Subjective vs. objective entries

Health care providers should only document factual and objective information from their own treatment and/or observation of the patient. When documenting information derived from other sources, for example, other health care providers, other medical records, or entries in the same medical record, be sure to reference the source of that information. Subjective documentation is far less clinically useful than objective information. Examples of objective/subjective charting include:

Objective statements	Subjective statements
Half of breakfast eaten	Diet taken fairly
No complaints of pain	Had a good day
Surgical incision healing- no signs of infection	Wound OK
Thrashing in bed	Appears restless
IV site clear and infusing at 40 drops per minute	IV running well

A means by which health care providers can document factual and relevant information is by specifically charting information based upon what is:

- **Seen** - charting observations regarding bleeding, deformities, drainage, color of urine, patient posture and/or attitude;
- **Heard** - the patient's complaints/statements, moaning, breathing abnormalities, bowel sounds;
- **Smelled** - malodorous drainage, alcohol or acetone on breath, fecal or vomitus odor;
- **Felt** - areas of induration, hot, cold, dry or moist skin, motion at a fracture site.

When a patient is discharged, it is good medical practice to write a final note commenting on the stability of the patient by noting the patient's vital signs, the status of recovery from the condition on admission, or for an elective admission, the status of recovery from the elective treatment/surgery. The note should completely document the discharge instructions given to the patient and/or the patient's family members.

Following a patient's discharge, health care providers should promptly complete the medical record in accordance with hospital requirements to enable the medical record department to secure the patient record expeditiously and safely.