Documentation in Nursing and Midwifery: Australian edition

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JAMES COOK UNIVERSITY

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Book cover image for the Australian edition by Eliza Bookall

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Preface

This open access textbook is intended to guide best practices for documentation in the nursing and midwifery profession. This resource is designed for students in undergraduate nursing and midwifery programs, and addresses principles of documentation, legislation associated with documentation, methods and systems of documentation, and key trends in the future of documentation. Incorporated into this resource is legislation and practice standards specific to Australia.

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Customisation

Acknowledgement of Country

James Cook University is committed to building strong and mutually beneficial partnerships that work towards closing the employment, health and education gap for Australian Aboriginal and Torres Strait Islander peoples. Our students come from many backgrounds, promoting a rich cultural and experiential diversity on campus. We acknowledge the Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the Australian lands and waters where our staff and students live, learn and work. We honour the unique cultural and spiritual relationship to the land, waters and seas of First Australian peoples and their continuing and rich contribution to James Cook University and Australian society. We also pay respect to ancestors and Elders past and present.

Kassandra Savage (JCU Alumni), 'Coming Together and Respecting Difference', acrylic on canvas, 2014, 90cm x 90cm. © Kassandra Savage, reproduced with permission of the artist.

Learning Outcomes

After reading this book, you will be able to:

- Describe the purpose for documentation.
- Discuss the ethicolegal and best practice standards for documentation.
- Outline the recommended guidelines for effective documentation.
- Identify and discuss the characteristics of key documentation frameworks.

1. Introduction to Documentation

Documentation is a permanent record of all transactions of care. It includes every form that is completed in relation to the care of the person. Collectively, these forms make available the formal, legal evidence of care provided to the person while they are seeking health care. Documentation also enables communication within the healthcare team. The information recorded in the documentation record is used to improve the continuity of care provided to the person while also assisting in informing the team's decisions about the person's current care needs. Effective documentation within the health record can therefore assist the health professional to provide person-centred care.

Documentation also enhances patient safety as it is a mechanism to communicate assessment findings and decisions made by and within the multidisciplinary team. The accurate and timely documentation forms an important component of a healthcare facility's ability to meet the *National Safety and Quality Health Service* Communicating for Safety Standard (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2021). By documenting, the healthcare team are able to communicate and track the progress or decline in a person's condition over time. The tracking of the person's condition is achieved through recording various assessment findings for the person, relaying the desired treatment plan for the person's current condition, and noting how the person has responded to the implementation of this plan of care. Such information is collected on numerous charts/forms such as those used to record the person's vital signs and fluid balance. **Table 1** provides examples of these different document types.

Table 1: Examples of different document types

Document type	Characteristics found in each document type
Admission form	This form is one of the first items that you will see in the chart/record of a person who is hospitalised. The admission form will vary between facilities, but generally includes demographic information about the person including their name, age, date of birth, gender, Medicare number, contact information/address, admission date, the reason for admission, and the person's emergency contacts (i.e. next of kin). Importantly, the admission form normally identifies and highlights any known allergies. It may also include other health issues, a list of current medications, personal items that may have been brought in with the person (e.g., dentures, glasses, or assistive devices, valuables), and whether the person has an advance health directive in place.
Progress notes	This type of documentation refers to free-text entry space that allows for open-ended documentation. Progress notes include a record of your assessment and care of the person including recording the person's current health status and/or their response(s) to the care provided. Members of the multidisciplinary team all write notes in this same section of the health record. To ensure clear communication within the healthcare team, it is essential that each health professional clearly identifies which discipline they belong to when entering their notes (e.g., Nursing or Midwifery). Nurses and midwives typically follow a specific framework when documenting their progress notes. These frameworks are discussed further in Chapter 5.
Referrals and consultations	Referrals are used to seek expert advice from another health specialty. For example, a general practitioner may refer a person to a surgeon to seek advice on whether surgical intervention is required to treat the person's presenting complaint. Referrals typically contain an overview of the person's presenting complaint, assessments performed to date and any relevant medical, surgical and medication history. Consultation reports communicate the recommendations from the consulting health professional about adjustments to the existing treatment plan. The format is similar to that of progress notes.
Medication administration record	This form is commonly referred to as the MAR and typically includes a list of all medications that are ordered for the person including the medication name(s), dose, route, frequency, the date the medication was ordered, and the date the order will expire. The MAR also details any consideration for administration, such as serum drug level results (e.g., an INR for warfarin administration). In Australia, MARs have been standardised as a strategy to reduce the likelihood of medication errors. There are two main types of the MAR: the National Inpatient Medication Chart (NIMC) and the Pharmaceutical Benefits Scheme Hospital Medication Chart (PBS HMC).
Flow sheet and graphic record	These forms are commonly completed by nurses or midwives and include the documentation of physiological data such as vital signs, pain assessment findings, and weight. These records can also include routine documentation related to intrapartum birth care, hygiene, mobility, nutrition, and pressure area care. They allow health professionals to observe trends in data over time and recognise cues that may indicate the need for further interventions to be implemented.
Nursing or Midwiferycare plans	This form summarises the overall plan of care for the person based on their current condition. The care plan will indicate the anticipated frequency of specific nursing or midwifery interventions (e.g., how often vital signs should be performed, wound care frequency) while also incorporating information about the level of assistance the person needs with regards to their activities of daily living. The care plan must be updated regularly to reflect any changes in the person's condition, and where possible, should also incorporate specific goals that are formulated with the person.
Perioperative patient record	This form details the safety checks that are performed prior to, during and following the person's surgical procedure. It may also include a section detailing the person's specific postoperative orders and observations pre-and post-surgery.

