

Documentation

The patient record is the legal document of care provided and the patient's response to that care. The role of nursing in documentation is to record all nursing assessments and interventions as well as the effectiveness of the interventions. Documentation in the patient record is an essential means of communication with health care team members.

There are many reasons for nursing documentation.

- First and foremost, the medical record is a communication tool for multi-disciplinary clinicians to record their assessments and plan of care, which enhances continuity of care for the patient. Nursing acknowledges their unique contribution to the patient's care along with the effectiveness of the interventions in assisting the patient to achieve optimal outcomes. Clinicians document patient's problems including any reason for longer length of stay, which may impact discharge.
- Secondly, as a legal document, the medical record reflects nursing care provided to the patient along and the patient's response to the care. The medical record may also be a valuable reference relative to disability and personal injury claims as well as workers compensation cases.
- Third, the medical record is the primary method for reimbursement. Third party payers review the medical record to make determinations regarding need for hospitalization and reimbursement. Insufficient or the absence of documentation may be the cause of nonpayment to the hospital. In the future, reimbursement for nursing services will be based on documentation contained within the medical record.
- Lastly, documentation is a Joint Commission of Accreditation of Healthcare Organizations (JCAHO) mandate for accreditation of the hospital.

Diagnostic reasoning is the reflective process the nurse undertakes in critically analyzing data based on the nursing dataset and ongoing assessment to identify patient problems and plan care. The primary method of documenting identified problems is the problem list, which can be based on nursing diagnoses or medical diagnoses.

Interventions are part of the patient's individual's plan of care. The nurse formulates interventions that address problems identified on the problem list.

Outcomes are the goals identified by the nurse in conjunction with the patient to achieve optimal level of functioning.

Patient education provides the patient and family with specific knowledge and skills they need to meet the patient's ongoing health care needs upon discharge. This is documented in the patient record in regards to the problem "knowledge deficit".

Discharge documentation provides written information of the patient's condition with the plan for follow-up care.