Key aspects of documentation

What every nurse manager needs to know

As a member of a nursing management team, you must assume responsibility for ensuring complete and accurate documentation. In today's culture of accountability, your title and scope of responsibilities will bring under scrutiny your commitment to safe and quality patient care, so you need to accept the responsibility whether it is part of your job description or not. You must recognize the importance of good clinical documentation. It is also vital that you assist staff in practicing defensive documentation and in avoiding the potential for legal consequences if a case is reviewed for alleged medical malpractice.

The medical record must be accurate and complete because the information it contains is critical for a number of people and functions. It is used to communicate patients' programs to other staff and the various clinical and ancillary departments involved in their care. It is used by the system's quality and risk-management department and the utilization-management committee. In some cases, the accuracy and completeness of the clinical record is essential to healthcare researchers. It is also referred to when professional care rendered was considered negligent. In addition, its content is regulated by the state in which you practice, audited by insurers (both private and public), and reviewed for compliance with accreditation standards.

Documenting completely and accurately is considered a professional standard of nursing practice. For every step in the nursing process, the care delivered must be documented. The nurse manager must assist nurses in fulfilling the necessary requirements of good clinical care and documentation. Doing so not only validates the universally recognized professional approach to patient care, it supplies other care providers with consistent, clear communication and validates critical decision-making that is often necessary for quality patient care.

There are many research studies that have attempted to identify why nurses do not value the importance of their documentation. One study by Moody and Snyder claims an estimated 15-20% of the nursing work time is spent in documentation. In addition, documentation has changed over the last few decades in both its appearance and the advent of new technology. What is still missing with these changes is the failure to demonstrate patient continuity of care and the evaluation of patient outcomes (Irving 2006).

The quality of the care provided to patients can only be measured by the quality of the nursing documentation. The major reasons for documenting nursing care include:

- Documentation of the plan of nursing care

- Evaluation of the effectiveness of the nursing care provided

- Facilitation of communication between the patient/family and other providers

Failure to completely document can have legal consequences. If documentation is incomplete, contains gaps, or is not consistently completed according to the organization's policies, it can be used to support an allegation that negligent care was provided.

Incomplete documentation allows for juries to conclude that the nurse did not:

- Collect sufficient data and plan appropriate care

- Implement appropriate interventions, according to professional and institutional standards

- Make good clinical decisions

- Communicate effectively

Nurse manager responsibilities

As a nurse manager, it is your responsibility to assist staff in adhering to both clinical and documentation standards. It is also your responsibility to provide continuing education, professional feedback, and input into policy and documentation-system changes whenever possible. It is to your advantage to fulfill these responsibilities because if your staff is involved in a medical malpractice case, your ability to manage and meet quality and risk-management standards will be called into question.

As a member of the nursing-management team, you must not only demonstrate a commitment to providing safe and efficient patient care, but also ensure that every clinical record reflects that commitment. That is, although you must ensure that nursing staff comply with up-to-date standards, it is equally important to ensure that they document that compliance accurately and completely.

Your role is to support an efficient and effective documentation system and to create an expectation that the system be followed.

Nursing management can demonstrate support for such a system by:

- Developing an efficient system that meets the requirements of regulatory standards.

- Involving the end users in the development of the system.

- Emphasizing the importance of documentation through written guidelines, policies, job descriptions, and performance appraisals. The language should include stipulations for daily supervisory oversight, audits of the system, and feedback to the staff.

Let the nursing process be your guide

The nursing process, as outlined by the American Nurses Association (ANA) *Nursing Scope and Standards of Practice*, provides us with an established, scientific approach to providing nursing care. Not only does each step guide us in our approach, it tells us how to validate what we saw, heard, felt, smelled, said, and did while providing that care. The process accounts for all significant data and actions taken by a registered nurse, the documentation of which is used for critical decision-making. Therefore, your documentation of patient care should follow the framework of the nursing process.

Assessment

The first step of the nursing process is assessment. In this step, the nurse collects information about the patient's condition, which could include the patient's history, the physical exam, laboratory data, and so on. So as not to become overwhelmed, the nurse must decide which information is most useful to the care of the patient. For example, a nurse could limit the assessment data to the admission signs and symptoms, the chief complaint, or medical diagnosis. This first step in

the nursing process—assessment—should always be evident in the medical record as it provides a complete clinical picture of the patient.

An assessment should include both subjective and objective data. When documenting this data, beware of inappropriate documentation practices and focus on risk management.