Discharge plan and summaries	These forms generally include information about the preparation for the person's discharge. The documentation found on this form will likely include specific step-by-step instructions that the person should follow when they are discharged such as: • Education about their condition or disease. • A list of medication including the name, dose, route, and frequency as well as adverse effects to watch for. • Guidance surrounding the person's diet (i.e., what they should eat, how often, what they should avoid, fluid restrictions etc.). • Information about mobility and mobility aids, such as specific goals in terms of activity and exercise (amount and frequency), and information about aids such as crutches or a walking stick and how to use them. • Access to resources in the community such as home care assistance, rehabilitation, and meal-delivery services. • Information about when to seek health care if the person experiences specific symptoms, adverse effects, or complications. • Information about appointments related to follow-up care. • The date/time of discharge and how the person will return home (e.g., transportation and whether they are accompanied by someone). Any instructions provided to the person should be clear and written in plain (jargon-free) language that the person can understand.

The documentation format described above is sometimes referred to as a source-orientated medical record. As the type of forms used, their purpose, and their layout all differ slightly between healthcare facilities, nursing and midwifery students must be cognisant of the need to review and adhere to the local policies and procedural guidelines of the facility where they are attending their professional experience placement.

Clinical Insight

Nurses and midwives are accountable to practice in accordance with their facility's policies and procedures. This need is stated in Standard 5.3 of the *Registered Nurse Standards for Practice* (Nursing & Midwifery Board of Australia [NMBA], 2016) and Standard 5.4 of the *Midwife Standards for Practice* (NMBA, 2018c).

Documentation is currently in a state of change as paper-based charts are progressively replaced with electronic health records (EHR) across the Australian healthcare system. Electronic health records involve the use of computers or other digital devices (e.g., tablets) to record clinical data about the person's medical history and their plan of care. EHRs are considered an integrated medical health record and have been designed to improve the quality, completeness, depth, and accessibility of health information provided to patients; enhance the communication between members of the healthcare team; provide increased access to health information for healthcare recipients; and increase the portability of medical records and other personal health information between facilities and with the person. There are numerous benefits for introducing an EHR within an organisation such as: improving clinicians' time efficiency (i.e., multiple health professionals can enter data simultaneously), reducing the risk of errors of omission (e.g., most electronic MARs provide automated notifications/reminders relating to medication timing or when a new medication is ordered thereby enabling timely administration), and decreasing the risk of errors of commission (e.g., the health professional is less likely to misinterpret a specific finding or order related to the person's care as they do not need to decipher another health professional's handwriting). Two main EHR systems currently exist in Australia: the personal EHR (*My Health Record*) and a facility-specific EHR (e.g., *ieMR* used by Queensland Health).

Explanatory Note

The deployment, maturity, and use of EHRs differs among organisations, states, and territories. It is therefore important to note that EHRs are not simple replacements for paper-based medical records.

While data is collected and recorded differently in paper-based records and EHRs, the principles for producing quality documentation are largely the same. These principles are further explained in the later chapters of this book.

2. Indications for Documentation

Documentation is an essential part of healthcare provision in Australia. Documentation is used as a tool to: enhance intra- and inter-professional communication; improve patient safety: improve the quality of healthcare provision (e.g., through risk minimisation and management, education and research purposes); meet the needs of the activity based funding system in Australia; and finally, as a legal requirement. **Table 2** provides additional information about how documentation is used in health care.

Table 2: Indications for documentation

Indication	Purpose
Communication, continuity of care, and clinical judgement	Documentation **communicates clinical information** about a person including data related to their current state of health and illness. The documentation record is therefore a **vehicle of communication** within the multidisciplinary healthcare team. By each member of the healthcare team documenting their assessment findings, the plan of care for the person and the outcomes associated with the care provided with, and to, the person is coordinated and connected. That is, **continuity of care** is better enabled. Additionally, the documented data allows for health professionals to incorporate this information into their clinical judgement and decision-making about the future care needs for the person.
Patient safety	Linked with communication, documentation can assist with **patient safety**. Patient safety involves partnering with other health professionals and recipients to prevent and minimise unsafe acts, reduce harm, and respond accordingly to potential hazards (ACSQHC, 2021). Actions to achieve patient safety involve providing timely, clear, and comprehensive documentation. In doing so, a common understanding about the person is promoted amongst the multidisciplinary team which in turn promotes more effective decision-making about the person's emerging care needs. Documentation can include directives and care plans related to patient safety, such as the use of falls and allergy alerts.
Quality improvement	**Quality improvement** involves constant reflection and commitment to working toward the best outcomes associated with healthcare systems that are safe, effective, person-centred, timely, efficient, fiscally responsible, and equitable. Chart audits and reviews (e.g. hand hygiene audits) aid with the evaluation of healthcare provision and compliance with professional standards such as the *National Safety and Quality Health Service Standards* (ACSQHC, 2021). These quality improvement initiatives can help identify necessary changes in practice and foster evidence-informed approaches to care. For example, a quality improvement study could reveal high rates of incident reports related to falls. The study findings could then prompt the organisation to introduce additional educational sessions about falls prevention.
Funding	Documentation records can influence state and federal **funding** for healthcare delivery. For example, Australian public hospitals are funded using activity based funding whereby hospitals receive funding based on the volume and level of complexity of the patients they treat. It is therefore essential that health professionals (and organisations) maintain clear and comprehensive records of the care and services provided so that each episode of care is assigned the correct Australian Refined Diagnosis Related Group (AR-DRG).
Legal	In addition to supporting high-quality and safe patient care, it is important to consider the **legal aspects of documentation**. The health record is a legal document that provides evidence of the assessments conducted on the person and the care and services provided. The health record may be subpoenaed for proceedings related to cases such as negligent practice, coroner's inquests, violence, child welfare, and criminal offences. These proceedings may take place many years after you have cared for the person, therefore, the health professional is somewhat reliant on their documentation to recall the situation being investigated. Consequently, a health professional's documentation must be clear, accurate, and reflective of the assessment that was performed and the care provided. It may be useful to remember the saying: "If it's not documented, it wasn't done" (i.e., your documentation must be complete, or it will be presumed that care was not provided).
Research	Nurses, midwives and other health professionals sometimes review documentation records as part of their **research**. For example, they may examine factors (e.g., patient satisfaction, health outcomes) related to nurse-sensitive indicators/outcomes. For example, a research project might focus on the impact nurse ratios has on morbidity and mortality rates in a particular unit, or it may analyse documentation notes to assess how nurse-led discharge planning after surgery corresponds to the rates of hospital readmission in a certain population group.
Population and public health insights	A review of health records can provide insight into specific **populations** and **public health issues**. For example, reviews of health records can help health professionals track data and identify trends across patient groups or organisations. These reviews may provide information related to the transmission of diseases and epidemics, the effectiveness of interventions, or complications associated with certain locations or demographic groups. For example, influenza-related hospital admission rates and mortality rates are recorded and tracked each year.

