Nursing documentation is a critical component of nursing, for all levels of nursing practice. Documentation allows nurses to account for the care which is provided by bringing together the available facts about nursing diagnoses, interventions, outcomes, and standards of care. This course explores the underlying purposes of documentation, professional and regulatory requirements, and processes and best practices for adequate documentation, which accurately reflect the patient's severity of illness and transition for care.

Legal aspects and implications of documentation, and strategies to reduce legal risk, are addressed. Principles and practices of defensible nursing documentation along with guidelines for improving documentation are highlighted.

Course Objectives

- Identify the importance and purpose of complete documentation in the medical record.
- Discuss different nursing documentation methods and factors to consider in selecting a documentation system.
- Discuss the evolution of computerized nursing documentation and requirements surrounding its use.
- Identify the organizational, institutional, and legal standards and regulations that affect nursing documentation.
- Describe documentation techniques and strategies to improve documentation.
- Discuss steps in the nursing process to improve documentation.
- Identify documentation considerations for specific areas of nursing practice and patient care.
- Identify areas of nursing practice that pose a risk for legal consequences and the proper documentation techniques that can be used to mitigate that risk.
- Discuss the legal importance of, and nursing responsibilities in connection with, informed consent and the importance of the Patient Care Partnership.
- Explain the need for incident reports in nursing practice and the proper method of documentation.
- Describe documentation methods used in specific settings.
- Discuss the role and function of advanced practice nurses and their documentation practices for quality metrics.