

Table 1
ANA's 6 Essential Nursing Documentation Principles

Principle 1 <i>Documentation Characteristics</i>	This principle defines high-quality nursing documentation as inclusive of the following characteristics: <i>"accessible, accurate, relevant, consistent, auditable, clear, concise, complete, legible/readable, thoughtful, timely, contemporaneous, sequential, reflective of the nursing process, and retrievable on a permanent basis in a nursing-specific manner"</i> (ANA, 2010, p. 12).
Principle 2 <i>Education and Training</i>	Nurses must receive adequate training and education on the various facets of nursing documentation according to professional standards and their employing organization's policies and procedures. Training must include competency in using the EMR system specific to the employing institution and proficiency in any site-specific software utilized. Nurses must also be provided adequate time to complete documentation.
Principle 3 <i>Policies and Procedures</i>	Each nurse must become familiar with organizational policies and procedures related to documentation and maintain efficiency during EMR downtime or periods of electronic system malfunction.
Principle 4 <i>Protection Systems</i>	The medical record (paper-based or electronic) must offer appropriate security measures for protecting data and patient information according to the organization's requirements, industry standards, and federal mandates. These protection systems include regulations outlined by the Health Insurance Portability and Accountability Act (HIPAA), which mandate patient confidentiality practices.
Principle 5 <i>Documentation Entries</i>	Everything entered into the medical record must be <i>"accurate, valid, and complete; authenticated (factual), the author is identified, and nothing has been added or inserted; dated and time-stamped by the person who created the entry; legible/readable; and composed using standardized terminology including acronyms and symbols"</i> (ANA, 2010, p. 14).
Principle 6 <i>Standardized Terminologies</i>	Nurses should document utilizing standardized terminology to describe the planning, delivery, and evaluation of nursing care. Using standardized terminology helps with data aggregation and analysis.

(ANA, 2010)

Guidelines For School Nursing Documentation Standards Issues And Models

Ian Pickup



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