Risk Assessments	The NSQHS standard covering implementation of comprehensive care highlights that to provide person-centred care it is essential to perform regular **assessments** (on admission and at the beginning and throughout each nursing shift). An element of this assessment is performing risk assessments (such as assessing for the person's risk for falls or developing a pressure injury). The type of risk assessments undertaken with the person is dependent on several factors including the person's characteristics (e.g., their presenting problem, age, or comorbidities), their treatment pathway, and each facility's policies and procedures.

Explanatory Note

Documentation is critically important in cases that involve violence because the health record may be used as a source of evidence in legal proceedings. Therefore, nurses and midwives must clearly and comprehensively document their detailed assessment. It is important that you incorporate direct quotes from the person and place them in quotation marks, even if they are expletives (swearing). Photographic images are also necessary to document cases of physical and sexual violence. In cases of bruising, swelling, lacerations, and/or contusions, use a measurement tool as a point of reference. Consult your organisational policies about photography and record-keeping, including guidelines related to designated devices for recording images and how the person is identified in the picture.

Clinical Insight

Nursing informatics refers to processing, storing, and retrieving documented data to optimise healthcare delivery and improve patient outcomes. It is an evolving speciality that uses familiarity with nursing's front line role in a clinical setting combined with an understanding of clinical processes and workflow to maximise data and technology in daily nursing practice.

3. Ethicolegal, Safety and Quality Considerations in Documentation

Nurses and midwives are legally obliged to complete documentation. There is a duty of care **to avoid acts or omissions**, which could be reasonably foreseen to injure or harm other people. This duty of care means that you must anticipate risks for the people you are caring for and undertake preventive strategies to mitigate this risk. A significant component of this process includes timely and accurate documentation to promote communication for safety.

While quality documentation contributes to improving patient outcomes as it enables communication between members of the multidisciplinary team, it also provides the principal form of evidence for any healthcare-related legal case. Consequently, the importance of quality documentation cannot be underestimated. In this chapter we discuss privacy, confidentiality and the legislation pertaining to documentation.

Clinical Insight

Clinical governance is a shared responsibility to ensure that all patients receive the best care. The healthcare team share the common goal of optimising patient care and therefore, share accountability for the care we deliver. Quality documentation assists in demonstrating your professional accountability as it records your transactions of care.

Prior to undertaking a professional experience placement, it is recommended that nursing and midwifery students review the local policies and procedures of the organisation where they are attending placement. However, it is also vital that nursing and midwifery students are also aware of their state/territory's **legislative** and **regulatory requirements** for documentation including being familiar with the appropriate laws that legislate the collection, use, and disclosure of personal health information by health information custodians. Health professionals are bound to comply with these Acts as found in **Table 3.**

Table 3: Relevant Australian Acts related to the protection of personal information

Location	Legislation
Australia	Freedom of Information Act 1982 (Cth) Australian Privacy Principles 2014
Australian Capital Territory	Privacy in the ACT
New South Wales	Privacy and Personal Information Protection Act 1998 (NSW) Health Records and Information Privacy Act 2002 (NSW)
Northern Territory	Information Act 2002 (NT)
Queensland	Information Privacy Act 2009 (Qld) Right to Information Act 2009 (Qld)
South Australia	Information Privacy Principles
Tasmania	Personal Information and Protection Act 2004 (Tas)
Victoria	Privacy and Data Protection Act 2014 (Vic) Health Records Act 2001 (Vic)
Western Australia	Freedom of Information Act 1992 (WA)

Personal health information is defined as specific information about an individual in oral or recorded form that relates to physical or mental health, provision of health care (including identifying a provider of health care), a plan of service, donation of body parts or bodily substance, payments or eligibility for healthcare, medicare number. Personal information is kept private. People have a legal right to this privacy, and there are laws that guide health service providers in how information about the health of individuals is collected, recorded, stored, and when and how this information can be used and shared. My Health Record (MHR) is an Australian system of personal health information that can be viewed securely online, from anywhere, at any time. Individuals can choose to share their health information with the health professionals involved in their care. The individual can manage your My Health Record by adding their own information and choosing their privacy and security settings.

Confidentiality ensures people or entities protect another person's or entity's information that has been conveyed in confidence and which is not readily available to the public. 'Medical confidentiality' obliges a health professional to protect (limit access to) the information discussed in confidence between themselves and a patient or client. There is no specific confidentiality legislation in Australia, so in a strictly legal sense it is governed by 'common law'. However, there is a commonly understood duty for confidentiality that is found in various professional standards and governance documents. For nurses and midwives, this information is made clear through the NMBA's key codes and guidelines including the *Code of Conduct*

for Midwives (2018a), the *Code of Conduct for Nurses* (2018b), *The ICN Code of Ethics for Nurses* (2021), and the International Confederation of Midwives' *International Code of Ethics for Midwives* (2014). Exemptions apply in the case of mandatory reporting (such as notifiable diseases or suspected child abuse) and in the presence of a subpoena as a result of judicial discretion.

Clinical Insight

People's information can only be disclosed on a need to know basis or in cases of mandatory reporting

Security of information is maintained through the clear guidelines of each hospital or health facility. These policies are based on appropriate legal principles. With the rise of electronic information, mail and communication systems in the healthcare environment, health organisations are focused on maintaining safe and secure systems to preserve the confidentiality of personal health records. Clinical staff are advised how to maintain safe and secure use of electronic information systems in accordance with their employer's guidelines.

