Writing in Nursing

Nurses not only care for the physical needs of patients, but also further and create legal, medical, and academic knowledge in the form of workplace documents such as charts, lab reports, and nursing research. On the job, the health of a patient may depend on the nurse's ability to speak and write. Communication with colleagues is crucial in nursing since it can affect the quality of care for patients/clients. Writing must be supported with accurate client observation and up-to-date researched evidence. Audiences include health care providers, nurses, patients or clients, staff, and administrators at clinics and hospitals.

Types of writing

- Nursing Processes (care plans with client history, diagnosis, interventions and outcomes)
- Health History
- Statements of Philosophy (principles and experiences that have shaped career, implementation of principle, field of specialization)
- Lab reports and Case Studies (Analysis of data, interpretation of lab results)
- Research Papers (formulate a relevant research question and come to conclusion based on review of published research; or synthesize information from sources to answer questions about a nursing practice)
- Literature Reviews (synthesis of published work on a nursing issue; Summary of arguments or findings of recent scholarship; critical review or analysis of findings)
- Experiential/ Reflective Narratives
- Position Papers (take a stance on relevant controversy in field; construct argument based on research)
- Charts:
  1. Flowcharts: context-dependent
  2. Care-plans: 1) definition of the problem; 2) interventions and/or solutions; and 3) evaluation of success of interventions and solutions
  3. Narratives: nurses’ notes and observations of patient’s treatment history

Types of Evidence

- Empirical evidence
- Quantitative (measurable data)
- Qualitative (observable behaviors)
- Lab test results
- Data from nurse’s charts
• Research finding in journals  
• Direct observations of patient’s physical or mental health

Writing Conventions

• Record communications with others; all components of a patient’s history must be properly recorded  
• Data-driven evidence must be based on accurate, detailed information  
• Clear, objective tone and confidentiality and sensitivity are important  
• Do not use the first person except for reflective writing  
• 3rd person objective voice is used for research, reviews, case studies, position papers, and when describing nursing practices  
• Passive voice is often used to record observations and procedures  
• Direct quoting is rare; paraphrase to show knowledge and to be more concise  
• Use standard abbreviations  
• Remember your audience:  
  1. Use plain language for clients, avoiding medical jargon 
  2. For health care professionals, be precise and use relevant medical terminology

Terms / Jargon/ Acronyms

• OSHA-Occupational Safety and Health Administration  
• HIPAA- Health Insurance Portability Accountability Act  
• PSQIA- Patient Safety and Quality Improvement Act  
• PHI- Protected Healthcare Information  
• DHHS- Department of Health and Human Services  
• http://nursing.flinders.edu.au/students/studyaids/clinicalcommunication/page_glossary.php?id=13 (contains a long list of acronyms used in clinical communication)

Citation Style

APA- American Psychological Association

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SOURCES: