# **TRIBHUVAN UNIVERSITY**

**INSTITUTE OF MEDICINE**

**POKHARA NURSING CAMPUS**

**RAMGHAT-12, POKHARA**

**Lesson Plan**

**On**

**“WRITE CLEAR & LEGIBLE CLINICAL NURSING NOTES”**

Submitted by:

Pratibha kurmi

Roll no: 11

BNS 2nd year

Submitted to:

Respected,

Dr ratnashila bastola Mam

lecturer

Pokhara Nursing Campus

Submitted on: 2079/11/29

Lesson Plan

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| Subject: Nursing concept & principles – I (Theory)  Course No: BN 04  Topic: Write clear & legible clinical nursing notes  Date: 2079/11/29  Time: 10am- 11 am  Place/Venue: BNS 1st year classroom  Duration: 55-60 min  Language: Nepali+ English  No. of Students: 37  Level of Students: BNS 1st Year  Name of Supervisor: DR. ratnashila bastola mam  Name of Student Teacher: pratibha kurmi  Level of Student Teacher: BNS 2nd Year  Teaching learning method: Brainstorming, interactive lecture, discussion  Teaching learning media:powerpoint ,newsprint, whiteboard |

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| General Objective:  At the end of this classroom teaching learning session, the students will be able to explain ways to write clear & legible clinical nursing notes. |

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| **SN** | **Specific Objectives** | **Content** | **Time (In Min.)** | **T/L Activities** | | **Evaluation** |
|  |  |  |  | **Method** | **Media** |  |
|  | At the end of this classroom teaching learning session, the students will be able to: | Introduction:   * Greet/ self * Review * Topic * Objectives * Pretest | 10 min. | Interaction + Brainstorming | PowerPoint presentation , photo | What is Documentation? |
| 1 | introduce documentation | Introduction of documentation | 5min | Illustrative lecture + Discussion | PowerPoint presentation+ Picture | What do you mean by documentation? |
| 2 | explain purposes of documentation | Purposes of documentation | 5min | Illustrative lecture + Discussion | PowerPoint presentation +newsprint | What are the purposes of documentation? |
| 2 | explain ways to write clear & legible clinical nursing notes | Ways to write clear & legible clinical nursing notes | 30min | Illustrative lecture + Discussion | PowerPoint presentation+ picture | What are the ways to write clear & legible clinical nursing notes? |
| 5 | post-test  summary | Post-test  Summarization  References  Home assignment  Plan for next class | 7 min | Student’s participation |  | Learner’s response to questions? |

**Specific skills**

* Make effective presentation
* Write clear & legible nursing reports

**Definition of documentation**

Documentation is the act of client’s status and care in a written form.

Or

Documentation is any printed or written record of activities. In health care, it should include the following:

* Changes in the client condition.
* Administration of the tests, treatments, procedures, and client education with the results of and client’s response to them
* Clients response to an intervention
* Evaluation of expected outcome
* Complaints from the client and family.

A nursing notes is an ethical and legal responsibilities of nurses to keep accurate appropriate client’s information in his /her medical record or chart. Any alteration in medical record can create ethical and legal problems.

**Types of documentation:**

1. **Recording**

Recording is a brief account of the personal history, medical history, results of diagnostic test, finding in physical examination, treatment and nursing care, progress note and condition on discharge. Types of record are as following:

* Outpatient tickets
* Case sheet or chart
* Doctors order sheet
* Progress and consultation sheet to write daily progress and consultations
* Nurses records include plan of care, record of care and reports of observation
* Graphic chart for vital signs
* Report of laboratories findings and examination
* Diet sheet
* Declaration form
* Intake output chart
* X-ray
* Anesthesia chart.

**2.charting**

A chart is permanent, written and complete record of health history and sociological information obtained a person admitted to a hospital by listening to him, looking at him and treating him. Commonly used charting are:

* Graphic sheet
* Case sheet
* Doctors order sheet.
* Nurses record sheet
* Intake output sheet.
* Urine sugar test sheet and insulin chart.

**Purposes of documentation:**

1. Communicating & providing continuity of care
2. Accountability
3. Education
4. Research
5. Audit & monitoring
6. Legal aspect

**Guidelines for Documentation:**

The following guidelines provide expectations and suggestions to assist nurses in achieving complete and accurate documentation of client care within any setting.

