Concept of writing in nursing Part 2 – nurses' notes writing related activities

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Today’s Learning Objectives

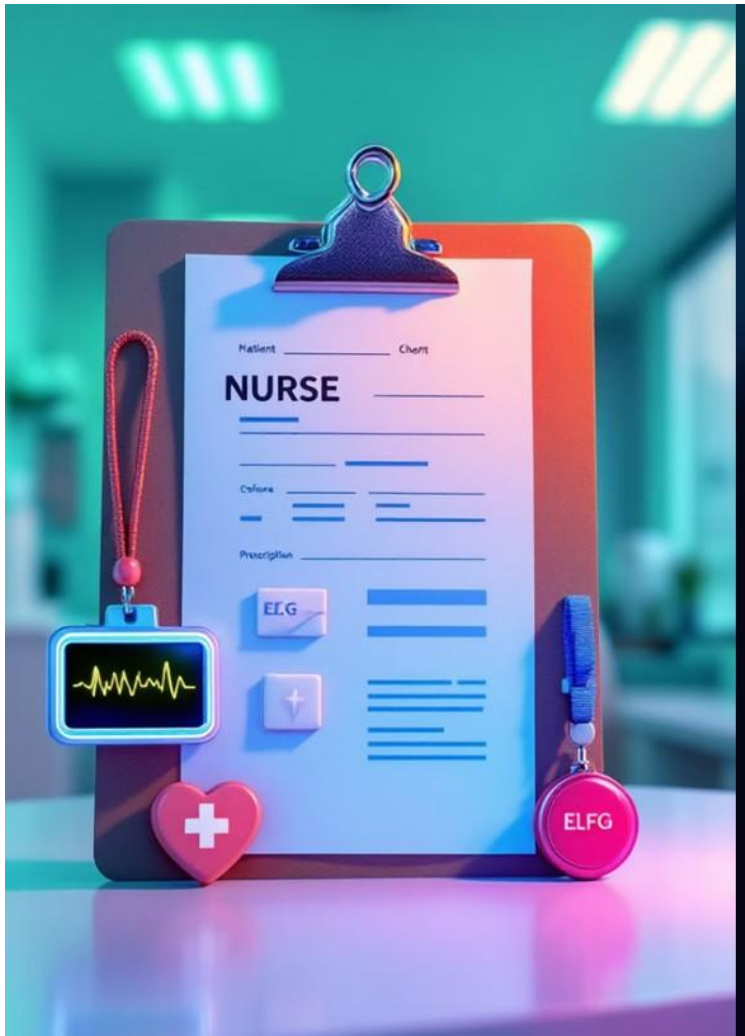
- Understand the core principles of effective nurses' notes.
- Identify Subjective vs. Objective data.
- Explore common charting formats (SOAP, DAR).
- Practice writing clear and concise notes through activities.
- Recognize common errors and how to avoid them.
- Learn about approved abbreviations.

Quick Review – Why Notes Matter

- Communication: Sharing vital info with the team.
- Continuity of Care: Ensuring smooth patient handovers.
- Legal Record: It's a legal document!
- Quality Improvement: Data for research and improving care.
- Billing & Reimbursement: Justifying care provided.

The Golden Rule of Charting

"If it wasn't documented, it wasn't done."



Types of Nursing Documentation

Nurses handle various documents. These include shift reports and patient assessments. Medication records, care plans, and incident reports are essential. Discharge summaries ensure continuity of care.

Shift Reports

Summarize patient status changes between shifts.