Subjective data

In this context, subjective data are data that can be observed, but not measured. Statements made by the patient or family/significant other are examples of subjective data. Although every conversation may not be relevant to the interaction, there will be times when a patient's words need to be recorded to establish a clear picture of how the patient perceives his or her status.

For instance, if the patient says something that can be used to demonstrate mental, behavioral, or cognitive status at the time of the assessment, documentation of the conversation can be used to measure progress or decline over the course of treatment. If patients are unable to speak or are cognitively impaired, nonverbal cues are essential in determining whether there has been any change in status.

These conversations with the patient/family will need to be captured in the clinical record in order to provide other clinicians with an accurate depiction of the patient's current status.

Objective data

Nurses establish patients clinical status based on objective data, which are observable and measurable. Physical exam of patients, which include key assessment techniques such as inspection, palpation, percussion, and auscultation, provide objective data about patients' health status. In simpler terms, nurses' objective assessment is based on what is seen, heard, felt and smelt. Healthcare providers find this much easier to validate and include in their documentation than subjective data. Objective data also includes the results of diagnostic tests.

When recording this data, however, there are risks your staff should consider. If the objective data is not reviewed in a timely manner, a reviewer of the clinical record may point out that you failed to interpret the data and address significant changes of condition. There also may be situations in which critical objective data were present but there was no subsequent documentation of an appropriate intervention.

In addition, if the absence of critical objective data resulted in a gap in the clinical picture of the patient, it may contribute to a lack of appropriate intervention identification. All of these situations can lead to quality and risk-management issues.

Unacceptable assessment documentation

When documenting subjective or objective data, be careful to do so thoroughly and appropriately. The following examples of entries into the medical record illustrate several common mistakes:

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1. The entry:

Neuro signs WNL

The problem:

Which aspects of the neurological assessment are within normal limits (WNL)? Does "WNL" refer to cognitive, visual, musculoskeletal, cranial nerve, Coma Scale, or something else? Lack of documentation of a complete neurological assessment can lead to an accusation of failure to document assessments according to contemporary nursing standards.

The solution:

Develop a neurological assessment tool that is based on current standards and ensure that staff complete the tool according to the policy and documentation guidelines.

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2. The entry:

Grand mal seizure

The problem:

This is not a complete assessment. It is the nurse's responsibility to give a complete clinical description of the incident so that any reader can visualize what happened.

The solution:

Ensure that your documentation of this episode has a beginning, middle, and end. Start by documenting the patient's status prior to the incident, if known. Describe any report of an aura, color, posturing, or physical change during the seizure. Record the length of time of the seizure and the condition of the patient immediately following it, including both subjective data (what did the patient tell you about the incident?) and objective data (what were his or her vital and neurological signs?) assessed by the nurse.

Here is an example of how the nurse should have documented:

Mrs. S. was ambulating to the BR with PCT. Pt. stated she "felt funny." Pt. slowly slid to floor with assistance. Pt. noted to turn pale white, facial grimace was fixed during incident, contraction of large muscle of all extremities. Episode lasted 30–60 seconds. No observation of respiratory or cardiac distress. VSS after episode (taken within 1 minute), see flowsheet. Incontinent of large amount of urine (500 cc). Speech slurred, disoriented, and complained of tiredness for first 30 minutes following episode. No other neurological signs affected, see Neuro flowsheet. No laceration of tongue. First observed episode.

3. The entry:

[Incomplete I&O sheet]

The problem:

Incomplete intake and outtake (I&O) sheets. Incomplete I&O sheets can lead to allegations of improper assessment and insufficient data gathering. It could then be argued that these omissions led to a lack of decision-making, which resulted in the patient being harmed.

The solution:

Ensure that all I&O sheets are completed in their entirety. Check for accurate dates, times, and quantities measured for both intake and output.

Gaps in documentation on any clinical assessment tool leave the provider and the facility open to allegations that they failed to document assessments or failed to address significant changes of condition. In the case of an incomplete I&O, it could be alleged that the lack of analysis, intervention, and accurate documentation was the cause of circulatory collapse, dehydration, renal failure, infections, skin breakdown, or even death.

For the nurse to arrive at a nursing diagnosis and the development of a nursing plan of care, the assessment findings are crucial. Be sure you develop an assessment tool that assists in recording a nursing examination thoroughly, accurately, and clearly.

