

## **21 STEPS TO LEGAL DOCUMENTATION**

1. Always follow facility policy and procedure for charting.
2. Chart in black ink.
3. Include client name and health record and 3<sup>rd</sup> party payor number on each page.
4. Enter date and time per entry.
5. Record data on the right form.
6. Use standard abbreviations approved by agency.
7. Sign each entry with first name, last name and initials of your title. If you carry over to a new sheet, sign both entries.
8. Chart in chronological order. If entry is done out of order, enter date and time of when entry was to be made. Example: Charting for \_\_\_\_\_ (date) \_\_\_\_\_.
9. Use every line so your entry cannot be altered.
10. Do not erase or write between the lines. If you make a mistake, draw a line through or circle the mistake, write "error" and initial the error.
11. Record care as close as possible to the time it was provided.
12. Document only on the clients for whom you care.
13. Record data you can SEE, HEAR, SMELL and TOUCH.
14. Eliminate bias, judgment and labels.
15. Do not generalize. Be specific – chart in measurable terms.
16. Document symptoms in the client's own words.
17. Ensure continuity by noting problem, nursing action taken and changes in status.
18. Document safeguards used to protect.
19. Document all physician visits and consultations whether in person or per telephone.
20. Document all discussion of questionable physician orders, confirming, canceling or modifying of orders. Include time and date and actions as a result.
21. It is not enough to chart changes in condition, refusal of Meds/Tx. What are you going to do about it? What did you do about it?