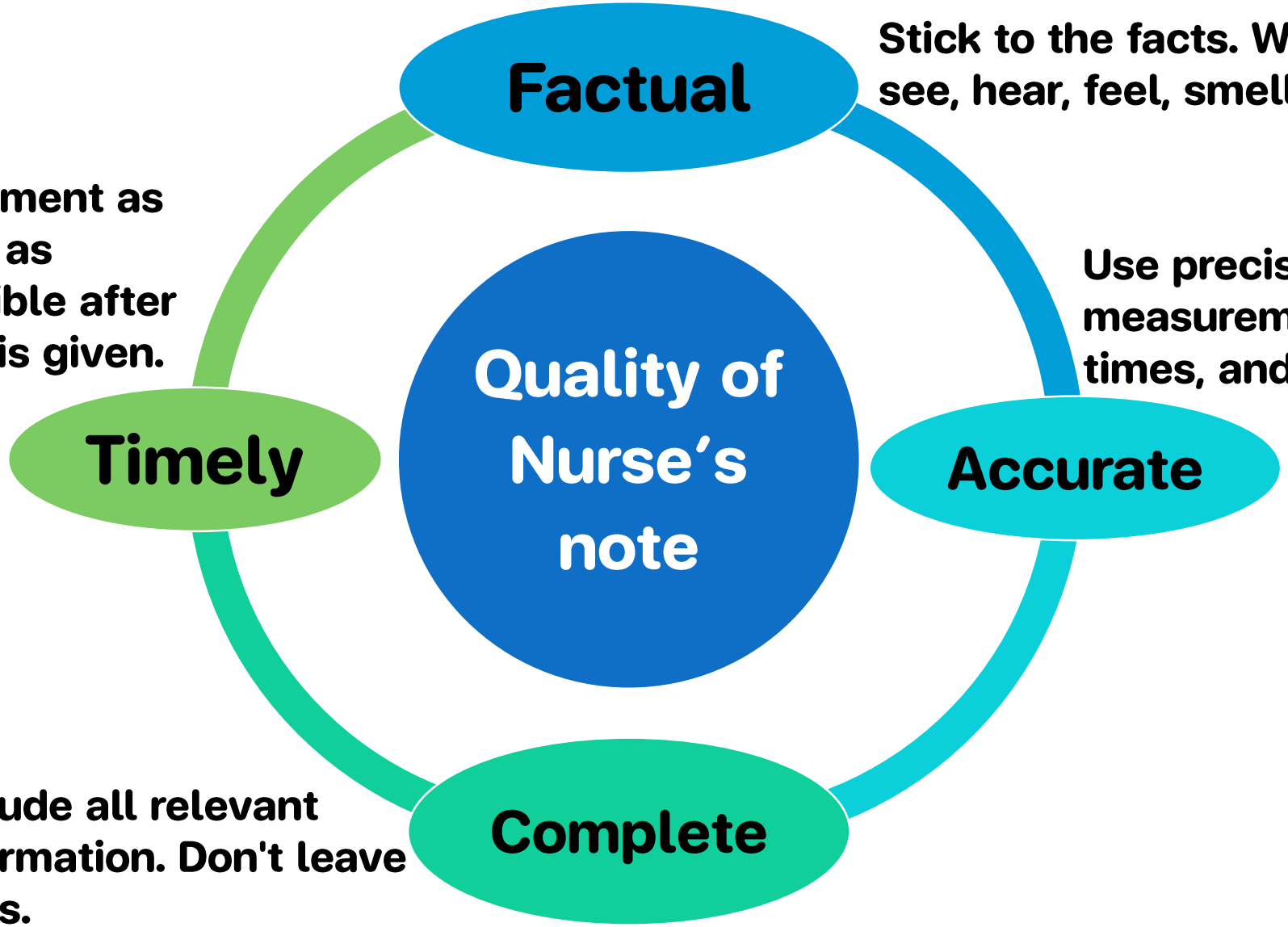
Care Plans

Outline patient-specific goals and interventions.

Incident Reports

Document unexpected events and actions taken.

Be F.A.C.T.-ual! (Key Principles)



Factual

Stick to the facts. What did you see, hear, feel, smell?

Accurate

Use precise measurements, correct times, and exact details.

Complete

Include all relevant information. Don't leave gaps.

Timely

Document as soon as possible after care is given.

Objective vs. Subjective Data

What They Say?

Subjective Data (S):

- What the patient *tells* you.
- Their feelings, perceptions, concerns.
- Use direct quotes when possible.
- *Example: "Patient states, 'My head is pounding.'"*

What You See?

Objective Data (O):

- What you *observe* or *measure*.
- Factual, measurable, observable.
- *Example: "Patient grimacing. BP 150/90 mmHg. Temp 38.5°C."*

Activity 1

Is it Subjective or Objective?

