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 correct charting, patient to go anywhere without that body part!

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

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 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

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