1. **Objective/Factual Documentation**: Nurses must document accurately, completely, and objectively including any errors that occurred. It should contain descriptive, objective information about what the nurse sees, hears, feels and smells. Nurses must record clearly, legibly and accurately and use appropriate terminology. Correct spelling and the use of exact measurements ensures that a health-care record is accurate and demonstrates a level of competency and attention to detail on the part of the nurses. Because health-care records reflect accountability for the care provided, nurses should document their own observations and actions only.
2. **Timeliness**: Documentation is enhanced when client information is entered frequently into the client health-care record. Documentation of an intervention should never be completed before it takes place. Documentation in chronological succession assists in revealing a change pattern in a client's health status. Information must be entered on the health-care record even if it is out of chronological order.
3. **Use of Space:** Documentation must not have empty lines or spaces, and the time when assessments and interventions were completed must be noted. "Not applicable" or "N/A" should be noted rather than leaving a space blank.
4. **Use of Abbreviations:** Nurses need to know what, if any, abbreviations are acceptable in their agency. Many organizations are currently developing policies that are aimed at reducing the number of common but preventable sources of errors.
5. **Follow-up:** Document any follow-up of assessments, observations or interventions that have been done, including whether a physician or other care provider has been notified regarding the client. Failed attempts to reach a physician or other care provider, the follow-up action taken, and the client's response to interventions should be documented on the client's health-care record.
6. **Correcting Errors:** To correct an error in a paper-based health-care records system, one method that can be used to appropriately make corrections is the slide rule. The slide rule is completed as follows: cross through the word(s) with a single line, and Insert your initials, along with the date and time the correction is made; then enter the correct information/ explanation
7. **Recording Medication Administration**: Document the administration of medications immediately administration. This prevents errors such as another nurse administering medication when the first dose was not recorded. The documentation of medications administered by others is not acceptable, and nurses should only record medications they have administered themselves. The nurse should also document in the health-care record additional pertinent information related to the process of administering medications (i.e., self-administration, client questions, client refusal of medication), related interventions (i.e., client education, communication with a prescriber) and outcomes of care (i.e. therapeutic drug response, side effects)
8. **Recording Assistance with Care**: In most circumstances, when a nurse assists another nurse in providing care (e.g. when assisting another nurse to ambulate a patient or insert an IV), the nurse providing care documents the actions and the client's responses and notes that another care provider assisted.
9. **Designated Recorder in Emergency Situations**: In some emergency situations (e.g. during cardiac arrest) documentation may be done by a designated recorder. When acting as a designated recorder, the recorder identifies the persons involved and the care they provided.
10. **Clarification of Orders:** If an order is poorly written, never guess or rely on group consensus to interpret that order. Always call the writer for clarification. There is a high risk for error and potential for an unsafe event to occur.
11. **Recording a Telephone Conversation with a Client:** When advice is given by telephone, the nurse is relying on the client's own assessment of the situation. The nurse does not have the benefit of examination and objective findings. The health-care record should include the date (including year) and time of the call, the nature of the call, the response by the nurse, and the follow-up recommendations.
12. **Interactions with other Health-care Professionals:** All health-care professionals are responsible for documenting the care they provide or the actions taken. The system used should record all interactions with members of the health-care team, including clarification of orders, failed attempts to reach other team members & follow up action taken.
13. **Client Education:** Documentation of educational interventions requires knowledge and skills that are complex and comprehensive. The nurse needs to consider the following when documenting client education:

* Document each formal (planned education) as well as informal (unplanned) teaching activity.
* Written education entries should include:
* a brief description of the material taught
* the methods used for teaching
* the involvement of and the interaction between client and family in the teaching/learning process, and evaluation of the teaching objectives with validation of client comprehension and learning
* timed and signed entry
* Incorporate follow-up education requirements.

1. **Documenting an Incident in the Health-care Record:** When an incident occurs, pertinent data should be documented on the health-care records of the clients involved in the incident.

In a malpractice case, the jurors usually view the medical record as the best evidence of what really happened. For this reason, al documentation should be neatly written and legible. Illegible handwriting is handwriting that cannot be read or understood by others. This would account for sloppy writing, and often misspelled words and poor grammar. Illegible or poorly written documentation makes you look careless and distracted. Take the time to write neatly and clearly. Do not cover up anything in chart with white out.

**Summary:**

Documentation means "to give written information that is proof or support of something that has been done or observed." The purposes of documentation are: - Communicating & providing continuity of care, Accountability, Education, Research, Audit & monitoring, Legal aspect. The ways to write clear and legal nursing notes are Objective/Factual Documentation, Timeliness, use of space, use of abbreviation, follow up, correcting errors, client education, clarification of order etc.

**Post test**

**Objective questions**

**Multiple choice questions[2x1=2]**

1. **Purposes of documentation are:**
2. Education
3. Research
4. Accountability
5. All of above

**2.Which of the following documentation used by the head nurse to communicate information about patient has sudden hemorrhage to another head nurse in the next shift?**

1. Cardex record
2. Assignment record
3. Shift record
4. Incident report

**Write T for[true] and F for [false] [2x1+2]**

**1.Any alteration in medical record can create ethical and legal problems. […..]**

**2.Do not use an abbreviation unless you are sure that it is commonly understood and in general use. […..]**

**Home assignment**

Read out the ways to write clear & legible clinical nursing notes.

**In next class:**

In next class we will discuss about interview and communication skills required in special circumstances.

# **References:**

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