S 1. "I feel dizzy when I stand up."
O 2. Respirations 28/min, shallow.
O 3. Patient crying at the bedside.
S 4. "The pain is a 9 out of 10."
O 5. Wound edges red, 1 cm gap noted.
S 6. "I didn't sleep at all last night."
O 7. Urine output 50 mL in the last 4 hours, dark amber.

Structuring Your Notes

- **Narrative**: Story-like format.
- **SOAP / SOAPIE / SOAPIER**:
  - Subjective, Objective, Assessment, Plan (+ Intervention, Evaluation, Revision).
- **PIE**:
  - Problem, Intervention, Evaluation.
- **Focus Charting (DAR)**:
  - Data, Action, Response.

Deconstructing SOAP

S

- **Subjective:** What the patient says. *("My chest hurts.")*

O

- **Objective:** What you see/measure. *(BP 160/95, HR 110, diaphoretic, SpO2 93%.)*

A

- **Assessment:** Your nursing diagnosis/impression. *(Acute chest pain, potential cardiac event.)*

P

- **Plan**: What you will do. *(Administer O2 as ordered, notify Dr. Smith, prepare for EKG.)*

SOAP Example

- **Date/Time:** 24/05/2025 22:30
- **Problem:** Abdominal Pain
- **S:** Patient states, "My stomach hurts really bad, like a 8/10. I feel nauseous."
- **O:** Patient guarding abdomen, grimacing. Abdomen distended, firm, + bowel sounds in RLQ, absent elsewhere. T 38.8°C, HR 120, RR 24, BP 130/80. Vomited 150 mL clear fluid x1.
- **A:** Acute abdominal pain and nausea, possible appendicitis or bowel obstruction.
- **P:** Made NPO. IV line initiated R forearm, 0.9% NS running at 100 mL/hr. Administered Ondansetron 4mg IV as ordered. Dr. Jones notified, awaiting assessment & orders. Vital signs q 30 mins.
- **Signature:** *A. Nurse, RN*

Focus on DAR

D

- **Data**
- Subjective *and* Objective information supporting the focus.
- *(S: "I can't catch my breath." O: RR 32, SpO2 89% on RA, audible wheezing.)*

A

- **Action**
- interventions.
- Positioned patient in high-Fowler's. Administered Salbutamol nebulizer as ordered. Started O2 via NC at 2 L/min.)

R

- **Response**
- Patient's response to your actions.
- (RR decreased to 24, SpO2 increased to 95%, wheezing reduced. Patient states, "Breathing feels easier.")

DAR Example

- **Date/Time:** 24/05/2025 22:45
- **Focus:** Shortness of Breath
- **D:** Pt c/o "feeling breathless." Appears anxious. RR 32/min, shallow. SpO2 89% on room air. Audible expiratory wheeze bilaterally. HR 115.
- **A:** Assisted pt to high-Fowler's position. Administered Salbutamol 2.5mg via nebulizer over 10 mins as per MAR. Commenced O2 at 2L/min via NC. Reassured patient.
- **R:** Post-nebulizer, RR 24/min, SpO2 95% on 2L O2. Wheezing significantly decreased. Pt states, "I feel much better now." Appears less anxious.
- **Signature:** B. Nurse, RN

Activity 2 - Mini Case

Scenario

Mr. Tan, 68 years old, post-hip replacement Day 1. You enter his room at 10:00. He is grimacing and holding his right hip. He tells you, "The pain is back, it's about a 7/10." His vital signs are stable. He has an order for Morphine 2mg IV PRN (as needed) for pain.

What would be your 'D', 'A', and 'R' points? (Just brainstorm, don't write the full note yet).

Language – Be Precise!

- Use standard medical terminology.
- Be specific, not vague.
- Use action verbs.
- Instead of: Patient walked in hall.
  - Try: Patient ambulated 50 meters in hall with walker, steady gait.
- Instead of: Patient peed a lot.
  - Try: Patient voided 800 mL clear, yellow urine.
- Instead of: Gave pain meds.
  - Try: Administered Morphine 2mg IV in R hand at 10:15 for hip pain (rated 7/10).

