MedPro Group
a Berkshire Hathaway company

Checklist

Improving Nursing Documentation

Documentation is a critical component in healthcare because it memorializes patient care, facilitates communication among caregivers, assists with nonclinical processes (e.g., reimbursement, accreditation, and credentialing), provides data pertinent to quality improvement, and may provide information that is critical to the defense of a legal action.

Nurses play a pivotal role in documentation. They are responsible for documenting their patients' care in a thorough, timely, consistent, and objective manner. The American Nurses Association has specified six principles of nursing documentation to guide nurses in producing high-quality documentation, including (1) documentation characteristics, (2) education and training, (3) policies and procedures, (4) protection systems, (5) documentation entries, and (6) standardized terminologies.[1]

The following checklist contains questions related to these principles so organizational leaders can assess their management of nursing documentation.[2]

	Yes	No
Nurses' Responsibilities		
Do nurses always double-check the patient's name (including the spelling) and date of birth as the first step in documentation?	☐	☐
Do nurses ensure that they document patient information that is factual, accurate, relevant, clear, concise, comprehensive, timely, complete, and auditable?	☐	☐
Do nurses follow standardized documentation formats specified by organizational policies, and are they consistent in their documentation each time?	☐	☐
Do nurses document notes throughout their shift in "real-time" instead of doing so at the end of the shift?	☐	☐

	Yes	No
Nurses' Responsibilities (continued)		
Do nurses include all relevant information and actions about a patient's care, including the patient's baseline mental status, patient's description of problem, all assessments including vital signs, clinical parameters/problems, interventions, medication records, test results, diagnoses, patient responses and outcomes (including changes in patient status), and treatment plans?	☐	☐
Do nurses document the patient's allergies, allergies to medications, and special waivers (e.g., personal and religious beliefs)?	☐	☐
Do nurses use quantifiable data with descriptions and measurements for depth when documenting about patient wounds?	☐	☐
Do nurses remain objective in their documentation and not include personal opinions, assumptions, speculations, or subjective assessments about patients or other healthcare employees?	☐	☐
Do nurses ensure that the findings they document are communicated to, and acknowledged by, the healthcare team and the patient?	☐	☐
Do nurses use correct medical terminology and spelling in their documentation?	☐	☐
Do nurses document only with standardized terminology — including abbreviations, acronyms, and symbols — as specified by organizational policy?	☐	☐
Do nurses always document communications with other healthcare providers (including phone calls) and include their name, title, time of interaction, remarks, and any action taken?	☐	☐
Do nurses put statements by other healthcare providers or team members in quotation marks when documenting?	☐	☐
Do nurses ensure their documentation is HIPAA-compliant and protects the patients' privacy?	☐	☐
Do nurses avoid problematic words such as "accidentally, assume, confusing, could be, may be, miscalculated, mistake, unintentionally, inadvertently, unexpectedly, appeared, apparently, and seems to be" in their documentation?	☐	☐

	Yes	No
Nurses' Responsibilities (continued)		
Do nurses avoid using copy/paste when they document in electronic health records (EHRs) or only use it with extreme care when policy permits?	☐	☐
Do nurses clearly indicate when they are documenting on behalf of another healthcare team member using their own login credentials (e.g., during surgery or emergency situations)?	☐	☐
Do nurses document the informed consent process, within their scope of practice and according to organizational policy, for procedures and treatments? Does documentation include the patient's understanding of the procedure, risks, benefits, and alternatives?	☐	☐
Do nurses document complete medication administration (medications given, dosage, and time) and patient response?	☐	☐
Do nurses document patient education, including the topics discussed, the patient's comprehension, and any additional materials provided?	☐	☐
Do nurses document preventive measures, such as fall risk identification bands and signage?	☐	☐
Do nurses document all incidents and adverse events, including falls, medication errors, and unexpected outcomes?	☐	☐
Do nurses document patient refusal and/or nonadherence with medical care or medications, along with notification to the healthcare provider about it?	☐	☐
When documenting a patient's symptoms, do nurses follow with implementation of treatment/intervention and the patient's response?	☐	☐
Do nurses document body system abnormalities with specific details?	☐	☐
Do nurses document acute abnormalities found during a physical exam with the intervention that was initiated as well as the patient's response?	☐	☐
Do nurses document the use of interpreters or auxiliary aids to assist with patient communication?	☐	☐

