Narrative Charting / Documenting -Formats

This is intended to be a general overview of types of non-computerized charting you may encounter or be asked to complete in practice. As institutions transition to computerized charting the way we record patient care changes, and you can expect to be oriented to specific computer charting systems at the facilities that utilize them.

- First a general note about 'charting by exception.' In general, we do not have to write down things that would be 'normally' expected in a healthy person, but of course there are 'exceptions to the exception.' We almost always cover neuro and respiratory even if they are fine, and we like to cover elements of care that directly relate to their illness (e.g. if they were short of breath earlier and now, they are not…) or their ability to care for themselves independently (go home / discharge) -Eating, toileting, ambulating safely.

- All notes are dated and signed, we cannot erase or scribble out things, if errors are made (and lots are….) make a single line through and initial it. Charting should be done in black (or blue is allowable sometimes) ink. Red ink is used at Interior Health to indicate medications given within the narrative chart (mostly in the ER before a MAR has been generated) but this is not common practice in many other facilities. Do no leave any spaces in your charting (where other people could add things after you signed the note).

- Nurses need to establish that they took responsibility for patients in their care. The time of their first assessment generally needs to be within 1hr of taking an assignment (shorter for acutely unwell patients). The assessment sets the 'this is how I found things' picture for the day.

There are many different formats for writing down and communicating your nursing assessments and interventions. Here are a few with examples and key pieces to consider:

Narrative
Very common, short paragraph describing your patient findings and interventions all together.

Example:
0730 Alert, oriented X 3. Responsive to verbal stimulation and appropriate. Took breakfast well. Breath sounds clear bilaterally to bases no adventitious sounds heard. Coughing and deep breathing independently. Abdomen soft, non-tender, dressing present to LLQ dry and intact. Hyperactive bowel sounds present in abdomen. Peripheral pulses present and strong in all extremities, skin warm and intact, appropriate for ethnicity. Slight edema present to ankles bilaterally I.V. D/5/W at 100 cc/h infusing with #18 angiocath in L forearm per pump, no edema or redness present at IV site. Pt ambulating to the bathroom without assistance or difficulty. No complaints of discomfort at this time.
----------*J. Lomen, R.N.*

Here's a 'recipe' you can use to build this:

- There are some things (as noted above) we will always put in: Neuro, resp, eating, skin, walking, so they form the framework. (This list will change depending on what area you work in.)
- Then think about what the patient is being treated for (perhaps abdominal surgery in this case). What assessments tell you that this person is getting better or getting worse in that area? What aspects of their presentation are present due to this? Plan to put them in.
- Then think about what people need to do in general, and perhaps this client in particular, to look after themselves at whatever they deem to be their home living situation. Generally, it is the 'discharge triangle:' Eating, Sleeping, Toileting, and physical movement between those things. Plan to put that in.
- Now take a systems approach and plug it in starting at the top and working your way down generally (it is okay to hop around a bit if needed).
- Lastly think about all the 'foreign' things attached to / plugged into the client (e.g. IV's, catheter, dressings, oxygen, etc. make sure to talk about them and assess them if needed).

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Systems Focus (Narrative)

This is basically the same as the narrative charting above, except each body system is called out as you go through it. This allows future readers to find things faster when they want to compare findings.
This is how many facilities prefer narrative charting if it is used.

Example:
07:30

Neuro: Alert, oriented X 3. Responsive to verbal stimulation and appropriate. ----------
Resp: Breath sounds clear bilaterally to bases no adventitious sounds heard. Coughing and deep breathing independently. ----------
GI: Took breakfast well. Abdomen soft, non-tender, dressing present to LLQ dry and intact. Hyperactive bowel sounds present in abdomen. ----------
CV: Peripheral pulses present and strong in all extremities, skin warm and intact, appropriate for ethnicity. Slight edema present to ankles bilaterally ----------
Tubes / Drains: I.V. D/5/W at 100 cc/h infusing with #18 angiocath in L forearm per pump, no edema or redness present at IV site. ----------
Safety: Pt ambulating to the bathroom without assistance or difficulty. No complaints of discomfort at this time. ----------J. Lomen, R.N.

This is a bit awkward sometimes, as the sections don't always fit together nicely, so you'll actually more likely see this (which is fine too):

Neuro: 0730 Alert, oriented X 3. Responsive to verbal stimulation and appropriate. Breath sounds clear
Resp: bilaterally to bases no adventitious sounds heard. Coughing and deep breathing independently.
GI: Took breakfast well. Abdomen soft, non-tender, dressing present to LLQ dry and intact.
CV: Hyperactive bowel sounds present in abdomen. Peripheral pulses present and strong in all extremities, skin warm and intact, appropriate for ethnicity. Slight edema present to ankles
Tubes / Drains: bilaterally I.V. D/5/W at 100 cc's infusing with #18 angiocath in L forearm per pump, no
Safety: edema or redness present at IV site Pt ambulating to the bathroom without assistance or difficulty. No complaints of discomfort at this time. ----------J. Lomen, R.N.

- Just jamming it all together but calling it out in the sidebar as each topic is covered on that line.

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Additional Charting Format Tools

Here are some other formats that you may see as well. They are less holistic and generally focus on a particular element of care:

SOAP(E)
(Originally this system did not cover the evaluation portion of the nursing process, you will sometimes see it referenced without the "E" at the end.)
This is a problem oriented charting system. This style originated from the medical model. Documentation is focused on the patient's problem(s). Often you need a separate SOAPE for each problem.

