

If It Isn't Written Down, It Wasn't Done

A sophomore nursing student in her first medical-surgical rotation charted the following: "Pt. ambulated to the bathroom with assistance." However, the student abbreviated assistance as "ass." The student's instructor grasped the teachable moment by commenting aloud that it would have been pretty difficult for the patient to go anywhere without that body part! Thus was I introduced to the nuances of correctly documenting my nursing care.

Through the years, nursing has struggled to find a documentation system that would be accurate, quick, comprehensive, meaningful, and read. Remember SOAP charting? Charting by exception? Remember the battles over who could write on nursing notes versus progress notes? The advent of the electronic patient record is putting its own spin on the timeworn concept of documentation. Hospitals send out continual reminders to avoid the use of certain abbreviations to reduce the risk of errors in ordering and charting, and even nursing journal editors have recently discussed how to use certain abbreviations—if at all—when providing clinical information in articles.

The title of this editorial is taken from a sign posted years ago on a wall at my clinical site to remind clinical trial nurses that, from the standpoint of the research, if they did not document impeccably, the trial monitors would be very unhappy and the nurses would be held accountable. I have no doubt that many a malpractice trial has hinged on whether critical information was written on an official form.

In clinical sites, much energy is expended to facilitate correct and proper documentation. At its best, documentation is usually time-consuming and laborious—a combination guaranteed to result in avoidance behaviors and slapdash execution. In an effort to help, institutions have developed every permutation of checklist, abbreviated charting convention, and electronic, tape-recorded, and transcribed format. Somewhere on the dusty shelves a generic "progress notes" form is waiting to be used when longhand, detailed recordkeeping cannot or should not be avoided. Unfortunately, the situations that drive us to write the more extensive notes are the extreme cases.

I recently found myself wondering about documentation. Three things had occurred to give me pause. A recent opinion circulated among nurse editors indicated that financial

conflicts of interest are not of particular concern to nursing journals. In our case, I absolutely know that is not true. The assessment was based on the failure of most nursing journals to note the financial interest of authors. We do state when an interest is disclosed, but the *Oncology Nursing Forum* does not state when no financial interest exists. We will make that change.

An opportunity to consider spending more time working in a clinic specializing in the care of women with breast cancer also had me

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wondering about my documentation habits. I had experience recording things such as post-operative arm measurements, depression and anxiety, and quality-of-life assessments while working as a research nurse in this same clinic. Which of those assessment and documentation skills would I or could I bring to the job of clinic nurse in a clinic where very little charting was done by the nurses who I know provide detailed, compassionate care?

Finally, the Institute of Medicine's ([IOM's], 2007) report on psychosocial care of patients with cancer and the Oncology Nursing Society's (ONS's) position "Psychosocial Services for Patients With Cancer" (see page 337) made me wonder how we communicate the extensive work that we do. Providing emotional support to patients is as natural as breathing for most of us. When we see patients and families in need, we are ready with supportive techniques, advice, and referrals to experts. Our units are often well-stocked with pamphlets and brochures detailing the myriad resources available in our setting, in our local area, or from the American Cancer Society or the National Cancer Institute. We devote entire lectures at the ONS Congress and Institutes of Learning to psychosocial care and patients' quality of life. Concerns about our patients' coping is integral to the care we provide, but how often do we record those interventions and document that we provided the emotional support that we

say we provide? We chart dressing changes, vital signs, medication administration, patient teaching—a whole range of nursing care—because we know that documentation is vital; however, when it comes to interpersonal exchanges with our patients, many of which are calculated as therapeutic in nature, we do not take the time to record regularly.

I can almost hear the collective groan as you read this. Just what we need, more paperwork. Most of us are likely recalling the voluminous charting about psychosocial issues that we did as undergraduate and graduate students. Of course, that is not realistic in day-to-day practice, but if psychosocial care is such a fundamental part of our nursing care, how else will we get recognition for our work if we have no concrete way of displaying it? How will we be able to follow-up on our work and the work of other nurses without a chronologic record of what we tried?

I have no solutions to this dilemma, but we can do better. We must raise our consciousness and recognize the need for methods to facilitate good charting within the context of our varied clinical sites. Perhaps the answer is a checklist or shorthand notations. We need valid, reliable, and easy-to-use assessment tools for a variety of psychosocial symptoms and a way to monitor the progress of those symptoms as interventions are used. We need to develop the tools, try them in practice, and share our experiences in writing and at meetings. The processes to develop the tools are tried and true; we need only think about applying them to the emotional and psychological care we provide so automatically. Someday soon, I will receive papers evaluating the implementation of the IOM (2007) recommendations. The papers will begin by noting that a chart review revealed that no psychosocial care was provided at hospital X on a regular basis. The authors will reach that conclusion because no documentation was found in the charts. Let's change that scenario. Write it down so we know it happened.

Reference

Institute of Medicine. (2007). Cancer care for the whole patient: Meeting psychosocial health needs. Retrieved April 8, 2008, from http://www.nap.edu/catalog.php?record_id=11993

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