Reference (include title, author, journal title, year of publication, volume and issue, pages)	Evidence level (I-VII)	Key findings, outcomes or recommendations
Australian Commission on Safety and Quality in Health Care (2017). National Safety and Quality Health Service Standards: Guide for Hospitals (2nd Ed.). Sydney: ACSQHC.	II-IV	Provide a framework for promoting best practice in healthcare safety and quality standards as they reflect current evidence and Australian guidelines.
Blair, W., & Smith, B. (2012). Nursing documentation: Frameworks and barriers. Contemporary Nurse, 41(2), 160-168	V	A systematic review of nursing documentation studies which identified different frameworks for nursing documentation and the barriers to implementation.
Collins, S. A., Cato, K., Albers, D., Scott, K., Stetson, P. D., Bakken, S., & Vawdrey, D. K. (2013). Relationship between nursing documentation and patients' mortality. American Journal of Critical Care, 22(4), 306-313.	IV	A retrospective cohort study conducted over a 15-month period at a tertiary medical centre which related nursing documentation to patient mortality. The study found that more frequent comment and vital sign documentation, due to greater nursing concern about a patient's status, was linked to an increased probability of patient cardiac arrest.
De Marinis, M. G., Piredda, M., Pascarella, M. C., Vincenzi, B., Spiga, F., Tartaglini, D., Alvaro, R., & Matarese, M. (2010). 'If it is not recorded, it has not been done!'? consistency between nursing records and observed nursing care in an Italian hospital. Journal of Clinical Nursing, 19, 1544-1552.	III	A non-randomised cohort study performed over a 6-day period of patients undergoing major abdominal surgery which evaluated how consistently nursing cares were being documented. The study showed that less than half of all nursing interventions were documented in the nursing records, which suggested nursing records did not provide an accurate report of nursing activity. Thus, our section on "planning" has been developed to improve documentation of nursing care.
Häyrinen, K., Lammintakanen, J., & Saranto, K. (2010) Evaluation of electronic nursing documentation—Nursing process model and standardized terminologies as keys to visible and transparent nursing. International Journal of Medical Informatics, 79 (8), 554-564.	IV	A retrospective cohort study conducted over a 4-year period at a tertiary hospital which examined whether electronic nursing documentation was compliant with the nursing process model and the use of standardised terminology. The study found that the use of the nursing process model in progress notes was lacking, and the use of standardised terminology was inconsistent. This study thus informed the use of professional nursing language in our guideline.
Jefferies, D., Johnson, M., & Griffiths, R. (2010). A meta-study of the essentials of quality nursing documentation. International journal of nursing practice, 16(2), 112-124.	V	A systematic review of nursing documentation studies which identified the key features of quality nursing documentation and the issues that could arise in clinical practice.
Johnson, M., Jefferies, D., & Langdon, R. (2010). The Nursing and Midwifery Content Audit Tool (NMCAT): a short nursing documentation audit tool. Journal of nursing management, 18(7), 832-845.	II	A retrospective randomised cohort audit of 200 nursing documentation records across 10 metropolitan hospitals using the Nursing and Midwifery Content Audit Tool. The standards and criteria presented in this study form the basis of the RCH Nursing Documentation Principles.

Databases searched:	☑ CINAHL (Ebsco)	☑ Medline (EBsco)	☑ Pubmed (NLM)	☑ Nursing (Ovid)	☑ Emcare (Ovid)
Keywords used:	nursing documentation, nursing reports, literature review, progress notes, nursing assessment, electronic medical record				
Search limits:	published between 2009-2019				
Other search comments:					