MAXIMISING POTENTIAL THROUGH INDIVIDUAL ATTENTION BY UTILISING UNIQUE AND REVOLUTIONARY METHODS.

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Before you write anything – first find out why you need to write a note

Nurses notes are simple pages with lines at the top reading: nurses notes or progress notes but there's a lot more to them. The information you write in these pages are legal documents. There are times when you do need to write and others you simply don’t. It is important to know what to write in these documents. But more important is to understand who you’re writing for, and why and when you need to write them. You need to understand the basics of nurse’s notes.

If you want to create good nurses notes, think of it in a different way. Think of nurses notes as – nurse’s legal documentation.

Rule # 1
Know who you writing a note for. When you write something, you are doing so because someone will read it. You are writing it for someone. You are writing an idea that someone will interpret. In the case of a nurses note you are writing to the state. When writing your documentation is important to have that in mind. You are also writing for you DON. If something serious have happened, most likely these two entities will be reading, sifting and scrutinizing every line in your notes. So how do you write? very carefully without leaving nothing to chance.

It all boils down to documentation. If you didn’t document, it simply didn't happen. If you gave the right medication but documented the wrong one – you gave the wrong medication. This is just to illustrate how serious, nurses’ documentation is. Rule #1 is the main building block of nurses notes. You are documenting the work you did so you can prove you did the work. Likewise you are documenting events that happened so you can also prove they did happen. So nurses notes can also be seen as proof of work you did.

But you can’t simply write everything that happens on a shift. You would have to spend all you time just writing and nurses have no time to begin with. So you need to prioritize what needs to be written and what doesn’t.
Rule # 2
Learn **why** you need a note. Some young nurses are preoccupied with **how** to write long nurses notes, but pay little attention to **why** they need to write a note in the first place. Once you understand the reasoning behind why you need a note; the rest is easy because you are just filling the blanks and connecting the dots.

**To write or not to write are equally important.** Nursing documentation cannot be erased; once you write is there forever. If you make a mistake or forget something you can always write a late entry. But you can never delete a note from the records. So remember, the more important a situation is, the more you should think before you write. If in doubt ask other nurses or your DON before you start writing.

The first step is to decide if documentation is needed. But there are 3 additional steps – **situation, assessment and what did you do about it.** Don’t limit yourself to a cookie cutter idea. There are several ways to write a note, but it makes it easy if you apply these four principles. This is basically your regular ISBAR but configured a little differently.

Rule # 3
Keep your timing correct. When incidents happen timing is very important; they are crucial marks that validate, illustrate and punctuate events. You might right excellent notes but if you don’t document when they happened step by step they can be misconstrued and tell a different story. This is something that is somewhat neglected but you only have to go through a serious situation once to know how important it is to stamp the time when anything and everything took place.

**ISBAR**
Introduction
Situation
Background
Assessment
Recommendation
Breaking down even further

Decide if you need to document an event
Describe what happened
Provide your clinical/nursing assessment
Explain what you did about the situation
Decide if you need to write a note

This is the most important step and requires critical thinking. There are times you absolutely need to document and others you are better off not writing anything at all. Redundant and useless information in medicine can be confusing and counterproductive. Remember that 99% of the time, no one will ever read these notes; only when something goes wrong they might be reviewed. If in the future a patient sues the hospital because of some suspected wrong doing, your notes will be examined under a microscope and every word you wrote or didn’t write could put you and your employer in jeopardy.

Don’t write a note about a situation if you can’t follow up with. Remember, every important situation you document must have a follow up or you might consider not approaching it at all. This also mean you’ll make sure that the next shift will follow up. This might seem weird but you should almost evaluate a gravity of a situation by the amount of time and resources you have available to deal with. If something is really serious you certainly have the time, if you’re not sure then it might not be so important. This is part of your time management and prioritization skills. Don’t start something if you cannot finish. Notes are powerful use it wisely.

Make a list of significant events, better yet ask the DON what are the usual events the unit or facility are looking for and what kind of documentation is needed. They might vary from place to place. In some institutions there is more scrutiny placed on certain events then others. So you first check with the culture of your workplace. Always check with your DON.

There are several situations that need documentation. They could range from a conversation with a patient to a change of condition or a incident completely unrelated to any patient, for example: someone walks in the nurse station and threatened a staff member. So is entirely up to your critical thinking. My advice is
to only document important events that are unstable and have a potential to escalate into a bigger problem. Your documentation has the purpose of protecting you, the organization you work for and the patient. The core value of your nurses notes should be the provision of accurate, nonjudgmental, and useful information for anyone who needs to learn about a significant event in the past. Let me give you an example.

