Professional Nursing Services
10615 York Road
Cockeysville, MD 21030
(410) 683-9770

Nurses Notes: Assessment & Documentation Tips

1. Be extra careful when you think you are "too busy." It is at your busiest time that the importance of documenting is the most crucial. Be aware of critical times such **as:**

- abnormal vital signs
- taking verbal orders
- noting physician's orders
- verifying medication orders

2. Avoid general statements. Beware of general statements that can be misconstrued. For example, you wrote "Tolerated well"

What did you mean?- How do you know they tolerated it well… what were you looking for to let you know? What did you find- or not find- that substantiates your findings.

A better option is "GT feeding completed with 120ml h20 flush; tolerated with no reflux or residual noted; no abd distention or returns with GT venting"

3. The Initial Assessment section is a form of Charting by exception- this means that you document to clarify the items circled that require more detail and add items that are not in the prompt list

4. All documentation should be::
Objective- chart what you can see, hear, feel measure and count ONLY
Legible
Free of grammatical/spelling errors
Free of errors/erasures
Completed in black ink
Accurate- do your charting at the time of the activity- or as close to completion as possible

5. Late entries and any corrections – one line strike through with error written clearly above and initialed by the writer.

6. Allergies should be highlighted and flow sheets filled out completely.

7. No charting should be done in advance.

8. Charting patterns including flow sheets will be reviewed. "Always the same" charting, where the notes are written the same way every day, may raise doubts. Patient assessments such as fall risk or skin assessments must be carefully performed and documented; failing to do so is a common error.