Practice Guideline:

Documentation in Day and Resident Camps

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These statements assume that the camp's nurse is licensed by the State in which the camp is located and that s/he retains responsibility for performing nursing actions such as documentation practices that are compliance with general nursing standards of practice. In addition, the camp nurse should be familiar with pertinent State requirements, American Camp Association (ACA) Standards, and Association of Camp Nurses (ACN) Standards of Camp Nursing germane to documentation. Camp nursing documentation often includes a variety of forms such as health records, medication records, incident reports, and/or facility logs. These forms of documentation are integrally linked to providing evidence of comprehensive assessment, care, and nursing services provided at camp.

The following statements guide documentation practices for camp nurses. Documentation:

1. Reflects the provider's scope of practice and is appropriate to that scope of practice.
2. Complies with pertinent legal and state requirements and guidelines.
3. Reflects the nursing process: assessment, diagnosis, planning, implementation and evaluation.
    a. It includes a camper or staff member's response to a nursing intervention (i.e. providing medication for leg cramps requires that the nurse documents if the pain improved over time).
    b. It includes nursing action at a secondary or tertiary level of care.
    c. It includes comment to whom a problem was reported when an individual had to leave camp prior to resolution of a health problem.
4. Is completed in a timely manner (as soon as possible after an event).
5. Is retained for the legally appropriate duration of time.
6. Uses the legal name of individual(s).
7. Includes the date and time that nursing care is provided.
8. Is written in an organized, logical pattern from the initial encounter with a healthcare provider through the final outcomes of an event or situation.
9. Is consistently factual; its information is a source for initial and ongoing nursing services.
10. Provides a comprehensive description of care provided by the nurse during the camp experience. It includes:
    a. Preventative care (i.e. medication administration);
    b. Illness assessment (i.e. vital signs on camper with influenza-like symptoms);
    c. Injury intervention (i.e. triage care for twisted ankle); and/or
    d. Education.
11. Includes information about communication as well as attempts to communicate with custodial adults regarding the minor (camper) as appropriate to nursing services and care. Ideally, communication should occur during and after the camp experience.
12. Is legible and uses appropriate grammar and spelling.
13. Is signed by the individual(s) completing the form(s).
14. Utilizes only accepted nursing and medical terminology, abbreviations and notations.
15. Is *SMART* (Specific, Measurable, Appropriate, Realistic, Timely)

References

- American Nurses Association. (2010). ANA's Principles for Nursing Documentation. Retrieved from http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/PrinciplesforDocumentation.pdf.aspx
- Berman, A., Snyder, S., Kozier, B., & Erb, G. (2008). Fundamentals of Nursing: Concepts, Process, and Practice (8th ed.). Pg 258-262. Pearson Prentice Hall; Upper Saddle River, NJ.
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- Medical Terminology Abbreviations retrieved from: http://www.medicalterm.com.au/Free%20Pdf%20notes/Medical%20Terminology%20Abbreviations.pdf OR http://www.delmarlearning.com/companions/content/1401852467/student_resources/termabbrev.pdf