	Yes	No
Nurses' Responsibilities (continued)		
Do nurses document that the patient and family (if applicable) were informed of the patient's condition, treatment, progress, and self-care recommendations?	☐	☐
Do nurses document any complaints, questions, or concerns from the patient and family members, as well as the steps taken to address them?	☐	☐
Do nurses update and document patient information regularly to reflect changes in the patient's condition, medications, treatments, and interventions?	☐	☐
Do nurses ensure that discharge plans for patients are documented in the EHR?	☐	☐
Do nurses review their documentation to ensure accuracy, completeness, and compliance with legal and regulatory requirements?	☐	☐
Organizational Leaders' Responsibilities		
Are nurses given the opportunity to attend training sessions, workshops, or webinars that offer guidance on the technical elements of documentation?	☐	☐
Do nurses receive education about all organizational documentation policies and procedures, including security practices and HIPAA compliance?	☐	☐
Are nurses monitored for proficiency in the use of the technology systems associated with documentation?	☐	☐
Do nurses receive training on documentation protocols during EHR downtime?	☐	☐
Do nurses receive proper training when documentation systems, tools, methods, standards, and/or policies are changed or updated?	☐	☐
Are documentation systems thoroughly evaluated to ensure that they are designed and built to secure data, protect patient identification, and maintain the confidentiality of patient information, clinical professionals' information, and organizational information?	☐	☐
Are nurses encouraged to seek support for documentation concerns/issues from the organization, colleagues and mentors, and professional associations?	☐	☐
Are nurses given manuals, guidelines, templates, and examples of documentation to use as references or models?	☐	☐

	Yes	No
Organizational Leaders' Responsibilities (continued)		
Are nurses encouraged to periodically review and evaluate their documentation to identify inconsistencies and opportunities for quality improvement?	☐	☐
Are nurses included in planning for new documentation systems, upgrades to current systems, and any workflow modifications?	☐	☐

Endnotes

[1] American Nurses Association. (2010). *Principles for nursing documentation: Guidance for registered nurses*. Retrieved from www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf

[2] This checklist is based on information from the following sources: American Nurses Association, *Principles for nursing documentation: Guidance for registered nurses;* Lippincott Nursing Center. (2023, August). *Nursing documentation*. Retrieved from www.nursingcenter.com/getattachment/Clinical-Resources/nursing-pocket-cards/Nursing-Documentation/Pocket-Card_Nursing-Documentation_August-2023.pdf.aspx; National Commission on Correctional Health Care. (2022, December 19). *Defensive documentation for nurses.* Retrieved from www.ncchc.org/defensive-documentation-for-nurses/; Mednikoff, S. (2022, March 28). *Top tips and tricks to improve your nurse charting*. Retrieved from www.masmedicalstaffing.com/blog/top-tips-and-tricks-to-improve-your-nurse-charting/; 1Nurse.com. (2023, March 30). *Proper documentation: The key to avoiding legal issues for nurses*. Retrieved from www.linkedin.com/pulse/proper-documentation-key-avoiding-legal-issues-nurses-1nurse-com/; Dev, A. (2020, March 14). *Nursing documentation tips and guide*. Medely. Retrieved from https://medely.com/blog/nursing-documentation-tips-and-guide/; Indeed Editorial Team. (2023, February 23). 10 nursing documentation tips (and why it's important). Retrieved from www.indeed.com/career-advice/career-development/nursing-documentation-tips