A FREE GUIDE FOR NEW NURSES

Chart It Right

Documentation Dos & Don'ts Every New Nurse Needs

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Why Charting Matters

Your charting is more than a task on your shift checklist — it's your legal record, your communication tool with the next shift, and often your best defense if a patient's care is ever questioned. Good documentation protects your patient and it protects you.

Part 1: The Dos

1. **Chart in real time.** Waiting until the end of your shift to "catch up" invites mistakes and missed details. Chart as close to the event as possible.
2. **Be specific and objective.** "Patient appears comfortable" tells the next nurse very little. "Resting quietly, respirations even and unlabored, denies pain 0/10" tells them everything.
3. **Chart what you did and how the patient responded.** An intervention without a documented response is an incomplete story.
4. **Use only approved abbreviations.** When in doubt, spell it out.
5. **Chart patient and family education.** Teaching is part of your care and needs a paper trail.
6. **Time-stamp accurately.** If you're charting late, note the actual time the event occurred, not just when you wrote it.
7. **Chart changes in condition immediately**, even small ones — trends matter more than single data points.
8. **Chart notifications to providers**, including who you called, what you reported, and what they said back.
9. **Use direct quotes when relevant**, especially for pain descriptions or safety concerns ("patient states pain is a 4, 'like a dull ache'").
10. **Chart objective findings, not subjective interpretations.** Document what you observed, measured, or heard the patient/family say — not your personal read on the situation. "Patient grimacing, guarding abdomen, rates pain 7/10" is objective. "Patient seems to be exaggerating pain" is subjective and shouldn't appear in a chart, even if it's your honest impression.
11. **Proofread before you save.** A rushed note with the wrong name, date, or med can cause real confusion down the line.

Part 2: The Don'ts

1. **Don't chart for someone else — ever.** Each entry should reflect only what you personally observed or did.
2. **Don't leave blank spaces on paper charts.** Blank spaces can be altered later and raise questions.
3. **Don't use vague absolutes without support.** Back up "tolerated well" with what you actually observed.
4. **Don't copy-forward without verifying.** Confirm accuracy before reusing yesterday's note.
5. **Don't editorialize, vent, or assign blame.** Stick to facts, not opinions.
6. **Don't guess on times or numbers.** If you don't know exactly, note it as approximate rather than inventing precision.
7. **Don't wait to chart a fall, error, or safety event.** Delayed documentation on incidents looks worse than it is, even when nothing was wrong.
8. **Don't use charting to cover yourself after the fact.** Adding detail days later, outside your facility's amendment process, can look like a cover-up even when your intentions were good.
9. **Don't rely on memory for multiple patients' worth of details.** Jot quick notes during your shift so nothing gets mixed up.
10. **Don't skip charting because "nothing happened."** A normal, uneventful assessment is still worth a clear, brief note.

Part 3: Charting in Pediatrics — A Few Extra Notes

- **Vitals need context.** A heart rate that's "normal" for a toddler would be alarming in an adult — always chart vitals alongside age-appropriate norms if there's any ambiguity.
- **Parent-reported symptoms are data.** "Mother reports child has been more fussy and refusing bottles since this morning" is valid and important documentation, even though you didn't witness it yourself.

- **Developmental observations matter.** Noting whether a child is meeting expected milestones, or acting differently than their baseline, can be clinically significant.
- **Document parent teaching and understanding separately from the child's status.** Parents are often the ones carrying out care after discharge, so their comprehension is its own data point.

Charting by Exception

Many hospitals use a "charting by exception" (CBE) model, where normal, expected findings are covered by a standardized protocol or flowsheet, and your narrative notes focus only on what deviates from that baseline. Under CBE:

- You still need to know your facility's definition of "normal" for each parameter, since that's the standard you're charting against.
- Deviations, changes, and anything outside expected parameters still need full, objective detail — no shortcuts there.
- CBE reduces redundant documentation, but it doesn't reduce your responsibility to notice and document changes promptly.

Part 4: What This Looks Like in Real Life

> **SCENARIO 1 — GENERAL ASSESSMENT**
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> Before: "Pt seems okay today. Mom was worried but I explained everything."
> After: "Patient resting in bed, playful and interactive, afebrile, tolerating oral intake well. Mother expressed concern regarding fever spikes overnight; reviewed expected fever pattern with current illness and signs/symptoms warranting provider contact. Mother verbalized understanding."

> **SCENARIO 2 — MEDICATION ADMINISTRATION**
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> Before: "Gave Tylenol, pt fine."
> After: "Acetaminophen 160mg PO given at 1400 for reported headache, pain rated 5/10 prior to administration. Reassessed at 1445, pain rated 1/10, no adverse reaction noted."

> **SCENARIO 3 — FALL / INCIDENT**
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> Before: "Pt fell, no injury, family upset."
> After: "At approximately 0930, patient found on floor beside bed, alert and oriented, denies loss of consciousness. No visible injury noted on assessment; vital signs stable. Assisted back to bed, bed alarm activated, side rails raised. Provider notified at 0935, no new orders given. Parent present at bedside, updated on findings and plan of care."

> **SCENARIO 4 — DIFFICULT FAMILY CONVERSATION**
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> Before: "Family was difficult and kept asking questions."
> After: "Parent expressed concern regarding length of hospital stay and requested update on discharge timeline. Reviewed current plan of care and anticipated next steps with parent; encouraged parent to direct further questions to primary provider during rounds."

Part 5: FAQ

What if I make an error after I've already saved the note?

Never delete or white-out an entry. Follow your facility's official amendment/late-entry process, which typically involves a new dated addendum referencing the original note.

How much detail is too much?

Enough detail to paint a clear, accurate picture — without unnecessary narrative. If a detail doesn't add clinical value, it probably doesn't need to be there.

What if I'm genuinely unsure whether something needs to be charted?

When in doubt, chart it. A few extra seconds of documentation is almost always better than a gap in the record.

Do I need to chart normal findings, or just abnormal ones?

It depends on your facility's system. Some require documenting all findings, normal and abnormal. Others use charting by exception, where normal findings are captured by a standard flowsheet and your notes focus on deviations. Know which system your facility uses — and when in doubt, document anything outside the expected baseline.

Part 6: The 5-Second Gut Check

Before you hit save, ask yourself:

1. Would this note make sense to someone who wasn't there?
2. Is it specific enough to stand on its own?
3. Does it reflect only what I actually saw or did?
4. Would I be comfortable if this note were read back to me in a year?
5. Did I chart the response, not just the action?

Charting well isn't about perfect grammar — it's about painting an accurate, defensible picture of the care you gave. When in doubt, chart the facts, chart it now, and chart it like someone else's shift depends on it — because it does.

Kimberly Paige, RN | For more first-year nursing resources, visit my Gumroad shop.