Explanatory Note

When you access an electronic health record, your digital identity/footprint is attached to that record. This means that you should only access records of patients that you are looking after. For example, if you were to access records of family, friends or 'an interesting case', and you decided to read the case notes 'out of interest' then that EHR will show your name as having accessed the patient's record. This is a breach of the code of conduct, if you are not directly involved in their care. If the case ended with court proceedings, then you could potentially be called as a witness because your name is linked to the patient's documentation and therefore it would be assumed that you were involved in their care.

Ownership of healthcare records is held by the healthcare facility where the individual is being treated. It does not belong to the person or an individual health professional (Staunton & Chiarella, 2017). The Office of the Australian Information Commissioner (OAIC) provides useful guidelines in relation to the Freedom on Information Act 1982, which gives individuals the right to request access to government-held information. This right is supported by the Privacy Act (1988) and the subsequent 2014 Australian Privacy Principles. Principle 12 sets out specific details about access to personal information.

4. Documentation Principles

All health professionals are obliged to document the outcomes of their patient care encounters in a timely and accurate manner. While this is a central premise to producing quality documentation, each organisation will stipulate slightly different documentation guidelines. In this chapter, the general principles for effective paper-based and EHR documentation are presented.

General principles for documentation

General considerations for documenting include:

- Documentation should detail information such as assessment findings, risks related to care, the plan of care for the person, modifications to the care plan, interventions performed, and an evaluation of care provided.
- Omissions of care need to be documented including the reason why a particular intervention was omitted (e.g., the person refused an intervention).
- Documentation should be written or entered contemporaneously—it should occur at or near the time of the event, episode of care or when the encounter took place. Do not wait until the end of your shift to document, and never document prior to providing care.
- Documentation must be recorded chronologically.
- Documentation must be relevant, individualised, and specific. Avoid being verbose—extraneous information should be omitted.
- Do not 'double chart': avoid duplicating information on multiple forms including repeating information that has been documented on a care plan or clinical pathway in your progress notes.
- Only use abbreviations and symbols that are included on an approved list of the organisation where you are attending professional experience placement. Do not use abbreviations if you are unfamiliar with the organisation's list of approved abbreviations as there is the risk that an abbreviation may be misinterpreted by others (e.g., the abbreviation LOC could mean 'level of consciousness' or 'loss of consciousness'). If in doubt, write the word or statement in full.
- The information must be recorded on an approved clinical record document/program.
- If a retrospective entry is made, you must include the date and time in which the event occurred and the date and time that the entry was made.
- Avoid criticising others in your documentation.
- Never correct another health professional's documentation, even if it is inaccurate.

Clinical Insight

The FACTUAL mnemonic may assist in applying these core principles to your documentation:

Focused on the person
Accurate
Complete
Timely
Understandable

Always objective
Legible

Tips for improving objectivity

- Only document your own observations and actions. Do not document the observations and actions of other health professionals or on their behalf except in situations where you are a designated recorder, such as being a scribe during a Medical Emergency Team (MET) call.
- Avoid using words such as 'fine', 'good', 'poor', 'normal', 'large', 'abnormal', 'regularly', 'improved'. Instead, report objective data, specific dimensions, amounts or measurements, and use recognisable systems of measure (e.g., peripheral pulses 2/3 bilaterally in all limbs, 2cm x 2cm bruise, voided 400 mL in the last 6 hours) as this information is more meaningful and quantifiable to others.
- Use anatomical landmarks to report findings (e.g., right upper quadrant of abdomen).
- Report what you can observe not your opinion or interpretation of the situation (e.g., avoid using vague statements such as 'appears', 'looks like', 'seems'; see **Table 4**).
- When including others' accounts of the situation (e.g., the person's report of pain or nausea), place these statements in quotation marks.

Table 4: Examples of how to improve the objectivity of your documentation

Subjective example	Objective example
"James is non-compliant." *In this example, it is the nurse's opinion that James is non-compliant.*	"James refused his medications." *In this example, the nurse states what occurred during the medication round. This statement is free from judgement.*
"Jill is miserable." *In this example, it is the nurse's interpretation that Jill is miserable.*	"Jill is crying." *In this example, the nurse states the physical behaviour displayed by Jill. This statement is objective and therefore more accurate.*

Considerations when documenting by hand

- Ensure each page of the document includes the person's name, date of birth, and unique record number (URN).
- Patient identification labels can be used but they must not be placed over the top of an existing label.
- Prior to commencing an entry, check that the health record chart you have selected is the correct one by confirming the person's name, date of birth and URN.
- Make sure your writing is legible so that it can be read and understood by others. Consider printing if your cursive writing style is difficult for others to read.
- Write in complete sentences and ensure your entry is free from grammatical and spelling errors as such mistakes may lead to unnecessary or missed interventions.
- Black, insoluble ink must be used when documenting unless another colour has been stipulated and approved (e.g., when documenting for a specific observation). Black ink is used as it is less like to fade than other colours over time and it also yields the best photocopies.
- Gaps within the record or entry should be avoided:
    - If there is insufficient space to write a word in a progress note, draw a line and continue your note

in the next space. Draw a line to fill in any space after your signature and designation at the end of the note.
    - If the health record is unavailable at the time of documenting resulting in a gap in the progress notes, draw a diagonal line through the blank page or section to prevent other staff from using this space.
- The date should be written in dd/mm/yyyy format and times must be written using the 24-hour clock (also called military time; see **Figure 1)**.
- When documenting vital signs, medication administration, or other procedures, you should note the time that the task was performed.
- Each progress note entry should include information about the date and time that the entry was made.
- Errors in written documentation must remain visible. Do not scribble over the error or use correction fluid. Unless there is a specific organisational policy, draw a single line through the error and initial it. Some organisations have policies such as writing the word “error” above or near the error and indicating the date and time the correction was made.
- At the end of the entry, the author must sign their name followed by their printed surname and initials and designation (e.g., registered nurse, midwife, enrolled nurse, nursing or midwifery student).
- Additional details such as information about an external agency or a contact number may be added after the signature where appropriate.
- Health professional students must have their documentation witnessed by a registered health professional (e.g., a nursing or midwifery student must have a registered nurse/midwife review and countersign their documentation.