SOAPE Components:
S: Subjective data (what the patient tells you)
O: Objective data (includes measurements, i.e., vital signs, laboratory results, your observations/assessments, x-ray findings, and client responses to diagnostic and therapeutic measures.
A: Assessment (interpretations and conclusions from the subjective and objective data; the nursing diagnosis can be written in this part.)
P: Plan (-or intervention, what you are going to do or what you did; the plan of action is based on the above data.)
E: Evaluation (how did the plan work out?)

Example:
0800
***S**: Pt reports "Every time I get up, I feel very dizzy"*
***O**: Supine BP 120/70, BP Standing BP 90/40*
***A** :Decrease in BP when changing position. Pt is at risk of injury related to falls.*
***P**: Instruct to call for assistance when getting out of bed. All side rails up. Call bell placed within reach.*
E: Pt remains free of falls through shift

This is a simple charting system to use if you want to cover a particular issue -not as good for your daily assessment.
A nice element of this is that it calls out subjective from objective data.

DARP
This is another problem focused format similar to SOAPE

D: Data (what did you find -this is subjective and objective data together)
A: Action (What did you do about it?)
R: Response (How did your intervention work?)
P: Plan (What are you going to do next?)

Example:
D: *Pt reports "Every time I get up, I feel very dizzy" Supine BP 120/70, BP Standing BP 90/40.*
***A**: Instruct to call for assistance when getting out of bed. All side rails up. Call bell placed within reach.*
***R**: Pt remains free of falls through shift*
***P**: Push fluids, Contact Physician and request hydration, possible mediation change*

This covers a few different aspects of the event

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ADPIE
This is the classic nursing process.

A: Assessment
D: (Nursing) Diagnosis
P: Plan
I: Implementation
E: Evaluation

Example:
A*: Pt reports "Every time I get up, I feel very dizzy"*
D*: Risk of injury due to falls, related to low blood pressure, as evidenced by 30mmHg drop in orthostatic vital signs.*
P: *Instruct to call for assistance when getting out of bed. Side rails up, bed in low position. Call bell placed within reach. Push fluids, Contact Physician and request hydration, possible mediation change.*
I: *Pt participated in plan as outlined*
E*: Pt remains free of falls through shift*

Sometimes this format gets a bit awkward, but it allows nurses to contribute a diagnosis, which is a key element of our profession and independent practice.

SBAR
Sometimes used in handover, but actually designed for situational briefing in urgent situations (i.e. a significant event has occurred and the patient is being transferred to or you are consulting a different level of care). This is modified from military communication. Good for organizing a clear package for communication with providers, other caregivers. Convenient as they will often be expecting each section as it is presented. Most commonly used for interprofessional patient communication (i.e. Paramedics to nurses, nurse to physician).

S: Situation
B: Background
A: Assessment
R: Recommendation(s)

Example:
S: *Mr. Jones is complaining of being dizzy when they get up*
B*: I identified a blood pressure drop of 30mmHg when he stands up*
A*: I think he has orthostatic hypotension, I wonder if he may be dehydrated or if it is due to medications*
R*: I think he would benefit from additional hydration, do you feel comfortable ordering IV fluids? Additionally, is it reasonable to review his medications to look for a pharmacological source?*

This system is short and to the point, blends together medical and nursing viewpoints and empowers the sender of the information to recommend things they think are needed to remedy the situation regardless of their role in care.

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IDRAW

Designed as a true handover tool to maintain safe continuation of the plan of care. This tool provides health care team members with an effective and consistent communication tool to support the accurate and timely exchange of patient/client information during routine, non-urgent handover situations (e.g. shift report).

I: Identify Patient
- Identifies patient/client using two (2) patient/client identifiers.
- Provides the MRPs contact information.

D: Diagnosis and/or Current Problems
- Admitting diagnosis and date
- Estimated length of stay
- Current clinical problem(s)
- Reason for transition
- Patient/client goals
- In some clinical settings, may also include allergies; medications; test results; procedures; and/or advance directives.

R: Recent changes
- Brief summary of the last 24 hours of care.
- Provide what is important for the receiver to know about patient/client
- Most current vital signs

A: Anticipated changes
- Identify tasks that need to be completed for the patient/client.
- Provide a picture of what the next few hours might look like for the patient/client.

W: What to watch for
- Identify potential patient/client risks (e.g., safety concerns) that may occur during and/or shortly after transition.
- Receiver should be encouraged to ask questions to clarify understanding.

Example:
I: Mr. Jones MRN8675309 is a 68-year-old gentleman in Bed 702 They are a patient of Melissa Todd ARNP
D: Admitted with pneumonia 3 days ago and is generally doing well; anticipating discharge tomorrow or the next day. Still a bit breathless with activity, but no longer requires oxygen to maintain saturations.
R: They have been having some difficulty with orthostatic hypotension over the past shift so they have been told to call before getting up. Vitals were okay lying down though: T 36.8 P76 R 16 BP 120/70. I did orthostatics and the BP dropped to 90/40 right after getting up.
A: I think they are a bit dry and have asked the MRP for an order for some fluids. Assuming she agrees and orders it you can hang that with their next dose of antibiotics.
W: I'd keep an eye on them when getting up and recommend pushing fluids this morning. Hopefully their BP is good enough for morning medications. Do you have any questions for me?

Good video comparing SBAR and IDRAW:
https://youtu.be/zKY4DfHszJQ?si=0-aG1zEIoWFYby-a

Charting describes a professional 'picture' for future caregivers to compare to. Charting ability improves with practice. Take time to read other examples of charting, consultations, history and physical and others to see how they are structured and the types of words that are commonly used.

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