Dos and Don'ts

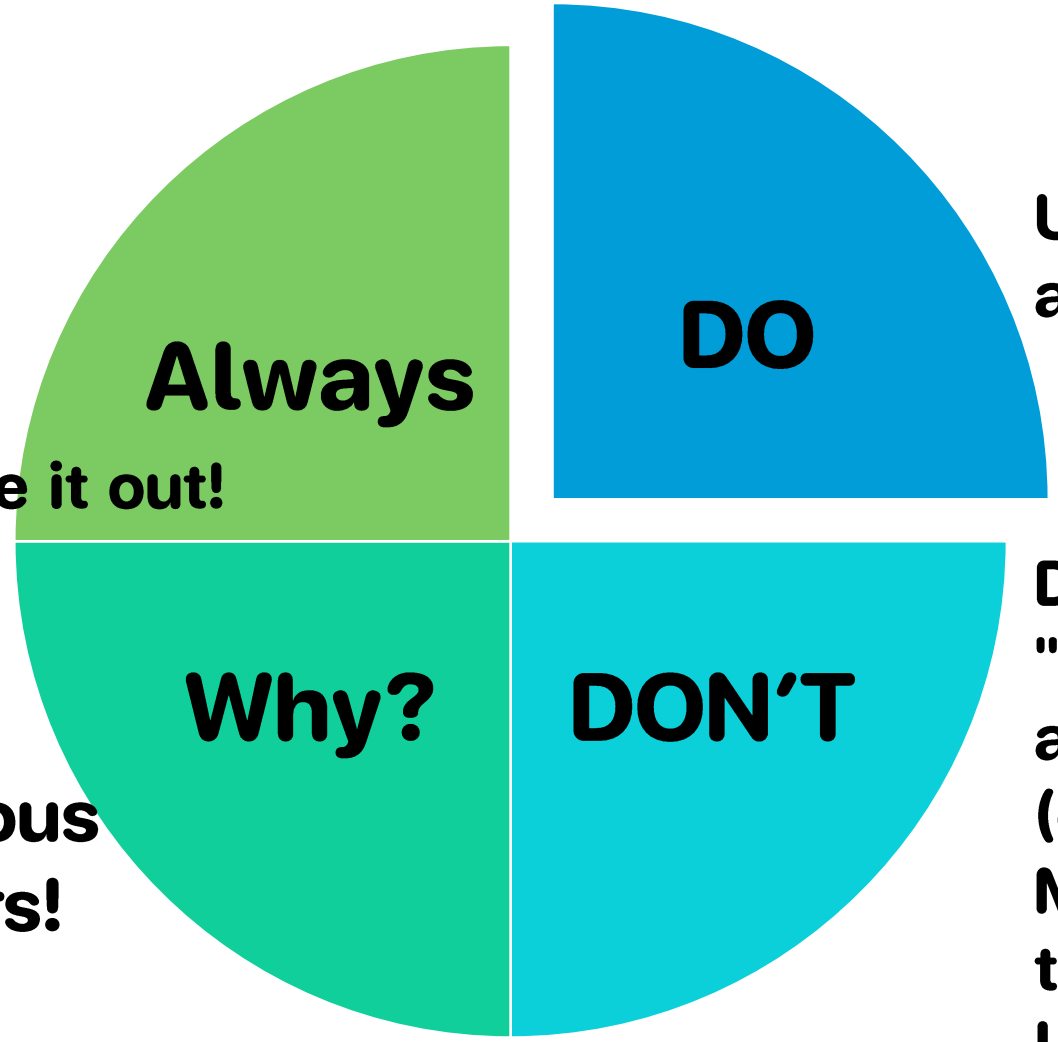
DO

Write legibly (if handwriting).
Use black ink (if handwriting).
Chart facts, not opinions.
Be concise but complete.
Sign with your name and title.
Correct errors properly (single line, initial, date).

DON'T

- **Use** white-out or erase.
- **Leave** blank spaces.
- **Chart** for someone else.
- **Use** vague terms.
- **Wait** until the end of the shift.

Abbreviations – A Warning!



Use *only* hospital-approved abbreviations.

When in doubt, write it out!

Don't use ambiguous or "dangerous" abbreviations (e.g., U, IU, Q.D., Q.O.D., MS, MSO4, MgSO4, trailing zeros, lack of leading zeros).

They cause serious medication errors!