24-hour clock	Standard time	24-hour clock	Standard time	24-hour clock	Standard time
0000	midnight	0800	8 am	1600	4 pm
0100	1 am	0900	9 am	1700	5 pm
0200	2 am	1000	10 am	1800	6 pm
0300	3 am	1100	11 am	1900	7 pm
0400	4 am	1200	Noon	2000	8 pm
0500	5 am	1300	1 pm	2100	9 pm
0600	6 am	1400	2 pm	2200	10 pm
0700	7 am	1500	3 pm	2300	11 pm

Figure 1: The 24-hour clock and standard time

Clinical Insight

The 24-hour Clock

Understanding the 24-hour clock can be confusing after 1 pm (standard time). Simply add or subtract when converting. For example, if the standard time is 2:15 pm, add 12 hours for the 24-hour

clock time of 1415 hours. If you are provided the time of 2230 hours, subtract 12 hours for the standard time of 10:30 pm.

Considerations when documenting in an EHR

- EHRs capture your digital identity and time stamps of your activities.
- EHRs differ in terms of layout and interface. Structured fields (e.g., vital signs parameters) must be entered according to the specific value format of the field. When entering data into unstructured fields (e.g., progress notes), follow the guidelines for handwritten documentation.
- Do not share your password with others.
- Do not enter data using somebody else's password.
- Do not walk away from the computer once you are logged in.
- If using a template for progress notes, ensure you update it so that it is individualised and provides an accurate description of the care provided for the person.

Explanatory Note

Signing your documentation by hand

Your university will provide further details about what additional information you should include when signing your documentation but generally it will include your signature, full name, university's name, and year level. Remember to have your supervising registered nurse or midwife countersign your documentation prior to leaving your shift.

Signing documentation in an electronic health record

It is essential to check for unsigned documentation and medications. Most systems will post an alert in the message centre to highlight any unsigned medication or documentation which needs to be signed off prior to the end of the shift.

5. Documentation Frameworks

Several **methods of documentation** are used to organise a nurse's or midwife's progress notes. Decisions about which method or framework you use may depend on the facility's policy and procedural guidelines for documentation. Otherwise, it is a matter of personal preference.

In this section, four documentation frameworks are presented: charting by exception, narrative, problem-focused, and systems-based documentation. Another method that is sometimes used to inform documentation is ISBAR (Identification/Introduction, Situation, Background, Assessment, and Recommendation), however this framework is typically used for verbal communication such as handover.

Charting by exception

Charting by exception (CBE) may be used in some health care facilities, particularly when a clinical (care) pathway or care plan has been implemented to inform and guide the care provided to the person. With CBE, the length and duplication of information are reduced as the healthcare team will follow a pre-determined treatment plan (i.e., a clinical pathway). While a health professional may need to make small notations about some aspects of care (e.g., ticking, initialling and dating when a specific assessment or intervention has occurred), the health professional will only expand on their documentation when a variation in the anticipated findings, routine care or care outcomes transpire. For example, the anticipated finding for a post-surgical pathway may be no signs of wound infection. If the person's postoperative wound showed no signs of infection during the dressing change, the nurse who was using a CBE approach would indicate the wound care was performed on the pathway but there would be no need for them to provide additional information about the appearance of the wound on the post-operative surgical pathway or progress notes. In contrast, if the nurse found signs of a possible wound infection they would need to make additional notes in the person's health record to describe their observations of the wound. For example, indicating whether the wound is exhibiting signs of infection such as redness, swelling, and/or purulent discharge.

Narrative documentation

Narrative documentation uses a chronological approach whereby information is documented in a **storied** format and **sequential order**. For example, you would document when the person's symptoms first started, what interventions were initiated and why, and how the person responded to these interventions. A storied format involves attending to 'the what,' 'when,' 'who,' and 'how' of the event that you are documenting about such as describing what happened when it happened, who was involved, how the person responded and so forth. For example: 'Joan is an 8-year-old girl who fell off her bike while riding with her mother, Jessica, to the corner store. Jessica reports Joan experienced a loss of consciousness for approximately 10 seconds and was confused when she awoke. Joan then voiced to Jessica that she had "I have a sore head, Mummy" within 20 minutes of the fall. Jessica brought Joan to the emergency department within 40 minutes of the fall.' As you can see, this example is both chronological and storied. Traditional narrative style documentation must also include any change in the person's condition and their response to the treatment or care provided.

Problem-focused documentation

Problem-focused documentation uses the **nursing process (or the process of woman-centred care)** to inform the nurse or midwives' reporting of patient care delivery and outcomes. Using this approach, the nurse focuses on the person's **issue/concern/problem** including describing what assessment data was

collected to evidence this problem. The nurse will then outline the plan of care that was used to address the problem and the evaluation criteria used to assess the care plan's effectiveness. Several mnemonics can be used to inform this documentation style:

- Focus charting or DAR (data, action, response) or DAE (data, action, evaluation)
- AIR (assessment, intervention, response)
- APIE (assessment, plan, intervention, evaluation)
- SOAP (subjective, objective, assessment, plan) and its derivatives including:
    - SOAPIE (subjective, objective, assessment, plan, intervention, evaluation)
    - SOAPIER (subjective, objective, assessment, plan, intervention, evaluation, revision)

Table 5 presents an overview of each of these frameworks.

