KRISP Project
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Public Health Nursing
prepare | inform | assist

Documentation for Public Health Nurses
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Multiple Purposes of Documentation:
Serves as a description of exactly what happened.
Becomes legal written documentation of a client's condition/status, interventions, and outcomes. Admissible in court as evidence.
Basis for evaluation of quality of care received and to improve the quality of care.
Creates an individualized and systematic plan of care.
Communicates to health care team/providers the standardized plan of care.
Assists in the determination and justification of compensation for services.
Can be used as data for research and educational purposes.

Standards for Good Documentation
Should be individualized and reflect the client as an active participant in his or her plan of care.
Should demonstrate the PHNs commitment to providing safe, effective, and ethical care.
Demonstrates that the nurse has applied within the therapeutic nurse-client relationship the nursing knowledge, skill, and judgment required by LHD and professional standards regulations.
Provides a comprehensible representation of the client's needs, goals, interventions, outcomes and evaluation of those actions.
Prioritizes the plan of care and diagnoses for a client.
Reflects the nursing process with measureable outcome and evaluation criteria.
Describes quality of care provided.
Maintains confidentiality of client health information, including passwords or information required to access the client's electronic or paper health record.
Demonstrates adherence to policies, standards, and legislation related to confidentiality
Minimizes duplication of information in the health record.
Must be clear, concise, objective, and free of personal bias.
Includes diagnostic statements (collaborative problems or nursing diagnoses), goals (outcome criteria) or nursing goals, nursing orders or interventions, and Evaluation (status of diagnosis and client progress).

SOAP acronym and descriptions
S - Subjective Data
What the patient tells you about the problem; usually expressed in the

client's own words and gives exactly what the patient states is the problem.

O - Objective Data

Observations made by the nurse that support or are related to the subjective data; may include physical assessment/findings; includes observation of the physical, psychological, social, or environmental situation of the client.

A – Assessment, includes Nursing diagnosis

The nurse's interpretation of the client's problem/condition; reflects analysis of both the subjective and objective data leading to conclusions regarding the client's complaint or problem.

P – Plan

The plan for dealing with the problem/compliant or situation; include comfort measures, referrals and advocacy, notifying physicians, type and topic of patient education, and other interventions; be concise yet descriptive so that others could carry out the plan.

Documentation Procedure

Make entry as soon as possible after the care or event.
Include patient identification (name, DOB, ID #, etc).
Date the entry.
Put entries in chronological order, indicating when an entry is late as defined by organizational policies.
Write legibly in black or blue black ink or type into electronic record.
Provide a full signature or electronic signature per the organizational policy, using only approved personal initials.
Write in past tense.
Use only abbreviations approved by the organization.
Use legal/standardized correction procedures for an entry error.

DO-Draw a single line through incorrect information.
DO-Write your initials above the strikethrough line.
DO NOT-Erase or use correction fluid; do not use delete in electronic records
DO NOT-Skip lines.
DO NOT-Write between lines.
DO NOT-Chart for someone else.
DO NOT-Leave blank lines above signature.

References

Carpenito-Moyet, L. J. (2004). *Nursing care plan and documentation: Nursing diagnoses and collaborative problems* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Cheevakasemsook, A., Chapman, Y., Francis, K., & Davies, C. (2006). The study of nursing documentation complexities. *International Journal of Nursing Practice*, 12(6), 366-374.