Chart for nursing notes

Introduction

The chart is inspired by a tool used by nurses when they document nursing activities.
The chart is preprinted and there is space for making notes of the patient's problems, objectives, actions and evaluation in relation to the nursing. Notes are continuously made in the chart.

Purpose

The purpose of this clinical method is for you to:

- develop ability to make an overview of the nursing on the individual patient
- develop your competences to identify, plan and evaluate nursing on the basis of relevant and reliable data collection
- practice professional nursing language and written communication.

Approach

1. You collect data using the chart for data collection e.g. from the electronic patient file (Appendix 1).
2. You indentify (as well as analyse and assess) the patient's problems.
3. You formulate aims.
4. You plan nursing actions.
5. You perform selected nursing actions and describe these.
6. You evaluate the extent to which you have met your goals as well as the quality of your actions including your collaboration with the patient.

Literature

1. Bekendtgørelse om uddannelse til professionsbachelor i sygepleje
2. Bydam, Jens; Hansen Janet M. (2005). *Sygeplejens fundament 1.* København, Nyt Nordisk Forlag.

3. Pedersen, Søren (2004); *Sygeplejebogen 1*, Gads forlag, KBH
4. Kristoffersen, Nina Jahren (1996). Almen Sygepleje 2. Patient og sygeplejerske, samspil, oplevelse og identitet. Gads Forlag.
5. EPJ. Sundhedsstyrelsens retningslinier for dokumentation 1996

1. Data collection Appendix 1

Patient:
Cause of admission:

Key words used in the electronic nursing file at Odense University Hospital	Collected data
Activity Personal hygiene, mobilisation, use of medical aids. The patient's physical, social and intellectual activities.	
Respiration and circulation Respiratory distress, cough, aspiration risk, blood pressure, pulse, temperature.	
Nutrition Under- and over-nourishment. Eating habits, nausea vomiting.	
Discharge of waste matter Constipation, diarrhoea, incontinence, cystitis.	
Skin and mucosa Skin, mucous membranes, hair, nails.	
Pain and sensory perception Acute and chronic pain Sensory disturbances in relation to vision, hearing, balance, touching	
Sleep and rest Tiredness, insomnia, restlessness, ability to concentrate	
Communication Ability to communicate, understand and make oneself understandable	
Psycho-social conditions Mental conditions related to mental and bodily conditions. Loneliness, abuse, coping, stress	
Sexuality Sexual or other problems related to cohabitation as a result of disease, nursing and treatment	
Knowledge and development Need for information and education, prerequisites for learning	

These data can be supplemented by data relevant to the patient's diagnosis.

Nursing notes **Appendix 2**

2: Problems	3: Aims	4: Planned nursing actions	5: Performed nursing actions	6: Evaluation