, length of time laser was used, and watts;
- Intraoperative x-rays and fluoroscopy, as well as any protective gear employed;

- Patient specimens and cultures obtained during surgery;
- Drains, catheters, wound packing, casting material, and dressings utilized, as well as their location and type;
- Implant placement and location (e.g., medical devices, synthetic and biologic grafts, tissue, bone), including the name of the manufacturer or distributor, lot and serial numbers, implant type and size, and expiration dates as appropriate, as well as other information required by the Food and Drug Administration;
- Radioactive implant implantation, comprising the time, number, location, and type of radioactive material implanted in the patient;
- During the perioperative period, the patient is given blood or blood products, medicines, irrigation solution, and other solutions;
- Wound classification;
- Anesthetic categorization and anesthetic mode are offered;
- Documentation of sponge, sharp, and instrument count results as needed;
- Time of patient discharge, patient state at discharge, patient disposition, and manner of transfer;
- Any significant or exceptional events relating to postoperative patient outcomes;
- Communication with family members or significant others during the medical procedure; and
- Patient and family education is provided.

C. Summary

- The ED has department-specific documentation tools, although progress notes should adhere to the framework outlined above, and in these clinical domains, the patient assessment and plan of care should be included in the progress notes at the start of each shift. Real-time progress notes are either recorded in the clinical comments part of the observation charts or in the in-progress notes.
- Documentation in the maternity ward is divided into three categories: antenatal care, intrapartum care, and postpartum care.
- It is vital to obtain information regarding the child's history and current state, whether in a hospital or another healthcare facility.
- Perioperative recording is critical for maintaining goal-directed treatment and comparing achieved to projected patient outcomes. The plan of care for the perioperative patient, includes assessment, diagnosis, outcome identification, planning, implementation, and evaluation.

D. Exercise

Task 1. Read and answer the following questions!

1. Explain the difference between nursing documentation in the emergency department and a regular inpatient room

   Answer

2. Explain required documentation when a nurse provides nursing care on the maternity ward!
   Answer

3. Explain, what should be documented when a nurse provides nursing care in the pediatric ward!
   Answer

4. Explain required documentation when a nurse provides nursing care on the perioperative!
   Answer

Task 2. Watch the following video using the link below, then make a summary of the material explained in the video.

1. https://www.youtube.com/watch?v=FRlpQhy2BC4
2. https://www.youtube.com/watch?v=Z3q1p_6_zOE
3. https://www.youtube.com/watch?v=lGz10g6LLlM
4. https://www.youtube.com/watch?v=T4JTbFpnIcg

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TEST

A. Summative Test

1. Attitude assessment

   Technique : Observation

   Instrument form : Attitude assessment sheet

   a. Affective assessment (Observation of activity and responsibility)

No	Student ID Number	Name	Aspect		Score
			Active	Responsibility	
1					
2					
3					
4					
5					

   b. Assessment rubric

No	Aspect	Indicator	Score
1	Active	✓ No visible indicators ✓ Visible indicators 1-2 ✓ Visible indicators 3-4 ✓ All indicator appears	1 2 3 4
2	Responsibility	✓ No visible indicators ✓ Visible indicators 1-2 ✓ Visible indicators 3-4 ✓ All indicator appears	1 2 3 4

   c. Indicators aspect

   - Active
     - ✓ Follow the teacher's instructions carefully
     - ✓ Dare to express ideas
     - ✓ Do or collect assignments according to a predetermined time
     - ✓ Students dare to ask

- ✓ Dare to answer the teacher's questions
- Responsibility
  - ✓ Carry out their duties well as individuals and as members of a group.
  - ✓ Accept the risks of the actions taken
  - ✓ Maintain cleanliness and tidiness of self and the environment
  - ✓ Admit and apologize for mistakes made.
  - ✓ Not blaming others for the mistakes of our actions

2. Knowledge assessment

Instruments used in the assessment of knowledge by giving assignments to be done at home or on campus.

No	Technique	Instrument	execution time
1	Written	blank question	After learning or during learning

3. Psychomotor assessment

Technique : Observation

Instrument form : Psychomotor assessment sheet

a. Discussion assessment

No	Student ID Number	Name	Aspect			Score
			Do activity	Accuracy in give information	Explanation procedure	
1						
2						
3						
4						
5						
6						
7						

b. Assessment rubric

No	Aspect	Indicator	Score
1	Active	✓ No visible indicators ✓ Visible indicators 1-2 ✓ Visible indicators 3-4 ✓ All indicator appears	1 2 3 4
2	Accuracy in the give information	✓ No visible indicators ✓ Visible indicators 1-2 ✓ Visible indicators 3-4 ✓ All indicator appears	1 2 3 4
3	Explanation procedure	✓ No visible indicators ✓ Visible indicators 1-2 ✓ Visible indicators 3-4 ✓ All indicator appears	1 2 3 4

c. Indicators aspect

- Do an activity.
  - ✓ Follow the teacher's instructions carefully
  - ✓ Dare to express ideas
  - ✓ Do or collect assignments according to a predetermined time
  - ✓ Students dare to ask
  - ✓ Dare to answer the teacher's questions
- Accuracy in the give information
  - ✓ Carry out their duties well as individuals and as members of a group.
  - ✓ Accept the risks of the actions taken
  - ✓ Maintain cleanliness and tidiness of self and the environment
  - ✓ Admit and apologize for mistakes made.
  - ✓ Not blaming others for the mistakes of our actions

- Explanation procedure
  - ✓ Follow the teacher's instructions carefully.
  - ✓ Dare to express ideas
  - ✓ Do or collect assignments according to a predetermined time

B. Scoring Test

1. Attitude assessment
   - Score description
     - ✓ Max score : 8
     - ✓ Score calculation : $\frac{\text{Total score obtained.}}{\text{Max score}}$ X 100

2. Knowledge assessment
   - Score description
     - ✓ Max score : 100
     - ✓ Score calculation : $\frac{\text{Total score obtained.}}{\text{Max score}}$ X 100

3. Psychomotor assessment
   - Score description
     - ✓ Max score : 12
     - ✓ Score calculation : $\frac{\text{Total score obtained.}}{\text{Max score}}$ X 100

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Nursing Documentation

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