Nurses Notes: Guidelines On What Not To Chart

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The significance of accurate, timely documentation by nurses and other members of staff cannot be emphasized enough. However, some types of documentation should not be entered onto the patient's medical record for various reasons. This piece contains a general list of notations that nurses should not document in the patient's chart.

The medical record is a permanent collection of legal documents that should supply an all-encompassing, accurate report concerning a patient's health condition. Physicians, nurses, social workers, dieticians, mid-level providers and other members of the interdisciplinary team contribute to each patient's medical record to paint a comprehensive picture of the patient's status along with any care that has been rendered. The patient's chart needs to contain enough pertinent data to enable each member of the healthcare team to render care in an integrated manner.

Most nurses have probably heard the old adage, "If it was not charted, it was not done!" However, some types of documentation should not be entered onto the patient's medical record for various reasons. Since the chart is a permanent record that is subject to entrance in court-ordered legal actions, nurses and other healthcare professionals must exercise extreme caution when documenting. The following is a very general list of the notations that nurses should not document in the chart.

**Never document nursing care before it is provided.**

Nursing staff should never chart assessments, medication administration or treatments prior to actually completing the tasks because this may contribute to an inaccurate record filled with incorrect data. If the medical record contains nursing care that was never performed, this is fraudulent in some cases. Always remember that other clinicians may depend on correct documentation to assist in formulating decisions regarding patient care.

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Do not routinely document care rendered by others.

It is allowable in several instances to document care, tasks or procedures performed by another individual. However, the documentation in the medical record must clearly indicate the individual who actually rendered the care. If the house nursing supervisor applied the four point restraints, be sure to identify him/her as the person who carried out the task. But do not regularly chart actions that have been performed by other people. If a coworker or super-ordinate does something incorrectly that results in patient injury or death, you do not want culpability.

Never leave blank spaces between entries.

In this day and age of prevalent electronic medical records, some facilities and healthcare settings still utilize paper charting. Nurses who still use paper and pen to chart must never leave blank spaces between entries. These unused spaces might be used by others to add questionable notations, so always be sure to draw a line across blank areas.

Do not chart that a patient is in pain unless you have intervened.

No prudent nurse would even think of documenting "Patient complains of radiating chest pain," without subsequently documenting what was done about the issue. Thoroughly chart all notifications, interventions and actions taken to avoid liability.

Do not record another patient's name in the medical record.

Let's assume that Mr. Wright gets into a physical altercation with his roommate, Mr. Robinson. The nurse is violating Mr. Robinson's confidentiality if she documents his name anywhere in Mr. Wright's medical record, and vise versa. To get around this issue, employ a vague description such as 'the roommate' or the 'patient in bed A.'

Whenever possible, do not document subjective descriptions.

Attempt to refrain from charting subjective descriptions such as "Patient's blood pressure is really high." Obtain accurate vital sign checks, intakes and outputs, and other objectively measurable data and record this information in a timely manner.

Do not openly criticize the care that was rendered by a coworker.

The medical record is a group of documents that should provide a comprehensive view of the patient's condition. Conversely, the medical record is not appropriate for criticizing care performed by other members of the healthcare team. Berating a fellow nurse, nursing assistant or technician in the nurses notes will accomplish nothing other than perhaps fuel the fire of state surveyors, malpractice attorneys and anyone who happens to read the chart at a later date.

Do not mention short-staffing in the medical record.

Documenting the existence of staffing issues in the medical record rarely, if ever, helps to increase the number of staff members. On the other hand, medical malpractice lawyers love reading nurses' notes that provide details about a facility's lack of staff.

Do not make insulting references to patients while charting.

Try to avoid referring to patients as 'drug seekers,' 'rude,' 'vulgar,' 'profane,' or 'crazy' when documenting. Utilize objective phrases and direct quotes whenever possible such as 'Patient states to this writer, "You are a ___ (B-Word) and I will kill you!"'

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Do not ever document the existence of incident reports.

Never document the preparation of an incident report in the nurses notes. The incident report is an internal document meant to facilitate improvement of systems and processes within the healthcare facility. If a nurse charts a note describing that an incident report was completed, this internal form now becomes subject to discovery by external medical malpractice lawyers if legal action were to arise at a future time.

More Tips For Charting (helpful video added by staff)