Table 5: Common problem-focused documentation frameworks

Framework	Main characteristics
DAR	**Data:** Objective and subjective assessment data that describe the focal area are identified. **Action:** The immediate and future nursing/midwifery actions/ interventions that will address the area of concern are described. **Response:** Outlines the person's response to the care provided.
APIE	**Assessment:** The subjective and objective assessment data are summarised and issues are identified. **Plan:** The formulated plan of care based on this data is outlined including presenting the goals that have been developed with the person. **Implementation:** Describes the specific measures taken to facilitate the person in reaching their goal(s). **Evaluation:** Outlines the effectiveness of the implemented interventions including the person's response.
AIR	**Assessment:** The subjective and objective assessment data are summarised and issues are identified. **Intervention:** A summary of the nursing/midwifery actions in response to the assessment data are described. **Response:** Outlines the effectiveness of the implemented interventions including the person's response.
SOAPIER	**Subjective:** Any information that is stated by the person or their family (e.g., "My leg is very sore around the wound"). **Objective**: Data that is measured or observed by the healthcare team (e.g., *The skin surrounding the wound is red, hot to touch, and swollen*). **Assessment**: Conclusions are drawn based on the subjective and objective data collected. (e.g., *Impaired comfort related to inflammation of the tissue secondary to injury*). **Plan**: Details the strategies employed to alleviate the person's problem. It may include both short- and long-term goals. **Interventions**: Describes the specific measures taken to facilitate the person in reaching their goal(s). **Evaluation**: Outlines the effectiveness of the implemented interventions including the person's response. **Revision**: This step involves modifying or updating interventions if the original interventions were not fully effective.

Systems-based documentation

Systems-based documentation uses a framework where information related to the person's current concerns and related assessment data is recorded against each specific body system. The body systems typically reported include the central nervous system (CNS), cardiovascular system (CVS), respiratory system (Resp), gastrointestinal system (GIT), metabolic, genitourinary (GUT), integumentary (Skin), musculoskeletal (MSK). The person's experience of pain and its management may be reported under CNS or the affected

body system. **Appendix 1** provides an example of data that may be included under each of these systems. When using this approach, the nurse may also report additional data about the person (e.g., wellbeing, support structures) and their care (e.g. additional procedures planned/performed, discharge considerations) using headings such as other, psychosocial, care planning, or discharge planning. A midwifery systems approach for an antenatal assessment is also included in **Appendix 2**.

An example of a completed progress note using this format is presented in **Appendix 3.** There is also an example of a poorly constructed progress note in **Appendix 3**. See how many mistakes you can identify in this example.

Clinical Insight

Check the policy and/or procedure of the facility that you are working in to ascertain their preference for documenting and follow these guidelines while you are attending placement or working in this healthcare facility.

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Glossary

Accountability	A principle of professional practice. It is being responsible for your own actions and decisions made in the process of providing nursing care.
Australian Commission on Safety and Quality in Health Care (ACSQHC)	An organisation that works to attain a safe and reliable health system of high standards. ACSQHC works with patients, consumers, clinicians, managers, policymakers and healthcare organisations to achieve these standards.
Australian Health Practitioner Regulation Agency (AHPRA)	An organisation that protects the public by regulating Australia's health practitioners in partnership with national boards (for example NMBA).
Chart	A person's medical record. It is a legal document that records evidence of the care provided to a person.
Charting	The act of entering information into the person's medical record.
Charting by exception (CBE)	A system of documenting only the important and new aspects of the person's status and care. Norms are not included in the notes.
Clinical governance	The systems used by a healthcare facility to enable clinicians and managers to monitor and remain accountable for the safety, effectiveness and quality care of people (for example, charting and incident reporting, contributing to a multidisciplinary team to ensure that patients receive comprehensive care through effective communication).
Clinical pathways	Also known as standard care plans, provide a standardised plan that outlines the nursing care required for a person with a specific diagnosis (acute coronary syndrome).
Communication	An exchange of information or ideas through speaking, writing or other forms (such as signs).
Confidentiality	A set of rules whereby law any information a person provides to their healthcare team will be kept private unless the person provides consent for disclosure to others.
DAE	Is similar to DAR, however, evaluation (E) replaces response in this framework.
DAR	Is a form of focus charting. The focus is the nursing diagnosis, data (D) is collected from the person (subjective and objective), actions (A) are implemented based on the person's condition, and the response (R) to the actions are evaluated for efficacy.
Duty of care	Is the responsibility to prevent harm, by avoiding acts or omissions that could be reasonably foreseen to harm other people. Healthcare professionals must anticipate risks for the people in their care and prevent harm from happening.
Electronic health record (EHR)	A digital version of a person's medical history, that is maintained by the healthcare professional over time. It allows healthcare professionals to simultaneously access and update patient information, It can include all the key clinical data relevant to the persons care, including demographics, progress notes, problems, medications, vital signs, past medical/surgical l history, immunisations, laboratory results and radiology reports. An example of an EHR is iEMR (integrated electronic medical record) used by Queensland Health which has such features as the vital signs being automatically uploaded to the persons' record, triggering early warning alerts if that person's condition deteriorates.
Incident reports	As part of risk management and reporting facilities will have a system for documenting actual or potential injuries, incidents and accidents in the workplace.
Information technology	This includes all digital technologies that support the electronic capture, storage, processing, and exchange of information used to promote health, prevent illness, treat disease, manage chronic illness. It includes systems such as telehealth. EHR, AusLab, EDIS, and other health digital platforms.
Integrated medical record	A chronological record of the person's care, on an integrated system used by all healthcare professionals for that individual.
ISBAR	A structure for providing and efficient and effective verbal handover (for example at shift change, or to escalate the care of a deteriorating patient).
My Health Record (MHR)	An online summary of your key health information that can be viewed securely by individuals and their health professionals across Australia.

