Do's & Don'ts of Documentation

Documentation best practices are key for nursing professionals to know to help protect your career from accusations of malpractice and to prioritize patient safety. This insightful infographic outlines top dos and don'ts of documentation to increase your risk management knowledge and workplace safety.

Take a look!

DO

- Before entering anything, ensure the correct chart is being used
- Ensure all documentation reflects the nursing process and the full extent of a nurse's professional capabilities
- Always use complete descriptions
- Chart the time medication was administered, the administration route, and the patient response
- Chart precautions or any preventative measures taken
- Record any phone call to a physician, including the exact time, message, and response
- Always document often enough and with enough detail to tell the entire story

DON'T

- Don't chart a symptom such as "c/o pain," without also charting how it was treated
- Never alter a patient's record – that is a criminal offense
- Don't use shorthand or abbreviations that aren't widely accepted
- Don't write imprecise descriptions, such as "bed soaked" or "a large amount"
- Don't chart excuses, such as "Medication not administered because it wasn't available"
- Avoid charting what someone else said, heard, felt, or experienced unless the information is critical
- Never chart care ahead of time, as situations often change and charting care that has not been performed is considered fraud

Other charting do's include: Always detail the time and date of entry when making late chart updates and consistently notate patient refusal of medication or other treatment.

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