Here are some risk management tips for documenting assessment findings:

- Describe everything exactly as found by inspection, palpation, percussion, or auscultation
- Do not allow the use of general terms such as "normal," "abnormal," "good," or "poor"
- Be specific, and include both negative and positive aspects
- Ensure that your policy on assessment includes the timeframe for assessment completion and documentation
- Encourage the staff to document their assessment as soon as possible after completing it

Nursing diagnosis and Nursing Outcome Classification

If nurses accurately perform the assessment process, they will be able to appropriately establish nursing diagnoses. This phase of the nursing process demonstrates that the nurse reviewed the appropriate data available at the time and made a professional determination of the clinical problem(s) at that time. Once the nurse makes a clinical nursing diagnosis based on a thorough assessment, the rest of the process falls into place.

The nursing diagnosis is defined by the North American Nursing Diagnosis Association International (NANDA International) as a "clinical judgment about the individual, family, or community responses to actual or potential health problems or life processes."

Therefore, the nursing diagnosis expresses the nurse's professional judgment of the patient's clinical status, the anticipated response to treatment, and the potential nursing-care needs. It guides the nurse and subsequent providers in their understanding of the patient's problem(s) and the plan of care developed specifically for that problem(s).

If your organization chooses to include the nursing diagnosis in its documentation system, you should promote consistency and use of correct terminology by adopting NANDA International terminology. The NANDA International diagnostic headings, coupled with the patient's clinical etiology, provide a clear picture of the patient's needs.

Below are some examples of nursing diagnoses.

- Risk for falls: Defined by NANDA International as, "increased susceptibility to falling that may cause physical harm"

- Related to neurological changes S/P seizure: The related factors are based on the risk factors as perceived by the etiology as stated by the nurse, and the patient's problem

- S/P grand mal seizure with neurological changes, unsteady gait

- Medication for seizure control has side effects for affecting gait and balance: Based on assessment data used

- History of fall within one hour of seizure, over age of 65, diminished mental status: Risk factors considered by the nurse

After making the nursing diagnosis, the nurse must determine the proper outcome for the patient.

Outcomes identification

The next step in the nursing process is to determine an expected outcome, or goal, for the patient. The outcome must be derived from the nursing diagnosis and documented as a measurable, realistic, and patient-focused goal. It must include a target time or date as well as an objective measurable action that the patient is expected to achieve.

Whenever possible, include the patient/family's perspective on the goal of treatment and the timeframe. The expected outcomes also should reflect the continuum of care, from admission, addressing immediate and intermediate outcomes, for planning for discharge and follow-up care.

History of nursing outcomes

The use of patient outcomes in documentation dates back to the mid-1960s, when for the first time nursing outcomes were used to evaluate the effectiveness of nursing care. The use of patient outcomes to evaluate healthcare dates back to Florence Nightingale, who recorded and analyzed healthcare conditions and the subsequent outcomes of those conditions during the Crimean War (Moorehead 2004).

> **Tips for documenting expected outcomes:**
>
> • Start with a specific action verb that focuses on the patient's behavior
>
> • Avoid verbs that describe the nurse's behavior (e.g., allow, let, enable)
>
> • Specify to which person the goals refer (e.g., family, friends)
>
> • Target dates must be realistic
>
> • Allow for flexibility of the date if the patient needs more time (Goldberg 1999)

Although nurses have documented outcomes of their nursing interventions for decades, there was no common language or associated way to measure the outcomes of these interventions in the past. Today, however, a research team at the University of Iowa has given nursing a standardized terminology for nursing-specific and nursing-sensitive outcomes. This comprehensive classification of nursing outcomes is called the Nursing Outcomes Classification (NOC).

The current 2004 NOC lists 330 outcomes for use in nursing documentation. Each NOC nursing outcome has a predetermined definition, a measurement scale, and associated interventions. Each describes a possible state, behavior, or perception of the patient (this is different from nursing diagnosis, which describes a patient's problem, either actual or potential). Once the nursing diagnosis is made the nurse seeks to resolve it through appropriate interventions (see example in Figure 1.1).

