MARGARET H. ROLLINS SCHOOL OF NURSING
PIE Guidelines – 2021

P. Problem – The nursing diagnosis (NDx) or statement of an actual or potential problem.
- Listed in priority order: ABC's, actual before risk
- Must be from **two separate body systems**
- Continuously reevaluate

I. Intervention – Nursing measures that restore, maintain, or promote the patient's well-being and facilitate medical care, for a specific NDx.
- *What you did* to help the problem
- Derived from your orders
- Charted in past tense (instructed, provided, maintained, assisted, encouraged)
- Not assessments (avoid saying "checked, monitored, etc.)
- No rationale needed

E. Evaluation – Initial assessments and patient's response (ongoing assessments) to a specific nursing intervention and/or medical treatment provided.
- Only those assessments and data that relate to the problem
- May include your observations of other disciplines providing treatment

Other Notes – Additional information about the patient, that would not come under a specific ND already being used.
- Notes are used for items not covered by I or E notes. (i.e. MD visit, family visit, abnormal event, wound description, or anything not R/T NDx #1 or # 2).
- *If many other notes exist, a new problem may be needed for the following clinical day*

As a reminder:
- PIE Notes should start with an E note (assessment).
- All entries need to be documented as **either** an I or E, with the appropriate problem number indicated; **ending with an E note.**
- Every entry needs to be initialed and timed. Draw a line through blank spaces.
- Never combine an I and an E into one note
- **Include at least one I and one E for each NDx**
- Make sure notes reflect what happened that day/cover the entire time care was provided
- Follow guidelines for correcting errors (SLIDE) and late entries
- Notes should be neat, no scribbles; **done in black in ink only**
- Avoid using "patient" or "normal"