Activity 3 – Spot the Errors

NURSING NOTE

DATE	NOTES
8:00 AM	Pt. seems ok. Had a good night.
[illegible] AM	Gave meds as ordered.
V100 3:00 PM	Vitals good.
D:29 PM	Did usual care
3.29 PM	Pt. looks tired, probably didn't sleep well.

What's Wrong Here?

Activity 4 – Write Your Own!

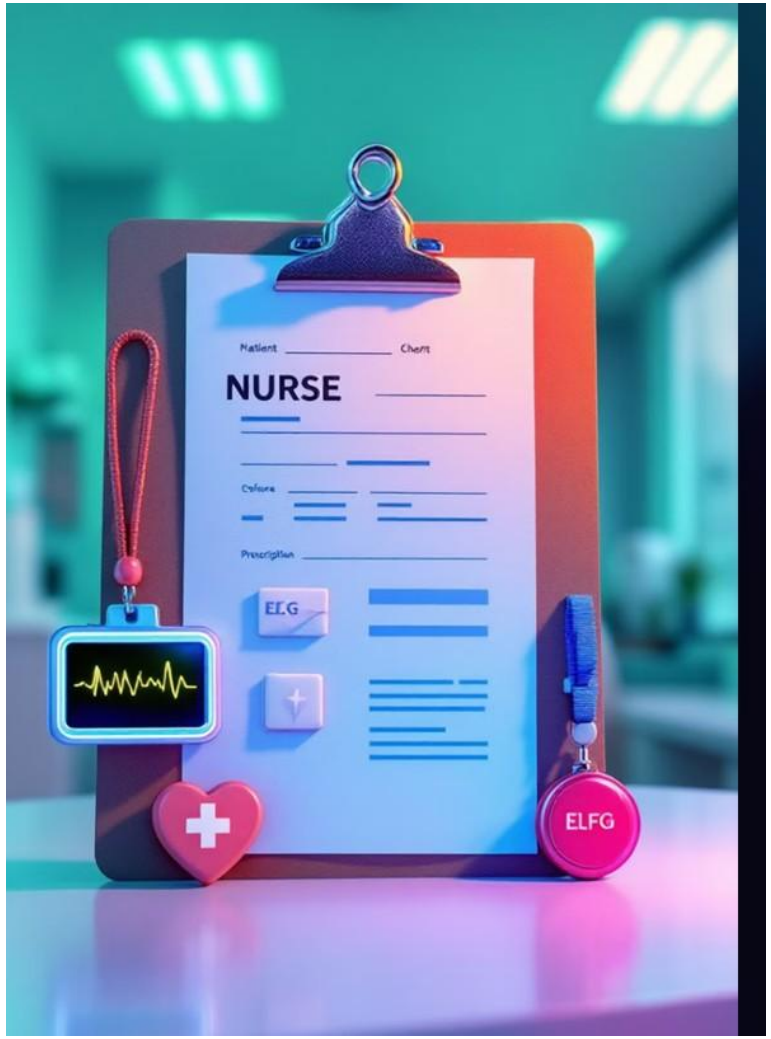
Scenario

It's 14:00. You are caring for Mrs. Somchai, a 55-year-old woman, Day 2 post-cholecystectomy. You assess her surgical wound. She tells you, "It feels a bit sore, maybe a 3/10." You observe the incision site on her RUQ. It is 10 cm long, clean, dry, and intact with 10 staples. There is no redness, swelling, or discharge. Her dressing is clean and dry. Vital signs are stable.

Write a brief DAR note in English documenting your assessment and findings.

Summary & Key Takeaways

"If it wasn't documented, it wasn't done."



- Nurses' notes are VITAL.
- F.A.C.T. is your guide.
- Be Objective & Subjective.
- Use standard Formats (SOAP, DAR).
- Language must be Precise & Professional.
- Handle Abbreviations with extreme care.
- Practice makes perfect!

Thank you

Future of Nursing Documentation

Emerging technologies will transform notes. Predictive analytics offer insights. Personalized care documentation will improve. Interdisciplinary communication will be seamless. Continuous innovation is expected.

∞

Continuous innovation

100%

Interdisciplinary communication

AI

Predictive analytics