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Clinical Documentation: Back to Basics

The American Nursing Association (2010) states, “Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice.” Documentation included in the medical record must include relevant and precise information about a patient for ensuring quality and safe care.

High quality documentation is:

- Accessible
- Accurate, relevant and consistent
- Auditable
- Clear, concise, and complete
- Thoughtful
- Timely, contemporaneous, and sequential
- Reflective of the nursing process (Assessment, Diagnosis, Outcomes/Planning, Implementation, Evaluation).

Entries into organization documents or the health record (including but not limited to provider orders) **must be:**

- Accurate, valid, and complete;
- Information is objective and truthful
- Author is appropriately identified
- Dated and time stamped by persons who created the entry
- Legible/readable; and
- Made using standardized terminology including medically approved acronyms and symbols. Use the Abbreviation look up resource available on the Ipage.

(American Nurses Association, 2010)

Consider using **SBAR** to communicate significant events with the care team in the patient’s medical record:

Situation:

- Provide a brief description for the current situation.

Background:

- Provide relevant background information for the patient.

Assessment:

- The nurse states their professional, objective opinion considering the current situation and background.

Recommendation:

- Recommend an action plan based on knowledge of patient and relevant data.

(Oppenheimer & Gaines, 2023)

When to document in the medical record

- Any emergent situation
- Patient transfer from clinic to Emergency Department, Inpatient or Procedural unit
- Any time a patient communicates a need or concern.
- Communication with patient or delegate that may require follow up (i.e., leaving a voicemail for patient offering an appointment with the clinic).

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Important considerations BEFORE conducting and/or documenting a SBAR conversation-

- Assess the patient
- Verify current orders for patient care
- Verify important information- Information you should verify includes reviewing chart for past encounter information and any significant laboratory or diagnostic tests and their results.
- Organize your thoughts- before communicating concerns and/or requests to the provider or care team concerning the patient, write down all relevant facts and organize into SBAR format.
- Have patient chart available and easily accessible during conversation and documentation
- Think like a provider- What could the provider's response be to my question? Consider the information that would be most helpful to the provider while considering a resolution to the current situation.
- Include direct quotes from patient and/or delegate where appropriate (including threatening comments and gestures) in the Nursing Note documentation section of chart.

Epic Training Center of Excellence Resources

- Ambulatory: Documentation Only Encounter tip sheet
- Ambulatory Pre-Charting Documentation tip sheet
- Smartlinks cheat sheet
- Telephone Encounter Documentation (Front Desk)
- Epic Documents Ipage
- Abbreviation look up

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Guide to Documenting the Patient's Voice Using Quotes

Table. Guide to Documenting the Patient's Voice Using Quotes

Effect	Example*	Possible Alternative
Probably useful		
Provides important contextual cues or clinical information	Chest pain that "feels like an elephant is sitting on my chest" Spontaneously reported that "this is the worst headache of my life"	-
Conveys the effect of illness on patient's life	Has persistent low mood, endorsing "I don't want to live like this"	-
Conveys patient values or preferences	When discussing treatment goals, she said, "If he cannot breathe without a tube, that will be a sign that he is getting worse. We do not want him to suffer. I want to make sure that we are with him at the end."	-
Probably harmful		
Casts doubt on integrity or competence of the patient to provide reliable testimony	Patient reports pain is "still a 10" Reports she had a "reaction" to the medication	Patient reports pain is still a 10 Reports she had a reaction to the medication
Conveys ridicule, contempt, or frustration by highlighting unsophisticated language or limited knowledge	He hasn't been able to keep food down because "it goes straight through me in the diarrhea" Wound was supposed to be "all closed up" Does not believe he has prostate cancer because his "bowels are working fine"	He hasn't been able to keep food in due to diarrhea Wound was supposed to have healed Is having difficulty accepting the diagnosis of prostate cancer because he expected bowel changes, which he has not had
Potentially misinterpreted		
Neutral phrases where quotes serve no clear purpose but could be read as scare quotes conveying doubt or judgment	She reports that she remains off her cigarettes for "a year" Her cousin states that her living situation is "not ideal"	She reports that she hasn't smoked cigarettes for a year Her cousin states that her living situation is not ideal

* Note that people in different contexts read these examples differently. It is difficult to make prescriptive rules about exactly which patient words should or should not be enclosed in quotes, but it is important for all clinicians to do so thoughtfully and respectfully. All examples cited in this table and in the article are taken from real clinical notes.

Beach and Saha (2021)

References

American Nurses Association. (2010). Retrieved from http://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf

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Oppenheimer, T. H. (2023). What is SBAR in nursing? Retrieved from https://nurse.org/education/sbar-nursing/