FIGURE 1.1	**Respiratory Status: Airway Potency (0410)**				

Domain-Physiologic Health (II)
Class-Cardiopulmonary (E)
Scale(s)-Severely compromised to Not compromised (a) and Severe to None (n)

Definition: Open, clear tracheobronchial passages for air exchange

OUTCOME TARGET RATING: Maintain at_____ Increase to _____

Indicators		**Severely compromised 1**	**Substantially compromised 2**	**Moderately compromised 3**	**Mildly compromised 4**	**Not compromised 5**
041009	Ease of breathing	1	2	3	4	5
041004	Respiratory rate	1	2	3	4	5
041005	Respiratory rhythm	1	2	3	4	5
041006	Moves sputum out of airway	1	2	3	4	5
041010	Moves blockage our of airway	1	2	3	4	5
		Severe	**Substantial**	**Moderate**	**Mild**	**None**
041002	Anxiety					
041011	Fear					
041003	Choking					
041007	Adventitious breath sounds					

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More recently, The Joint Commission has required all hospitals and long-term care organizations seeking accreditation to use systems that provide data about the organization's performance related to patient outcomes (Moorehead 2004).

A good example of the integration and use of outcomes identification can be found in home healthcare. The Centers for Medicare & Medicaid Services (CMS) require

all Medicare-certified home-health organizations to use the Outcome Assessment Information Set (OASIS) data set, which they have been doing since 1998. The OASIS outcomes system contains core measures that have been identified as applicable to all client groups. It also contains measures specific to client groups with a particular diagnosis or problem, the outcomes of which are measured on scales specific to them. Using the OASIS outcome system, nurses assess whether home-health clients have improved, stabilized, or deteriorated (Sparks 2001).

Planning

The next step in the nursing process is to develop a plan of care for the patient based on the nurse's assessment/diagnosis. Documentation of this phase demonstrates that the clinical status of the patient was recognized and that the nurse then developed an appropriate plan of care. It shows that the nursing process was in place and thereby decreases the risk of incomplete or incorrect care. Having a written "road map" helps everyone involved provide safe and quality care.

When developing a plan of care use the following guidelines:

- Review identified nursing diagnoses and rank them in order of priority

- Use evidence-based nursing interventions

- The documentation tool/system should include nursing diagnosis, expected outcomes, nursing interventions, and evaluation of care

- The plan of care should be used as a communication tool between all healthcare team members and the patient (Sparks 2001)

This step of the nursing process can be documented in a variety of ways. You can use a specially designed form, flowsheet, patient-care plan, nursing progress notes, clinical pathway, or specific software module. But whatever format is used, remember that the patient plan of care is a permanent part of the clinical record and must be treated as such. It should never be erased or destroyed. Adjustments to the plan of care should reflect a progression of care based on the patient's needs, using the organization's standards/protocols.

Implementation

Based on the nursing plan of care and contemporary standards of nursing care, the nurse then documents the care provided for the patient. This phase of the nursing process includes working collaboratively with other members of the healthcare team, the patient, and the patient's family.

Implementation may require some of the following interventions:

- Assessing and monitoring

- Therapeutic interventions

- Comfort measures

- Assistance with activities of daily living

- Supporting respiratory functions

- Supporting elimination functions

- Providing skin care

- Managing the environment to promote a therapeutic milieu

- Providing food and fluids

- Giving emotional support

- Teaching and/or counseling

- Referral to other agencies or services (Sparks and Taylor 2001)

Documentation will need to include the specific nurse's intervention and the patient's response to the intervention. It should reflect the coordination of care, health teaching and promotion, and any consultation that was done on behalf of the patient. Like the documentation of planning, the documentation of care provided can be assigned to a specific form or location in the clinical record.

Evaluation

In this step of the nursing process, the nurse reviews the progress made in achieving established outcomes. The documentation needed to validate this step includes the nurse's comments on whether his or her assessment, diagnosis, achievement of outcomes, plan of care, and nursing interventions were successful. In addition, when developing a documentation system or a continuing education program for

staff nurses, ensure that each nurse assesses the effectiveness
of the nursing process.

In determining whether the patient received high-quality care the nurse must ask
the following:

- Has the patient's condition improved, deteriorated, or remained the same?

- Were the nursing diagnoses accurate?

- Have the patient's needs been met?

- Did the patient meet the outcome criteria documented in the plan of care?

- Do I revise or discontinue the nursing interventions?

- Why did the patient fail to meet the goal? (Sparks 2001)

If the nurse uses the evaluation phase properly, the documentation will reflect
high-quality nursing care.

The graphic in Figure 1.2 shows the flow of the process and identifies the tools
associated with each phase.

FIGURE 1.2	Nursing process flowchart

ASSESSMENT

Definition: Subjective and objective data from patient's health history, physical examination, medical record, diagnostic test results.

