SULTAN QABOOS UNIVERSITY HOSPITAL
NURSING DIRECTORATE

6. DOCUMENTATION

Standard Statement:: Nurses are **required** to document timely and accurate report of relevant observations, including conclusions drawn from those observations. Documentation is an integral part of safe and appropriate nursing practice. Clear, comprehensive and accurate documentation is a record of the judgment used in professional practice.

STRUCTURE	PROCESS	OUTCOME
• Patient • Nurse • Multidisciplinary Team	A nurse maintains documentation each shift that is; • clear, concise and comprehensive ; • accurate, true and honest; • relevant; • reflective of observations ,not unfounded conclusions; • timely and completed only during or after giving care; • chronological;	**The Nurse Meets The Standards By:** • documenting assessment of the needs; • documenting the plan or approach to be used; • documenting intervention used; • documenting an evaluation of interventions and outcomes • Document descriptively the changes in patient's condition, plan and outcome of care. • Document reassessment of findings.

STRUCTURE	PROCESS	OUTCOME
	• a complete record of nursing care provided including assessments, identification of problems, a plan of care, implementation and evaluation; • confidential; • client focused; • completed using methods / format • **Include the initial assessment and reassessment after all interventions or abnormal vital signs.** • Ensure that all abnormal findings have been addressed by a notation that states the physician has been notified, an appropriate intervention has been performed, or it is not a new finding. • Correct errors –refer to hospital policy for accepted means of correcting error. • Document in chronological order with the correct time and date for each entry. If making a late entry , document" late entry" with date and time of the entry and the time that observation was made or care given by authorization.	• Satisfactory explanation can be provided to patient / significant others inquiry based on the records available. • Documentation facilitates communications among health care provider as to the problems and needs of the patient ,actions taken and the outcome.

STRUCTURE	PROCESS	OUTCOME
Nurse Physician	• Document concurrently as closed as possible to the time care was given. Delay recording increases the potential for omission, error and inaccuracy due to memory lapse. **POOLING OBSERVATIONS TO RECORD AT THE END OF THE SHIFT IS NOT RECOMMENDED.** • Use hospital approved abbreviations • Document only from first hand knowledge • Safeguard the confidentiality of documentation. **Documenting Verbal or Telephone Orders:** • Verbal Orders are only applied when no physician is available on site and in cases of emergency.	**The Nurse will:** • Write down the time and date on the physician's order sheet. • Write down the order given by the physician • Read the order back to the physician to ensure it is accurately recorded • Record physician's name ,state " verbal or telephone order" • Document that you have read back the order; to be sure you have heard it correctly. • Print your name, sign and identify your status/ID #.