Charting Quick Reference

Documentation · assessments · progress notes · pitfalls

DOCUMENTATION MUST-HAVES

- **Time & Date**
  Always document exact time of assessment and all interventions.
- **Objective First**
  Lead with measurable data — vitals, labs, wound size, SpO2.
- **Patient Response**
  Note how the patient responded to treatment or medication.
- **Quoted Speech**
  Use exact quotes for patient statements. Never paraphrase symptoms.
- **Avoid Assumptions**
  Chart what you observe and measure, not what you assume.
- **Late Entries**
  Label as "late entry," include correct time and clinical reason.
- **Error Correction**
  Single line through error, your initials, date. Never white-out.
- **Countersign**
  Follow facility policy for all countersignatures and co-signatures.

COMMON CHARTING PITFALLS TO AVOID

- **Vague language**
  "Seems uncomfortable" — chart exact observed behaviors.
- **Copy-paste errors**
  Verify every note is accurate for this patient, this shift.
- **Charting in advance**
  Never chart before care is given. Always chart after.
- **Missing follow-up**
  Called MD? Chart their response and any orders received.
- **Skipping abnormals**
  Every abnormal finding needs documentation and an action.
- **Subjective labels**
  "Uncooperative" — chart specific observed behaviors only.
- **Incomplete med notes**
  Always document route, dose, site, and patient response.
- **Missing timestamps**
  Every entry needs a time. Undated entries are legally weak.

PROGRESS NOTE FRAMEWORK — DAR / SOAP

- **D — Data**
  Subjective and objective findings. Vitals, labs, patient complaints.
- **A — Action**
  What you did: meds given, interventions performed, MD notified.
- **R — Response**
  Patient response after intervention, including specific time.

- **S — Subjective**
  "My pain is 7/10 in my left leg and started this morning."
- **O — Objective**
  What you observe: vitals, wound appearance, SpO2, skin color.
- **A — Assessment**
  Your nursing judgment: patient showing signs of fluid overload.
- **P — Plan**
  Next steps: monitor, notify MD, reassess in X hours, education.

NOTIFICATION DOCUMENTATION CHECKLIST

- [ ] Exact time of notification and method (call, page, in person)
- [ ] Name and full title of the person notified
- [ ] Information communicated — use SBAR structure
- [ ] Orders received or response given verbatim
- [ ] Your follow-up action and patient response with time
- [ ] If no response: time of attempts, chain of command used

★ REMEMBER
If it is not documented it did not happen. Your charting protects your patient and protects your nursing license. When in doubt, chart it out.