**Ongoing documentation:** you should get into the habit of documenting your work. The idea is that your are showing what you did for your patients. Remember if you didn’t document it didn’t happen. Chart frequently and every day but with the idea you are documenting what you did. In a way is like a diary of your work. If you talked to a family member; if you did a treatment; if you noticed changes and you have addressed these changes – make a not of it.

**Protecting yourself and facility example:** say you just admitted a new patient along with their family and things are not going well. The family is insulting you and question your knowledge in a condescending way, they are rude and make threats. Should you document the details of this stressful admission – you bet! These types of behavior will not stay in the room and, most likely the family will complain about you or file a complaint with the state blaming the facility. But if your documentation from the very beginning is consistent, non judgmental and accurate, these individuals will have a hard time building their case against anyone.

**Patient example:** Let’s say a patient is complaining saying “I can’t breathe” you assess and find nothing wrong with the patient. The patient continues to complain and you notice there is a psychosocial issue. The patient is depressed and has panic attacks that have been undocumented so far. At first it appears that there is no reason to document. But the next day this patient calls the DON saying: “Last night I could not breathe and the nurse didn’t do anything about it” you gently refer the DON to your notes. If you correctly have been documenting these events, consistently including what happened, your assessment and what you did about it – end of story. Without your documentation you have no argument, and the patient will have the ultimate say so over anything you say.

**Protect your employer example:** One day a patient falls from his weal chair. Upon your assessment you see that the WC was broken and this might very well have been the cause of the fall. You go back into the books and see that a repair have
been ordered a month ago and nothing was done. You think to yourself "I’m going to write that up and show them I’m on top of things". Don’t do it. If you do this I’ll guarantee you a visit to the office and have a talk to your boss. Please if you see something like that, talk to your boss or DON privately, and solve the problem internally. There is no need to register things of that nature to the state. If there is something that serious that need the state’s attention call the state, and write a note too if you want.

Your documentation is your only weapon when you’re alone out there. You want to document situations that are important and could escalate or complicate and you are responsible for. Every note you start should be viewed as a case you open and you keep adding more notes to it. Is really up to you to decide what is important. No one can tell you not to write a note, even though computer charting encourage you to just fill bubbles. Nurses notes can be seen as a right in self defense for situations that could potentially become out of control and damage you, your employer or the patient. Take charge.

Even though you don’t have to write about every single thing. You should keep a constant and regular writing that will reflect your work – kind of like you are keeping a diary of your work. Do that for each patient. You don’t have to write about every single thing but you should have samples of everything your touch. The more your write the more protection you’ll have.

Describe what happened
Ounce you decide to write about a case you want to start by simply stating what you’ve found. This is basically the first part of your documentation. It does not have to be pretty, or even grammatically correct. Of course all words should be correctly spelled but it does not have to be pretty writing. What did you see? Describe the situation in a few words. Leave nothing important or significant out of your description. Don’t give any opinions, at this point you are a impartial observer. Describe exactly what you found but pay attention to the big picture.

Here again you have to use critical thinking. Not only you will not register your personal opinion but you will also not register other people’s opinions. If a patient was upset and came up with a story that was not true such as “my mother was seating in a pool of blood” you don’t need to register their story – only say “the
patient was upset” by registering what the patient said you are officially creating doubt. If you didn’t write it doesn’t exist.

You should write your statement in such way that it does not lead to false or misconstruing of the facts at the same time it does no directly incriminate anyone. You never know the intent of those who will read your notes. If you have a serious incident ask another nurse to go over the note with you. Two thinking heads are always better than one, remember team work. Nurses notes are particularly powerful when all nurses work together and protect each other.

Your description should leave no questions to be asked. Always include all the crucial information concerning the event you are describing. For example: you write “the patient was complaining” it must be followed by – what was the patient complaining about. In other words your text should stand alone and have no open ended sentences. Anyone reading should have access to all information necessary to reconstruct the situation and not to have to ask any questions. In a court of law you’ll never remember what happened that night 2 years ago so add it while its fresh.

Your description of the situation is just a description of what happened as raw as possible, no judgment, no clinical assessment, and by all means add date and time.

**Your clinical assessment**

Because you are a nurse and a health care provider you’ll now assess the situation as a clinician. This is when you can actually give your opinion based on scientific data you collect. There is a critical difference between what happened and your clinical assessment. What happened is the raw data containing the basic elements of a situation. Your clinical assessment contain information you’ll will use to make recommendations and also justify your actions or non action.

What did you find as a clinician? How the situation affects the health care environment. How was the patient affected. Now is the time to register what you found and list all your findings. If the patient had a change of condition, what was the extent of the change, vital signs, what is the patient experiencing, and all other items of relevancy. In this assessment you can start by listing all your clinical findings and.