Narrative documentation	A diary or story format (sentence structure) in chronological order. It is used to document the patient's status, care, events, treatments, interventions, and the patient's response to the interventions.
National Safety and Quality Health Service (NSQHS) Standards	Aset of national standards to protect the public from harm and to improve the quality of health service provision.
Nursing informatics	Integrates information and communication technologies into nursing knowledge and data to promote the health of people, families, and communities.
Nursing and Midwifery Board of Australia (NMBA)	In conjunction with AHPRA is responsible for setting standards and policies that all registered health practitioners must meet (for example, professional registration, professional codes, standards and competency issues for all nursing and midwifery registrations in Australia).
Nursing process	A systematic method of planning and implementation of nursing care.
Objective data	Information that can be observed or tested. It can be seen, heard, smelled or felt, such as palpating a pulse or auscultating a blood pressure.
Person-centred care (PCC)	Places the person at the centre of the nurse's focus. The nursing care provided meets the individual needs and concerns of the person, leading to improved quality and safety of care provided and better outcomes for the person.
PIE	Is part of the nursing decision-making process. A problem (P) is formulated based on the data collected, interventions (I) are put into place, followed by an evaluation (E) of the effectiveness (or ineffectiveness) of the interventions.
Policy	A set of rules to outline the appropriate management of a situation that occurs frequently.
Privacy	The legal right that ensures your personal information is kept private.
Problem-orientated (or problem-focused) documentation	Information is recorded according to the person's identified problems.
Progress notes	Entries that are made into the person's medical record (chart) by all health professionals who are involved in the person's care. These entries are used to record the person's problems, treatment and progress to ensure continuity of care.
Quality improvement	Activities undertaken by the facility to ensure that organisational processes are continually improved to meet consumer needs.
Recording	The action of writing entries into a person's individual medical record.
Report	Conveying information to other health professionals about a person. It may be oral, written or electronic.
Right	A legal term that describes a person's entitlement (the right to privacy).
SOAP	A form of narrative documentation. It provides a structure for the nurse to follow to guide the inclusion of subjective data from the person (S), objective data about the person (O), assessment of the person (A) and the plan of care (P).
Source-orientated record	Is used by a specific department to make a notation in a specific area of a person's chart structured data elements. Refer to built-in templates or structures that guide the type of data to be entered in a specific field.
Subjective data	A statement by the person that relays how they are feeling (I feel nauseated and I have pain in my left side).
Unstructured data elements	Refers to free-text entry that allows for the open-ended documentation of patient data.

Appendix 1

Systems Approach – Documentation Guidelines

SITUATION/SUMMARY: Start notes with a quick summary of any significant events of shift, or the reason for nursing entry (eg admission, surgery, MET call, significant clinical change or treatment).

NEUROLOGICAL:

- Level of consciousness (Glasgow Coma Scale)
  - Alert and oriented to person, place, time
  - Delirious
  - Confusion
  - Lethargic
  - Stuporous (responds to painful stimuli?)
  - Comatose
- Pupil assessment – size (mm), shape, reactivity, EOMs, accommodation
- Motor movement – spontaneous, tremors, (posturing)
- Motor strength – motor scale 0-5
  - 0/5 = no movement or evidence of muscle contraction (flaccid)
  - 1/5 = no movement; some evidence of muscle contraction
  - 2/5 = movement with gravity eliminated
  - 3/5 = movement against gravity
  - 4/5 = movement against some resistance (generalised weakness)
  - 5/5 = movement against full resistance (normal)
- Sensory assessment
- Coordination assessment (if indicated)
- Cranial nerve assessment (if indicated)
- Visual deficits
- Auditory deficits
- Pain assessment
- Sedation
- Mental state/behaviour

Ask about and record response for associated signs/symptoms – headache, seizure activity, communication problems, verbalisations, affect, memory issues/problems, aphasias, numbness, paraesthesia, change in balance.

CARDIOVASCULAR:

- Heart rate (beats/min)
- Heart rhythm – regular/irregular.
- Cardiac auscultation – S1 and S2 heard? Any murmurs?
- BP (range)
- Temperature/colour/moisture of extremities
- Peripheral pulses (strength: 0, +1, +2, +3). Check all peripheral pulses bilaterally.
- Capillary refill x 4 extremities
- Oedema – generalised, dependent, pitting
- Diaphoresis

- ECG

Ask about and record response for associated signs/symptoms – chest pain, leg cramps, SOB, palpitations.

RESPIRATORY:

- Rate, rhythm, depth, work of breathing
- SpO2, oxygen use?
- Accessory muscle use, breathing through pursed lips?
- Thoracic excursion (i.e. chest expansion symmetrical?)
- Abnormal chest shape/size
- Tactile fremitus present?
- Breath sounds (presence of normal or adventitious breath sounds – describe)
- Sputum

Ask about and record response for associated signs/symptoms: orthopnoea, dyspnoea – (at rest and/or with exercise); cough (present, not present) (productive or non-productive); sputum – colour, consistency, amount, changes (increasing/ decreasing).

INTEGUMENTARY:

- Describe as dry/warm/cool/cold
- Colour (pallor, cyanosed, jaundiced, erythema)
- Turgor (sluggish, brisk)
- IV sites – type of catheter, gauge, number of lumens; location, when placed, site description, dressing (dry and intact); erythema, oedema, pain or heat at site?
- Describe abnormalities – scars, lacerations, erythema, oedema, pain, ecchymosis, abnormal hair loss, wounds [shape, size, location, depth, colour, exudate (colour, consistency, odour, amount)].
- Modified Waterlow Pressure Ulcer Risk score
- Pressure area pathology described and staged
- Hygiene requirements

Ask about and record response for associated signs/symptoms: pruritus.

GASTROINTESTINAL/METABOLIC:

- Current diet ordered (or usual diet regulations); amount currently eating (percentage)
- NGT/PEG – feeds or drainage
- Fasting or nil orally
- Dysphagia (solids, liquids, both)
- BMI, weight (stable or recent loss/gain)
- Bowel sounds – hyperactive, hypoactive, or present in all 4 quadrants
- Bowel habits – changes in colour, blood present, consistency, Bristol stool chart classification
- Abdominal palpation: masses? tenderness? guarding? soft/firm/rigid?
- Abdominal distension (present or not), girth measurements?
- BGL (if indicated)

Ask about and record response for associated signs/symptoms – nausea, vomiting (amount, colour, related to anything), diarrhoea, constipation, cramping, eructation, flatulence, haemorrhoids, usual frequency of stool. Describe consistency, colour. Any recent changes, any routines or aids used to maintain regularity.

