QUICK REFERENCE

Chart It Right

Documentation Dos & Don'ts Cheat Sheet — Kimberly Paige, RN

The Dos

- **Chart in real time** — don't wait to "catch up"
- **Be specific and objective**, not vague
- **Chart the action AND the response**
- **Use only approved abbreviations**
- **Chart patient/family education**
- **Time-stamp accurately** — actual event time
- **Chart changes in condition** immediately
- **Chart provider notifications** — who, what, when
- **Use direct quotes** for pain/safety concerns
- **Chart objective findings only** — not your interpretation
- **Proofread before you save**

Pediatric Notes

- **Vitals need age context**
- **Parent-reported symptoms are valid data**
- **Note developmental/baseline changes**
- **Chart parent understanding separately** from child's status

The Don'ts

- **Never chart for someone else**
- **Don't leave blank spaces** on paper charts
- **Don't use absolutes without support**
- **Don't copy-forward** without verifying
- **Don't editorialize or vent** — facts only
- **Don't guess on times/numbers**
- **Don't delay charting incidents** or errors
- **Don't add detail later** outside proper amendment process
- **Don't rely on memory** — jot notes during shift
- **Don't skip charting "nothing happened"** — chart the normal too

Charting by Exception

- Know your facility's definition of "normal"
- Deviations still need full, objective detail
- Reduces redundancy — not your responsibility to notice changes

5-Second Gut Check

1. Makes sense to someone who wasn't there?
2. Specific enough to stand alone?
3. Only what I actually saw or did?
4. Comfortable if read back in a year?
5. Did I chart the response, not just the action?