

# The Language of Nursing Notes

## Note-taking Tips and Tricks for Nurses

Between vitals, assessments, medications and treatments, nurses have a lot of information they are required to document. To make the note-taking process easier, they use abbreviations and mnemonics that allow for notes that are both concise and thorough to ensure the best care possible.

Because of those techniques, nursing notes have developed into a language of their own. Take a look at some common abbreviations, their translations as well as other tips for note-taking.



Before meals



As desired



Complains of



Diagnosis



Hour of sleep, bedtime

## Common Abbreviations (1)

While there are no standard lists of abbreviations, these are some of the most frequently used.



At night



After meals



Reaction time



Treatment

## Routine Mnemonics

A mnemonic is a method used for recalling complex sets of information. Because many nursing routines are both complicated and exact, nurses often use mnemonics like these to ensure that they are ticking all the necessary checkboxes:

### “SOAP”

For a patient's chart:



**S**

**Subjective data:** information provided by patient or family



**O**

**Objective data:** observable signs, symptoms, vitals and lab tests



**A**

**Assessment data:** diagnosis based on subjective and objective data



**P**

**Plan:** strategy for treatment, including short- and long-term measures

### “SAMPLE”

For a patient's health history:



**S**

**Symptoms**



**A**

**Allergies**



**M**

**Medications**



**P**

**Past medical history**



**L**

**Last oral intake**



**E**

**Events leading up to the illness or injury**

### “BALD CHASM”

For a patient's family health history:



**B**

**Blood pressure**



**A**

**Arthritis**



**L**

**Lung disease**



**D**

**Diabetes**



**C**

**Cancer**



**H**

**Heart disease**



**A**

**Alcoholism**



**S**

**Stroke**



**M**

**Mental health disorder**

## Note-Taking Tips

Whether completing a chart or writing notes for a colleague, there are a few things that nurses should always keep in mind:

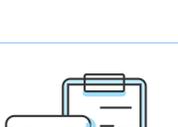


### Standardize notes:

Consistently using the same abbreviations will both improve note-taking efficiency and ensure readability.

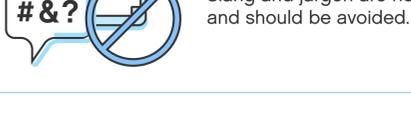
### Take notes immediately:

Taking notes too late after the fact may introduce omissions and errors.



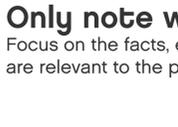
### Avoid slang and jargon:

Slang and jargon are not universally understood and should be avoided.



### Only note what's relevant:

Focus on the facts, events and observations that are relevant to the patient at hand.



### Date and sign everything:

This is especially important for time-sensitive subjects, like medication.

## Abbreviations to Avoid

Misinterpreted abbreviations, symbols and dose designations may lead to harmful medical errors. Thus, these abbreviations are best avoided and should be fully written out instead.

**Medical Center**      **ABBREVIATION**      **WRITE OUT AS**

**CC**

“Carbon copy” or “milliliters”

**D/C**

“Discharge” or “discontinue”

**>**

“Greater than”

**IU**

“International unit”

**<**

“Less than”

**µg**

“Microgram” or “mcg”

**Q.D.**

“Daily” or “Q day”

**Q.O.D.**

“Every other day”

**U**

“Unit”

These are just some of the abbreviations you're likely to come across while working as a nurse. Like dialects of a language, nursing shorthand differs from health care facility to health care facility, and it requires study and practice to master.

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