*When assessing think of:*
  * Vital signs*

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• Diagnosis
• Medications
• Psychosocial
• Progress notes
• Health history
• Pain

What did you do about it
To complete your documentation you add your own documentation of what you did to remedy, improve, and secure, the event you’re referring to. Your actions or recommendations will be based on your clinical assessment as well as your judgment as an RN. So when you produce your assessments have in mind that they must support and evidence your final actions (i.e. what did you do about it and why).

If you’re documenting something beyond your scope make sure you document that you let others know about and you have the confirmation that you did contact them. “What did you do about it” is a point everyone will be looking for when documentation is backtracked. No one wants the do nothing approach. Do something!

Good documentation is an art and is not about producing beautiful writing but creating documentation that speak for itself. Good documentation should be accurate and leave no desire for further questions. Remember – If you did something but didn’t document you simply didn’t do it – talk is cheap.

Nurses notes examples
They are kind of useless. You can Google “nurses notes exemples” and will see many different samples. But if you just trying to copy somebody else’s work without knowing what you are doing – you are basically wasting your time. Invest time understanding why you are supposed to write a note. Think of what kind of information others will need to know about what happened. If you know that by heart, you’ll never need to look at another nurse’s work. Know the above and you can’t go wrong. Remember, is not about how long or how pretty you write; its about the content of your note relative to the situation.

Reproduced from: http://www.mtspace.me/nurses-notes
Nursing documentation

Introduction

Nursing documentation is essential for good clinical communication. Appropriate legible documentation provides an accurate reflection of nursing assessments, changes in conditions, care provided and pertinent patient information to support the multidisciplinary team to deliver great care. Documentation provides evidence of care and is an important professional and medico legal requirement of nursing practice.

Aim

To provide a structured and standardised approach to nursing documentation for inpatients. This will ensure consistency across the RCH and improve clinical communication.

Definition of Terms

Documentation: encompasses all written and/or electronic entries reflecting all aspects of patient care communicated, planned recommended or given to that patient.

‘End of shift’ progress notes: nursing documentation written as a summary at the end or towards the end of shift.

‘Real time’ progress notes: nursing documentation written in a timely manner during the shift.

ISBAR: (Identify, Situation, Background, Assessment, Recommendation) framework for clinical communication

Admission assessment: Comprehensive nursing assessment including patient history, general appearance, physical examination and vital signs completed at the
time of admission.

**Shift assessment**: Concise nursing assessment completed at the commencement of each shift or if patient condition changes at any other time during your shift.

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**Process**

Nursing documentation will support the process;

- Patient assessment,
- Plan of care
- Real time progress notes
- Patient assessment

At the commencement of each shift, following handover, patient introductions and safety checks, a 'commencement of shift assessment' is completed. These assessments are documented on the Patient Care Plan. If there is more information gained from this assessment than space allowed, additional information is documented in the progress notes.

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**Plan of Care**

Taking into consideration the patient assessment, clinical handover, previous patient documentation and verbal communication with the patient and family the plan of care for the shift is made and documented on the Patient Care Plan. The plan should be negotiated with patients’ and their carers to ensure clear expectations of care, procedures, investigations and discharge, are set early in the shift. The plan of care should align with information on the patient journey board.
Real time Progress Notes

Documentation is captured in the patient’s progress notes in ‘real time’ throughout the shift instead of a single entry at the end of shift.

Any relevant clinical information is entered in a timely manner such as;

Abnormal assessment, eg. Uncontrolled pain, tachycardic, increased WOB, poor perfusion, hypotensive, febrile etc.

Change in condition, eg. Patient deterioration, improvements, neurological status, desaturation, etc.

Adverse findings or events, eg. IV painful, inflamed or leaking requiring removal, vomiting, rash, incontinence, fall, pressure injury; wound infection, drain losses, electrolyte imbalance, +/-fluid balance etc.

Change in plan (Any alterations or omissions from plan of care on patient care plan) eg. Rest in bed, increase fluids, fasting, any clinical investigations (bloods, xray), mobilisation status, medication changes, infusions etc.

Patient outcomes after interventions eg. Dressing changes, pain management, mobilisation, hygiene, overall improvements, responses to care etc.

Family centred care eg. Parent level of understanding, education outcomes, participation in care, child-family interactions, welfare issues, visiting arrangements etc.

Social issues eg. Accommodation, travel, financial, legal etc.

Progress note entries should include nursing content and evidence of critical thinking. That is, they should not simply list tasks or events but provide information about what occurred, consider why and include details of the impact and outcome for the particular patient and family involved.

All entries should be **accurate and relevant** to the individual patient. Generic information such as ‘ongoing’ is not useful.
Duplication should be avoided. Blanket statements about information recorded on other medical records are not useful, for example, ‘medications given as per Medication Administration Record (MAR).

Professional nursing language is used for all entries to clearly communicate assessment, plan and care provided. For example; ‘TLC’ does not reflect nursing care.

Structure

The structure of each progress note entry should follow the ISBAR philosophy with a focus on the four points of Assessment, Action, Response and Recommendation.

Identify. Positive patient identification and ensure details are correct on documents. Write the current date, time and “Nursing” heading. The first entry you make each shift must include your full signature, printed name and designation. Subsequent entries on the same shift must be identified with date/time and ‘Nursing’ but may be signed only.

Situation & Background. not often required for ‘real-time’ entries. Maybe relevant for admission notes or transfer from one dept to another.

Assessment. What does the patient look like? What has happened?

Action. What have you done about it? Interventions, investigations, change in care or treatment required?

Response. How has the patient responded? What has changed? Improvement or deterioration?

Recommendation. What is your recommendation or plan for further interventions or care?

Examples of real time progress note entries

2/7/2014
09:40 NURSING. Billie is describing increasing pain in left leg. Pain score increased. Paracetamol given, massaged area with some effect. Education given to
Mum at the bedside on providing regular massage in conjunction with regular analgesia. Continue pain score with observations.


14:30 NURSING. Routine bloods for IV therapy taken, lab called- low Na+. Medical staff notified, maintenance fluids reduced to 5ml/hr. Repeat bloods in 6/24. Encourage oral fluids and diet, if tolerated, IV can be removed.

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**Special Considerations**

**Emergency.**
The Emergency Department have department specific documentation tools, however progress notes should follow the structure as detailed above.

**Theatres.**
The Operating Suite uses ORMIS (Operating Room Management Information System) to record all surgical procedures.

**Nursing Admission - Day stay.**
May be used for patients staying less than 24hours in the areas of Day Medical Unit or Day of Surgery.

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All plans for care are documented on the Patient care plan and real-time progress notes should follow the structure as detailed above.

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**References**


Reproduced from: http://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Nursing_Documentation/
Senior Manager | Clinical Nursing Instructor
RN Geller is a Registered Nurse, has completed Honors (First Class), is a PhD Scholar (Psychiatric Nursing), Sociologist and a peer reviewer for four major journals and has been for the last 5 years. She was awarded an APA Scholarship to complete her doctoral studies, tutors privately in enrolled, undergraduate and post graduate nursing topics Australia wide and is a referee for six international peer reviewed journals. Her background is in emergency care, high dependency and intensive care nursing and was formerly a Lecturer in Nursing in a large Australian University. She is also the Managing Director, Canine Behaviourist and Head Trainer of Canine Essentials with a nationally recognised dog behaviour and training qualification. She is authorised to train and accredit Assistance Dogs (with a client base that focuses on mental health animal assisted treatment modalities). Her background is in emergency care, high dependency and intensive care nursing and formerly a Lecturer in Nursing at a large Australian university. Of particular interest to her is advocacy for health care issues such as the ethical aspects of patient admissions and need for holistic care, assistance animals as a treatment modality, legislative and policy adherence in relation to the use of assistance animals and protecting vulnerable groups in Australia. Her focus of research is in the area of dog-human relations in the context of health, concentrating on assistance animals and mental health.
Qualifications: CertFinMkts| BNurs| RN| BNgHons|CertIIIDogBehTrng| CPDT-KSA| Doctoral Scholar(PhD).

Consultation Hours

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Our Aims
Based in Adelaide (Highbury), South Australia, Nursing Tutoring Essentials Educators care very much about our students’ success and will be with you from the beginning of your enrolled nursing studies, your university degree, and all the way through to your postgraduate studies. Nursing Tutoring Essentials is an exemplary tutoring service that provides affordable and much-needed help to students through your educational journey.

Our aim is to provide affordable and revolutionary one-on-one high-quality education to all. We do this in order to maximise student retention, increase student satisfaction, and improve both internal and external examination pass rates. Nursing Tutoring Essentials is committed towards contributing to the knowledge development of our future nurses. We do this by creating a learning environment where knowledge is generated and shared through workshops, seminars, and tutoring. Nursing Tutoring Essentials aims to advance the science of nursing by working in tandem with nursing programs in preparing professional nurses who personify a culture of care.

Our Focus
Nursing Tutoring Essentials Educators are subject matter experts (SMEs), who have excelled, and are dedicated to providing the highest quality of education to all nursing students (enrolled or registered). Likewise, other university students can benefit from our SMEs in one form or other. NTE SMEs are also able to assist secondary students with assistance while they undertake their research projects (generally in year 11 or 12). Finally, NTE offers assistance to students where English is not their first language or while preparing for OET examination. Nursing Tutoring Essentials is also focused on the provision of evidence based practice in healthcare and is highly skilled in research methodologies and methods. From this, RN Geller can assist fellow Academics’ in the areas of research assessment, post-doctoral work, research analysis, sociological critique and providing consultation when expertise required.