DEFENSIVE DOCUMENTATION: LEARN HOW GOOD CHARTING CAN PROTECT YOU FROM LIABILITY.

Follow these fundamental principles to protect your patients and protect yourself.

1 CHART PROMPTLY.

Create a habit of documenting actions immediately after your observations or providing care. Prompt charting encourages fresh, detailed notes. If you wait until the end of your shift, you could forget to include important information that would otherwise help you defend against any liability claims.

2 KEEP IT NEAT.

You can't communicate properly if others can't read what you've written. Illegible handwriting wastes their time and could lead to improper care or a patient injury. If your handwriting is hard to read, print carefully. If you don't have enough room to write a legible message, place brackets around the blank section and write "See progress notes." Then document completely and neatly in the notes. Most importantly, clean, legible notes would support your defense against any malpractice claims in court.

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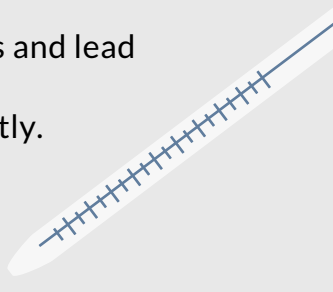
4 WRITE IN INK.

The medical record is a permanent document, so don't write in pencil. Use only black or dark blue ink to ensure legible photocopying. Avoid using a felt-tipped pen on multiple-page forms because the tip may not press hard enough.

5 USED APPROVED ABBREVIATIONS.

Unfamiliar or seldom-used abbreviations can confuse other caregivers and lead to potential patient injuries. Ask to see your facility's list of approved abbreviations. Familiarize yourself with them, and use them consistently.



6 WRITE CLEARLY AND CONSISELY.

Make sure each sentence has a subject. Strive to use short words in place of long ones. Avoid using words such as "appears" or "apparently" when describing signs and symptoms--they make you sound unsure of your observations and could harm your credibility in court.

7 SPECIFY TIMES.

Chart exact times, especially when you document significant patient events, changes in condition, and nursing actions. Avoid entries such as "0700 to 1500" because they imply inattention to the patient and the quality of care given.

8 CHART IN CHRONOLOGICAL ORDER.

Patient improvement or deterioration is easier to spot when events are charted in the order they occur. If you wait until the end of your shift to record all your assessments, you may inadvertently omit important clues about your patient's condition that can come back to bite you. If you must delay documentation, keep a list of notes to expand on when you chart.

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