Charting Guidelines and Progress Notes

Progress Notes

- A way to document all the care the nurse provides for a patient during one shift.
  - Every time the nurse repositions the patient, give medication, or helps the patient to walk, it must be written down
  - This patient record becomes a legal document of care and can be used as evidence in a lawsuit against a medical worker or medical facility

Rules of Charting

1. All writing should be done in BLACK INK
2. Handwriting must be neat and readable
3. Sign your name and title at the end of each entry
    1. Example: *Bob Smith RN*
4. Do not erase or scribble in the chart. If you make a mistake, draw a SINGLE line through it, write error and write you initials

    Error
    1. Example: *Ate 100% of ~~Dinner~~ Breakfast. BS*

Rules of Charting

5. Record ONLY objective observations.
    - Do not record your opinions or guesses.
    - DO record the patient's reactions to the procedure.
    - When recording a patient statement, use the patient's own words and enclose them in quotation marks
6. Record the proper date and military time for each entry.
7. Use only standard medical abbreviations

Rules of Charting

8. Write numbers and measurements in actual figures rather than using general terms such as "many" or "OK"
9. Leave no empty lines in the record.
   - If your entry does not take up the entire line you draw a line through the remaining space so nothing can be added
10. Use correct spelling

Rules of Charting

11. Patient's name is included on the chart and does not need to be re-written for each entry.

12. Complete the record as soon as possible after the activity being recorded.

- Record ONLY the cares you personally provided

Charting Assignment