Nurse Documentation Template

The famous nursing proverb is; '*If it's not written down; it didn't happen…*'

Write as you go. The NMC says you should complete all records at the time or as soon as possible. Try to avoid leaving your nursing notes to the end of the shift – write as you go. This will ensure everything you document is fresh in your mind and therefore accurate and up-to-date.

Start of notes

- Care taken over at (insert time you start to time you finish)
- Introduced myself to patient

Main Bulk

- **Observations** - how frequent are the patients observations, what is the news score, if scoring what for and have you actioned this ie informed a doctor or nurse in charge. What is your plan with observations if they have scored on there news? Do you intend to do them again to check there not scoring anymore. If a patient has declined or gone off the ward for a scan etc then document.
- **Medications** - has all medications been given? If not why? If unavailable have you ordered from pharmacy. If nil by mouth have you consulted the doctor. If declined then document. If nil medications prescribed or needed then document.
- **Pain** - any complaints of pain? If so what have you done about this? Have you given analgesia, what was the effect? Has the patient needed more? Do you think the doctor should be informed if analgesia is not working and possibly change the analgesia to something different.

Activities of daily living (ADL)

- **Hygiene** - has the patient been assisted for a wash, are they independent or full care required
- **Toileting** - has the patient passed urine, if so are they continent or incontinent. If they haven't passed urine have you actioned this? Have they got a catheter? Has this been draining, again if not have you actioned this? Has the patient had there bowels open? If so what type? We're they continent or incontinent. Have you filled in the stool chart. If they haven't when did they have them last opened. If a few days have you actioned this?
- **Pressure area care** - have you seen the patients areas (nurses must see patients pressure areas at least once during a shift). Are the areas all intact? Are they vulnerable? Are they red? Is the skin broken? Is the skin dry or excoriated? Have you put any cream on? Have they got a dressing? What is the date on this and does it need changing? If so what is underneath this, what have you redressed it with. Has the patient been referred to tissue viability of not have you done this? Is the patient on bed rest, are they mobile, do they need repositioning 2 hourly, 3 hourly or are they independent. Do they have an air mattress if not do they need one?
- **Mobilisation** - has the patient mobilised today, how did they get out of bed? Have they been seen by physio if they are a new admission. How long did they sit in the chair for? Did they decline if so what have you done to encourage this? Have you spoken with family to encourage.
- **Diet and fluids** - has the patient eaten and drunk well today? Are they on normal diet and fluids or modified consistency. Do they need assistance or encouragement. If the intake has been poor have you thought about a dietician referral and has the doctor been informed?

IVC

- Has the patient got an IVC. If so is it still needed, what is it used for? Can you remove if not needed. Is it in date - record the date. If it is out of date (the advice is 3 days) does the doctor no. Are they happy to keep this in. What is the VIP score (research VIP score so you have a true understanding of what this is).

Plan

- Has the doctor seen the patient today, what is there plan. Has the discharge team seen the patient. Any therapists or other members of the MDT.

Family communication

- Has the patient had any visitors? Have they been updated in regards to care. Any issues with relatives that needs actioning or someone senior informing? Has the doctor updated them or any other members of the team.

Other

- Has the patient got there call bell to hand
- Any other information you need to write, is the patient a falls risk, are they in a zoned bay, anything you feel relevant to that patient. Each note will be slightly different depending on area of work and each patients care is different
- Any concerns to raise? Has the patient had a settled day? How has the patients mood been?

Modification

Don’t forget once you have wrote the bulk of your writing you can always come back into it and add extra bits if something has changed that way nothing is left until right at the end. The NMC as said previously recommends documenting when something happens if possible to keep this fresh in your mind.