FLUID REGULATION:

- Input for this shift/output for this shift, 24 hour intake/output, positive or negative balance?

- IV fluid – solution, rate, additives

Ask about and record associated signs/symptoms – moist mucosa, skin turgor, thirst.

GENITOURINARY:

- How is patient voiding? E.g. voiding spontaneously, with IDC, urinal, bedpan, uridome, incontinent
- Urine – describe amount, colour, clarity, odour + urinalysis (specific gravity, urine glucose/ketones, protein, blood, bilirubin, nitrates). MSU, bladder irrigations

Ask about and record associated signs/symptoms – dysuria, nocturia, polyuria, anuria, oliguria.

MUSCULOSKELETAL:

- Muscle mass, tone, symmetry of muscle size?, presence of tremor? Contractions?
- Range of motion
- Splints, protective devices in use (document times on/off)
- Prostheses
- Alignment
- Mobility/immobility, gait
- Falls risk assessment

Ask about and record response for associated signs/symptoms – pain, weakness, spasm, abnormalities – joint deformities, spinal deformities.

PSYCHOSOCIAL:

- Family, visitors, discussions
- Emotional or mental health considerations
- Acute Resuscitation Plan

RECOMMENDATIONS:

- Planned procedures
- Medical requests
- Alterations of medication
- Discharge planning (referrals, appointments, home support, medications)
- Tasks yet to be completed or that need follow up

Revised TL 2015, EW 2020, EW 2022

Adapted from St Vincent's Hospital, Melbourne. svhm.org.au. October, 2020

Appendix 2

Pregnancy Systematic Approach for Antenatal Assessment – Documentation Guidelines

Situation/reason for presentation summary – Start notes with a brief summary of any significant events that led to today's presentation (e.g., pv bleed, fall, reduced fetal movements).

Current pregnancy details:

- Model of care
- Allergies
- Gravida/parity
    - Gestation
    - EDD
        - Placental location
        - Bloods –
            - Group & antibodies
            - Serology
            - Vaccinations
- Obstetric history – previous delivery gestation/mode of delivery
- Current medications

Risk factors including management plan

- GBS status
- Weight
- Antenatal VTE score
- Diabetes
- Abnormal Ultrasound findings
- PPH risk
- 3rd/4th degree tear
- Other risks

Observations on arrival

- Temperature
- Pulse
- Resp rate

· BP

· Urinalysis

Ask about and record for associated signs/symptoms (Hypertension– headaches, blurred vision, epigastric pain, oedema) (Febrile – urinary symptoms, maternal/fetal tachycardia, contractions)

Abdominal palpation

· Fundus – lie, presentation/attitude, position, engagement

· Fetal movements

· Fetal heart rate

Adopted from Queensland Health Antenatal Assessment documentation sheet (V.4)

Appendix 3

Here is an example of good documentation

JAMES COOK UNIVERSITY HOSPITAL INPATIENT PROGRESS NOTES	JCU Health Service KING 2678356 Susan F 12/02/1939 87 Clifton Street Aitkenvale 4814 PH (H) 47252356
DATE AND STAFF CATEGORY	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
23/02/21 1430 hours Nursing	SITUATION: Susan is Day 3 following administration of t-PA. NEURO: Drowsy, easily roused. Orientated to time, place and person. Pupil size 4 mm, round and reacting briskly to light. EOMs intact. Motor movement spontaneous and motor strength 5/5 in left side and 3/5 on right side. Nil pain reported. CVS: T38^{0}C. Dr Jarvis notified of increased temp. P80 beats/minute and regular, BP 140/90 mmHg. S1 and S2 heard, no added sounds. Radial and dorsalis pedis pulses 2/3 equal bilaterally. Posterior tibial pulse 3/3 both sides. Capillary refill < 3 seconds in all limbs. Peripheries warm to touch. TED stockings in situ. RESP: Rate 20 breaths/minute, $Sp0_2$ 99% on room air. Air entry equal and normal sounds heard in all lobes. No adventitious sounds. Susan is aware that a sputum specimen is required. GIT: Commenced on low fat, low cholesterol diet, tolerating well and eating approximately 80% of meals. Susan stated she would like to see dietician re diet. Abdomen soft non-tender in all four quadrants. Bowel sounds heard in all quadrants. Bowels open this morning, moderate brown Type 4. Weight 60kg. BMI 24. GU: Continent but states burning feeling when voiding, Urine SG: 1015, pH 7, trace protein, +ve leukocytes, +ve nitrates. MSU collected and sent. INTEGUMENT: Skin warm, pink, skin turgor normal. IV cannula in situ in right forearm, no redness, swelling, pain. No reddened pressure points. MUSCULOSKELETAL: Muscle mass and tone appropriate for age. Needed assistance to the shower due to mild right-sided weakness. Performing active limb exercises 2 hourly while in bed. PSYCHO-SOCIAL: Visited by daughter. Susan and her daughter concerned about patient returning to work as she doesn't have sick leave. Social worker contacted to discuss with Susan. PLAN: Sputum MC&S ordered and awaiting collection. Contacted dietician who will see Susan this afternoon. Await results of MSU. ANurse (A.Nurse, 1st year nursing student, JCU). AnnieBody (A.Body,RN) --

Here is an example of poor documentation

JAMES COOK UNIVERSITY HOSPITAL INPATIENT PROGRESS NOTES	Surname Jones U.R. No. Given Names Tom Sex M D.O.B. (Affix Patient Identification label Here)
DATE AND TIME	PROGRESS NOTES ALL NOTES MUST BE CONCISE AND RELEVANT
14/2/22 1120 Nursing	Pt described a feeling of a "sharp pain" over their heart and rated it a ~~[illegible]~~ 8/10. Pain began about 30 mins ago and thinks they are "having a heart attack" Reported no history of heart disease or hypertension Mark Meadows.