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Nursing Documentation

a shared understanding of information and/or messages exchanged between two or more individuals.

What is the difference between objective information and subjective information?

Objective information is true or valid outside of an individual's judgment, bias and/or opinion. Objective information can typically be verified, reproduced and/or measured by two or more individuals. Subjective information is often an opinion and/or judgment based on one individual's point of view or perspective.

Why is it important for health care professionals to avoid "labels" when completing health care documentation?

Labels such as "difficult," "needy" or "unpleasant" should be avoided when completing health care documentation because they may represent subjective information based on judgment, bias and/or opinion, and thus may prove to be inaccurate. Health care professionals must do what is in their power to avoid documenting inaccurate information. Inaccurate information included in health care documentation may lead to miscommunication among health care professionals and, ultimately, patient adverse events, and perhaps even patient mortalities. Health care professionals should focus on documenting accurate information when completing health care documentation to ensure patient safety.

Why should health care professionals complete health care documentation in a timely fashion?

Health care professionals should complete health care documentation as close to the administration of health care as possible to foster accurate, up-to-date information. Accurate, up-to-date information is essential to the administration of health care. Waiting hours after health care administration to complete documentation may lead to inaccuracies due to an inability to recall events as they actually occurred. Moreover, waiting to document health care data can deprive fellow health care professionals of vital information which they may

require to make important decisions regarding a patient's treatment and overall health. Health care professionals must have accurate, up-to-date health care data/information to maximize patient care. Thus, health care documentation must be completed in a timely fashion.

Conclusion

Health care documentation can refer to a digital and/or analog record detailing the administration of health care to patients[1,2]. It has been said that documentation is the foundation on which safe and effective health care is built upon. If completed effectively, health care documentation can be used in daily practice by health care professionals to communicate vital patient information to other health care professionals in order to facilitate positive health care outcomes and to decrease the potential for negative health care outcomes, such as adverse events and patient mortalities. Health care professionals must complete effective health care documentation to strengthen and reinforce communication among health care professionals and because it is their professional responsibility to do so.

In order for health care documentation to be considered effective it must function as a viable form of communication as well as a means to establish a detailed record of health care administration. There are many different forms of health care documentation; however, if health care professionals include specific characteristics in their documentation they can ensure it is effective. Characteristics of effective health care documentation include: objectivity, accuracy, clarity, completeness and the inclusion of accurate times and dates of health care administration.

Finally, health care documentation is essential to health care. When a patient is admitted into a health care facility, his or her health, overall well-being and quality of life often rely on the safe and effective administration of health care - effective health care documentation can be a means to provide patients with the safe and effective health care they rely on.

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