Do and Don'ts Documentation Narrative and Information Technology

- Use black colored ink pen for narrative documentation.
- Date and time entries
- Document care, medication, treatments, and procedures as soon as possible after completion.
- Document patient responses to interventions.
- Document consent for or refusal of treatment.
- Document calls made to other healthcare providers. What did you see, who did you tell (First and last name), what were your orders….
- Use quotation marks as appropriate for subjective data.
- Use correct spelling, grammar, and punctuation.
- Sign entitled each entry with author and last name as appears on license.
- Follow agency policies when an error is made. (i.e. draw a line through the error initial and date).
- Follow agency guidelines regarding late entries. Use only identification code name or password for computerized documentation.
- Do not share passwords. Maintain privacy and confidentiality of documented information printed from a computer.
- Do not document for others or change documentation for other individuals. Do not use unacceptable abbreviations.
- Do not use judgmental or evaluative statements such as "uncooperative patient".
- Do not leave blank spaces on documentation forms. Do not lend access, identification, computer codes to other people. Change passwords at regular intervals.
- Record accurately with the sequence of events.
- DO NOT write assumptions or conclusions.
- DO NOT pre-chart.
- Document your observations, not what someone told you.
- DO NOT falsify entries.
- Use name of interpreter, not a family member.
- Avoid arguing or criticizing in the chart.
- Copy and paste raises questions of accuracy.
- Watch for autofill and key word fill.
- Be very clear for edits made in the record- looks like falsified records.