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 report card has been 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 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 documentation was written on an official form. In clinical sites, much energy is expended in clinical sites, much energy is expended on the timeworn concept of charting, and even nursing journal editors have recently discussed how to use certain abbreviations—if at all—when providing clinical information in articles.

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At its best, documentation is usually time-consuming and laborious—a combination guaranteed to result in avoidance behaviors and slapdash execution.