PIE Documentation Outline

Nursing Diagnosis Form

The night before clinical you need to formulate what you think will be the top 2 nursing diagnoses for your patient based on your patient assignment and research.

Use your care plan book as your guide! (must be NANDA approved look at your list)*

You need to have at least 2 priority nursing diagnoses (problems) for your patient each day of care.

Write your two ND's on the form provided.

Problems = ND's = NANDA diagnosis

List in priority order

Remember your ABC's!

Actual problems *before* risk problems

When choosing your top 2 problems, you need to select NANDA's from different "body systems".

Ie. Cannot choose: Ineffective Breathing Pattern & Imp. Gas Exchange.

Clinical Reasoning = why you chose this problem

EO's

Formulate an expected outcome for each nursing diagnosis.

Remember your EO needs to be ***specific, measurable, attainable, realistic, and timed.***

Take out words like "normal"

Ongoing assessments

Think globally. List as many as you can think of. Use your resources.

Include a realistic time frame for each assessment

Interventions

Start with an action word

Need a time frame for each NI

You need *three* the night before clinical. Use your care plan book/resources to plan ahead.

PIE Documentation

Way to organize nursing notes

Groups information into three categories:

Problem

Intervention

Evaluation

Nursing care is documented using a *problem oriented* approach.

The nurse documents the nursing process & the individualized goal-directed care.

What is the patient's priority problem? (P)

What is your evaluation of the problem? (E)

What are you, as the nurse, doing for the patient to help the problem? (I)

What is the patient's response to your intervention? (E)

Problem (P)

The Nursing Diagnosis (ND) = actual or potential problem

This is derived from ongoing nursing assessments of your patient

Once initiated, the problem list must be continually addressed throughout their stay.

Problems are listed in priority order

Cannot delete or ignore until it is resolved.

Problems may change from one day to the next. Need to continually reassess.

Intervention (I)

Nursing measures that restore, maintain, or promote the patient's well-being and facilitate medical care for a specific ND.

What did you do for your patient to help with the problem?

Should reflect the care you actually provided

Orders you carry out are your interventions.

Always documented in past tense

Use verbs like: provided, maintained, assisted, encouraged

ie. Positioned in high fowler's position in bed.

Document after you have provided the care

May have many interventions for one ND

No rationale in your interventions!

Do not use the word “patient” or their initials.

It is *that* patient’s chart, therefore it’s implied who you are documenting on.

Assessments are not interventions!

Cannot use words like; “checked, assessed, and monitored”.

All interventions require an evaluation at some point in your notes.

Did your intervention, help the patient’s problem?

If you are having a hard time coming up with interventions, then re-evaluate if this is a true problem.

Your documentation should *only* include those interventions *you provided* during your time of care.

Example: Assisted with ambulation 250 feet with use of a walker.

Incorrect: Physical therapy ambulated 250 feet with a walker.

Evaluation (E)

Your assessment of the problem

What the *patient did* after a specific nursing intervention or treatment was implemented

Patient centered

Your analysis of how the interventions worked

Can revise your plan of care based on your evaluation

E notes need to evaluate your ND

Ex: NDx: Impaired Physical Mobility

Which Evaluation is correct?

E note = Feels better after getting out of bed, but SOB noted.

E note = Able to ambulate independently with a walker 50 feet.

May also have an evaluation of your problem based on something accomplished by another discipline. Ie. PT, Respiratory therapy, Radiology.

Ex: NDx: Impaired Gas Exchange

"E" note → Respiratory therapist performed chest PT at bedside.

This isn't something *you did* (not "I"), but something you Evaluated about your ND

Guidelines:

PIE Notes start with an E note

Can combine two "I" notes or two "E" notes when applicable

Cannot combine an "I" and "E" note in one entry!

An "I" is always your action and an "E" is patient centered.

Need *at least* one "I" and one "E" documented for each ND.

Your notes need to reflect what happened that day with your patient – should tell a story!

Late note format:

1015 I_2 - (Late note 0910) Instructed to use IS 10 times an hour.

PIE Charting Form

Need date, patient room #, your initials & signature all complete.

Each entry needs a time noted.

Choose whether your note is an Intervention (I) or an Evaluation (E)

Determine if your note is specific to ND #1 or ND #2.

0810 I_2 Encouraged to cough and deep breathe.

Write your notes in the lines provided.

Each entry needs to be **initialed**

PIE Rules

Notes are to be written throughout the day.

DO NOT wait until the end of the shift to start documenting!

Use only black, permanent ink

Chart what was actually done, only in past tense

Must be Legible

Should be in chronological order

State fact, not opinion!

No vague, meaningless statements- Be specific!

The chart should never contain:

Omissions

"If you didn't document it, you didn't do it"…

Contraindications or inconsistencies

Time delays or gaps

Alterations or the appearance of an alteration. "SLIDE"

Blanks on forms

Reflective PIE

When you document applicable information throughout the day

Then determine which note goes with which problem

May or may not be the problems you came into the day with

Must be priority order

Anything pertinent to your patient's care & well-being is documented

Gives a whole picture of what happened to your patient throughout your care

Use short-hand

Focus on the relevant information