

I am continually amazed when I go to patients chart to track a particular event, change in condition etc...and I find less than adequate documentation. It is scary actually, because all nurses have had it drilled into our heads that "if its not documented, it wasn't done!" The most recent was just last week. Report was given that a patient had received 120mg I.V. Lasix STAT the night before, but when I checked the chart for outcomes, I found that the nurse did not even document the event at all!! Her reason: This was a long term care resident, and didn't require daily charting!

Let's play the Devil's Advocate here...The patient in CHF does not clear...in fact he worsens overnight, and eventually ends up with Pulmonary Edema and dies. The doctor reviews the chart, see's the telephone order for the Lasix and signs it, but no notation in the nurses note regarding the outcome! The family wants to know what happened. They ask for the patients complete record. The case goes to court. As far as the family, prosecuting attorney, judge, and jury are concerned... the Lasix was not given!! Who is at fault?

In this day and age, nurses have to be extremely vigilant in their assessments, and documentation. Here you will find a list of Do's and Don'ts. I will also be adding disease specific documentation guidelines in the very near future, so check back often. Feel free to print these out and use them at work!

Do:

- ? Check to be sure you have the correct chart before you begin writing.
- ? Make sure your documentation reflects the nursing process, and your professional capabilities.
- ? Write Legibly
- ? On the M.A.R. be sure you document the Name of the medication (brand & generic is most beneficial), Dose, Route, & Time; and in the case of p.r.n. or STAT medications be sure to document the medication name, dose, route, time, & response in the M.A.R. in addition to the nurses notes.
- ? Record each phone call to a physician, or nurse practitioner, including the exact time, message, and response.
- ? Chart a patients refusal to allow treatment or take medication. Be sure to report this to your manager, and patients physician.
- ? Chart all patient care at the time you provide it.
- ? If you remember an important point after you've completed your documentation, chart the information at the time of remembrance, with the notation that it's a "late entry." Include the date and time of the late entry.
- ? Document enough to tell the WHOLE STORY.

Don't

- ? Don't chart a symptom such as 'c/o pain', **without also charting what you did about it, and the effects your actions had!!**
- ? Don't alter a patient's record. **This 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 give excuses, such as "medication not given because not available" without documenting how you went about obtaining the medication, and how you monitored & cared for your patient in the absence of the medication. Always notify the physician if & when a medication is not available because he/she may choose an alternative that you do have on hand!*
- ? Don't chart what someone else said, heard, felt, or smelled unless the information is critical, and pertinent to your patients status. In that case, use quotations and attribute the remarks appropriately.
- ? Don't chart care ahead of time; something may happen and you may be unable to actually give the care you've charted. Charting care that you haven't administered is considered **FRAUD**.

*The NSO actually stated "Don't give excuses, such as "medication not given because not available". However in the Long Term Care / Assisted Living Environments, healthcare providers rely on daily deliveries from pharmacy. A STAT delivery can take up to 6 hours at times. A recent example was of a resident that was exhibiting changes in mental status including, delusions, combativeness, and aggression toward other residents secondary to a urinary tract infection. The doctor ordered 0.5mg Haldol (Haloperidol) p.o. now, may repeat x1 in 1 hour if no effect. The facility did not have Haldol on hand. However they did have Ativan (Lorazepam). After realizing that the emergency kit did not contain Haldol, the nurse called the doctor and he in turn ordered Ativan 1 mg p.o. now. Then Ativan 0.5mg p.o. q4hours p.r.n. Agitation/Aggression x 2days. Re-evaluate patients mental status in 2 days, and notify M.D. for follow-up.

[Widely Accepted Medical Abbreviations](#)

Some information above was derived from the [Nurse Service Organization's](#) 1-day seminar "Avoiding Nursing Malpractice"