

Do's of Charting

- Do use approved abbreviations.
- Do write legibly.
- Do spell correctly.
- Do use black ink – unless facility policy dictates another color.
- Do be concise in statements, use short phrases.
- Do document in chronological order.
- Do quote patient subjective remarks.
- Do sign correctly – SNS as Sinclair Nursing Student.
- Do be specific in descriptions – how, when, who, details, actions/interventions.
- Do chart specific responses to treatments.
- Do correct an error without writing over, whiting out, scribbling out. Follow agency policy.
- Do document promptly.
- Do chart any change in condition.
- Do chart if doctor was notified.

Don'ts of Charting

- Do not use the words patient, he, she, or the patient's name in charting. Instead begin with verbs such as ambulate or nouns such as respirations.
- Do not use a, an, and, the – use a comma.
- Do not use unnecessary verbs.
- Do not use general terms such as good, well, poor, normal. Be descriptive and specific.
- Do not chart personal opinions, assumptions, conclusions.
- Do not leave blanks.
- Do not write complete sentences.
- Do not double chart from flowsheet to narrative unless policy of agency.
- Do not ever use whiteout or erasers pm a chart.