Tools: Physical-examination form
Consultation sheets
Nursing admission assessment
Graphic flow sheets
Flow sheet
Diagnostic test results forms
Computer software module

NURSING DIAGNOSIS

Definition: Clinical nursing judgment based on the assessment data.

Tools: Plan of care
Patient-care guidelines
Clinical pathways
Medication administration record
Progress notes
Problem list
Computer software module

OUTCOME IDENTIFICATION

Definition: Specific measurable outcome.

Tools: Nursing Outcome
Classification (NOC)
Plan of care
Clinical pathway
Computer software module
Federally mandated documentation systems

PLANNING

Definition: Establish care priorities, set measurable goals/outcomes with target dates, describe interventions.

Tools: Plan of care
Patient care guidelines
Clinical pathway
Discharge plan/pummary
Computer software module

IMPLEMENTATION

Definition: Actual nursing interventions delivered.

Tools: Graphic flow sheets
Flow sheets
Progress notes
Computer software module
Nursing Interventions
Classification (NIC)

EVALUATION

Definition: Reassess data, nursing diagnoses, and interventions for achievement of stated outcome.

Tools: Flow sheets
Clinical pathway
Computer software module

Organizational policies, protocols, and practices

When nurse experts are asked to review a medical record in preparation for a legal case, they rely heavily on the medical record to determine the following:

- Did the healthcare provider meet the policies and protocols of the organization at the time of the care?

- More importantly, did the healthcare provider meet the standards of nursing practice at the time of the care?

It is therefore the responsibility of the nursing management team to ensure that the nursing staff follows the established policies of the organization and that this compliance is demonstrated in the documentation system for that organization.

Organizational policies, protocols, and practices will always be called into review when there is an allegation of substandard patient care. Nursing practice will be held to national and local professional nursing standards, which are available through the American Nurses Association (ANA) and through specialty nursing associations such as the Association of Women's Health, Obstetric & Neonatal Nurses (AWHONN), Association of Perioperative Registered Nurses (AORN), American Association of Critical-Care Nurses (ACCRN), and others. If you derive your policies and procedures from these, your organization will be better able to justify the care that was delivered met established professional standards.

CASE STUDY
Good documentation reflects the nursing process

Scenario: A patient complains of chest pain. The nurse takes the patient seriously, as the subjective complaint may indicate a myocardial infarction. He or she acts quickly, performing a focused assessment and documenting the essential information. Here are the critical elements of good documentation of a patient with chest pain.

Documentation of what the patient said: Subjective data

2/15/07 16:00

Patient stated, "Nurse, I am having chest pain." See Pain Flow sheet for description, location, intensity noted. Patient in bed, increasingly anxious, used calm reassuring behavior with patient. Redirected her to focus on remaining calm for interventions to work. Patient responded, and pulse and respirations decreased. See VS sheet.

The patient's exact description of the symptom was noted, the nurse used quotations around the patient's words, rather than recording his or her interpretation of them.

On the pain flow sheet, the nurse indicates *pain was located in the substernal region, radiating to the left shoulder. Pain level 10 out of 10.* The nurse appropriately uses the pain scale to measure the level of intensity.

The nurse also notes on the pain flow sheet: *No preceding activity or past history of this type of pain. Steady pain: 2-3 minutes. No SOB.*

Patient care flow sheet indicated that the initial pulse and respirations at the time of the nurse's initial assessment of pain were

2/15/07   16:00   P:120 R: 40 BP: 146/90
2/15/07   16:04   P:96 R: 28 BP: 124/85

Documentation of what was assessed: Objective data

In the cardiopulmonary section of the patient care flow sheet, the nurse writes

SR (sinus rhythm), monitor fluctuated from S-tach to SR. No JVD.

O2 sats on RA: 92%

O2 sats on 4 L via cannula: 98%

Case Study
Good documentation reflects the nursing process (cont.)

The nurse documents the vital signs, noting sinus tachycardia, an increased respiratory rate, and above-baseline blood pressure for this patient. In addition, the nurse records auscultation of heart sounds (e.g., regular, irregular heart rate, murmur, gallops, rubs.)

The nurse assesses lung sounds and the respiratory rate and pattern, and measures abnormal O2 saturation via pulse oximetry. The patient's actions are already noted as increasing anxiety. There is no clutching of the chest by the patient. Skin assessment also is conducted and documented.

In the cognitive section of the patient care flow sheet, the notations indicated, No changes in mental status, no decreased level of consciousness, disorientation, or confusion.

In the narrative notes, the nurse notes, Skin cool, clammy, no peripheral edema, ashen in color. No cyanosis noted.

Documentation of what was done: Intervention
The nurse continues to document his or her interventions and the patient's responses.

Frequent monitoring:
- The VSs were noted every few minutes until the chest pain subsided. The nurse continues hourly VSs, pain assessments, and signs and symptoms of the patient.
- All treatment activities are documented, including cardiac enzymes, ABG's and EKG, SL NTG, morphine sulfate, etc.
- Fluid intake and output: Recorded every four hours.

Oxygen therapy:
- The nurse documents the patient's initial pulse-oximetry reading, respiratory-assessment findings, and ABG results, when he or she is notified.
- The pulse-oximetry assessments are documented every hour until within normal range, and every four hours thereafter. Based on ABG results, O2 could be decreased.
- O2 decreased to 2L

Continuous cardiac monitoring:
2/15/07 16:03 Patient placed on cardiac monitor. Patient informed as to the reason for continuous monitoring.

CASE STUDY
Good documentation reflects the nursing process (cont.)

The nurse notes the time the patient was first placed on the cardiac monitor (in MCL1) and the teaching about the reason for the monitor. He or she also records which lead is being displayed on the strip and the flow sheet. The patient's rhythm strip is labeled with the patient's name and strip intervals. Subsequent rhythm strips are obtained according to MI protocol (such as change in condition, ectopic beats noted, or arrhythmia). Each strip has a notation as to the heart rate and rhythm, PR-interval, and QRS-complex duration. The patient does have a ST-segment elevation, which is noted on the strip. 2/15/07 17:02 *Dr. Smith notified of 2mm ST elevation. New orders received and transcribed. O2 increased to 4 L, 12 lead EKG done. Stat SL NTG, Chest pain unrelieved by NTG. Morphine 2 mg. IV PRN given.*

The nurse does document notification of the physician for a significant change from the initial strip. He or she records the physician's response and his or her actions.

Drug and IV therapy:
The Medication Administration Record notes the names, dosages, times, and routes of the medications the nurse gives. The nurse also documents the patient's vital signs after each dose of nitroglycerin and morphine. The pain flow sheet indicates the patient's response to the NTG and morphine.

On the IV section of the patient-care flow sheet, the nurse documents his or her assessment of the IV site—the date and time the IV line is inserted, catheter gauge, and person who does the insertion. Also notes the catheter size, dressing type, and condition. During the remainder of the shift the nurse documents his or her assessments of the IV site and line patency.

Activity:
 2/15/07 17:30 Patient informed of activity limitations due to change in her cardiac status. Patient stated, "Don't worry, I'll call you before I do anything." The nurse notes the patient is on bed rest and his or her instructions regarding patient-activity limitations.

Communication:
The nurse is good at documenting his or her communication with other healthcare team members. It is found in his or her narrative notes, names, time of notification, etc.

Case Study
Good documentation reflects the nursing process (cont.)

Emotional support:

2/15/07 20:10 *Patient increasing in anxiety, attempted to get the patient to talk about her feelings. Offered medication to assist in decreasing her anxiety. Patient agreed to medication.* The nurse offers and documents emotional support to help the patient cope with the physical and psychological impact of her condition.

Transfer to ICU:

This patient does not need to be transferred, but if she had, the nurse would have documented the aspects of the patient's condition that warranted the transfer. The report to the ICU nurse would have been documented and, if applicable, a written record of the patient's belongings would have been included. The nurse also would have recorded the name of the person who accompanied the patient and which monitoring devices were in place during the transport. Someone would have to document how well she tolerated the transfer.

Documentation of what was taught
The teaching plan needs to be tailored to the patient's condition and treatment. Documentation of patient/family teaching needs to include what was taught, the method of teaching, the materials used for teaching, how well the patient/family understood the teaching, etc.

In this case, nurses discuss the following with this patient:
- Heart anatomy and physiology
- Disease process
- Diagnostic tests and the reason for them
- Treatment options such as angioplasty, stents, or thrombolytics
- Signs and symptoms of an MI
- Signs and symptoms to report
- Actions to take when chest pain returns
- Medication management (i.e., prescribed drugs and their names, dosages,
- times to take them, route, any potential side effects, and how to store the medications)
- Smoking cessation advice
- Diet management
- Activity and rest patterns
- Community support groups, cardiac rehab centers (Sparks 2001)

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