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The Importance of Charting and Documentation in the Nursing Profession

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NORTHERN ILLINOIS UNIVERSITY

The Importance of Charting and Documentation in the Nursing Profession

**A Capstone Submitted to the
University Honors Program
In Partial Fulfillment of the
Requirements of the Baccalaureate Degree**

With Honors

Department of

Nursing

By

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Dekalb, Illinois

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Introduction

Nursing is a profession that can take you to endless different directions, not just in the hospital. Some may decide to work in a clinic, a school, or even in aesthetics. Although the setting and workday are different, one thing remains the same: charting. Charting is an everyday, every patient requirement for all nurses. Every encounter with a patient is documented in an online database. Details of the encounter, such as patient and family history, medications, statements made, and tasks that are preformed are all written down, painting the scene like it's a movie. The documentation never gets deleted, so it is very important that all the information typed is clear, concise, and correct. Charts are frequently reviewed by legal teams for malpractice lawsuits, and if the charting is not clear or correct about an interaction with a patient, that nurse's license could be at risk for termination.

Purpose

Documentation is unarguably one of most important skills to learn before becoming a nurse, but most nursing schools do not have a class dedicated specifically to charting. This can create many problems for newer nurses who lack the experience and knowledge of how to properly word your documentation to avoid legal trouble. We are currently seeing an increase in nurses being charged with malpractice relating to charting mistakes and seeing all their hard work to obtain their degree and license go down the drain. This is a very real and very preventable reality for a lot of people in the healthcare field. The purpose of this project is to help educate nursing students and newer graduates on the proper way to chart, show examples of common mistakes, and specific wording to avoid, ensuring they have all the tools necessary to start their career out strong in the healthcare field.

Review of Supporting Literature

There has been a significant rise in malpractice cases involving nurses in recent media, and “documentation deficiencies were contributing factors in many nurses’ professional liability claims and State Board of Nursing matters” (Nurses Service Organization, 2022). Medical charts are legal documents, so why is there a lack of education about legal writing within nursing schools? In healthcare, “people’s lives often depend on the accuracy and availability of treatment information. During a single hospital visit, multiple healthcare professionals will make notes in a patient’s EHR, resulting in what sometimes feels like a game of telephone with lives at stake” (Nurses Service Organization, 2022). Having excellent documentation skills is vital to the nursing career, “documentation is utilized to determine the severity of illness, the intensity of services, and the quality of care provided upon which payment or reimbursement of health care services is based. Data from documentation provides information about patient characteristics and care outcomes” (American Service Association, 2022). A few common charting mistakes can lead to errors in a patient’s treatment – with malpractice lawsuits not far behind (Nurses Service Organization, 2022).

While reviewing real life cases regarding malpractice and charting, three major themes stood out to me. A lot of the cases were based on incomplete documentation, inaccurate text, or transcription errors. Incomplete documentation refers to when the nurse does not chart as much as they should have for a given intervention performed. The charting was either lacking important details or follow up information. Inaccurate text regards false information that was placed in the patient’s chart. This could be vital signs that were not correct, or lab values that were mistyped. Transcription errors are referring to people reading the chart and not

understanding the meaning of a documentation. This is commonly seen with shorthand and abbreviations or typing errors that led to devastating mistakes.

Documentation mistakes are an interdisciplinary issue within the healthcare field. Physicians are also at a height of medical malpractice lawsuits in The United States. In fact, “medical documentation issues play a role in 10–20% of medical malpractice lawsuits. Inaccurate, incomplete, or generic records undermine a physician’s defense and make a plaintiff’s lawyer more likely to take on a case” (Ghaith et al., 2022). All healthcare fields, not just nursing, that work directly with patients would benefit from an evidenced-based manual on the do’s and don’ts of charting.

Evidenced-Based Manual

Incomplete Documentation

A major issue regarding charting is incomplete documentation, “A study conducted by Genctuc et al. (2017) revealed that nurses do not record their actions to a great extent and they only record observations when there are abnormalities” (Mutshatshi et al., 2018). This becomes a problem when patient charts are reviewed, and it appears that vital steps in care were skipped over, just because they were never documented. A golden rule to follow is that if you did not chart it, you did not do it!

Do’s	<ul style="list-style-type: none"> • Do chart your normal findings! Not charting normal findings may suggest that those assessments were not performed. • Do write down every intervention you perform. Always remember; If you did not chart it, you did not do it!
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	<ul style="list-style-type: none"> • Do chart all precautions and preventative measures that were put in place. If no preventative measures or precautions are charted, it suggests that they were not done, and you could be found negligent.
Don'ts	<ul style="list-style-type: none"> • Don't chart "patient complains of pain" without charting what was done to address the pain. Also remember to chart reassessment of pain after pain intervention was completed. • Don't chart "patient refused treatment" without charting the education provided and that the provider was notified. • Don't forget to chart dates and times of task performance, information relayed, or when orders are given. If you are charting a late entry, make sure to note that so it does not appear that the task itself was done later than it was ordered to be done.

Inaccurate Text

The second problem being addressed is inaccurate text in patient charts. Proper and "accurate documentation is essential to avoid types of nursing documentation errors, and for helping to avoid patient deaths or increased liability for the caregiving facility, physician, or nurse" (Kluwer, 2018). If false information is entered into the chart, the wrong orders, tests, or diagnosis may be given which can lead to devastating consequences for the patient.

Do's	<ul style="list-style-type: none"> • Do make sure the correct patient chart is open before going into their room. • Do try to chart the patient care that is provided as soon as you do it. Waiting till later in the shift to chart may cause important details to be forgotten.
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	<ul style="list-style-type: none"> • Do take your own vital signs and do your own assessments, don't take another person's word for it. Remember, it is <i>your</i> license on the line.
Don'ts	<ul style="list-style-type: none"> • Don't jump to conclusions within the chart. If labs and other diagnostic tests are not back, jumping to a conclusion can cause other assessments and details to be missed. • Don't diagnose the patients. Even if you think that you know exactly what is happening to them, it is not within our scope of practice to diagnose. • Don't copy and paste columns of previous charting to save time. Even if you think that nothing has changed with the patient after reassessing them, copy and pasting the previous charting can indicate that you did not actually reassess the patient, and be deemed as negligence.

Transcription Errors

The last source of many errors being addressed is transcription, or the “transfer of information from an order sheet to nursing documentation forms” (Massachusetts Coalition for the Prevention of Medical Errors, 2001). Transcription errors also refer to charting that does not paint a clear picture of events for the person reviewing the record. If there is not a clear understanding of the events that took place, it creates room for argument for negligence on behalf of the nurse or other healthcare staff.

Do's	<ul style="list-style-type: none"> • Do confirm new orders with the provider using the verbal read back method. • Do chart enough details so a clear picture of care is painted. • Do read over what you are charting before you save it so that you ensure what you are typing makes sense.
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Don'ts	<ul style="list-style-type: none">• Don't chart “will continue to monitor” if you will be away from the patient’s bedside. If something goes wrong with that patient, and you were not in the room monitoring, you could be found liable because you were supposed to be monitoring.• Don't use shorthand or abbreviations that are not widely accepted.• Don't make excuses or chart defensively.
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Conclusion

Charting and documentation are a large part of every healthcare role, especially nursing. It is not uncommon for a nurse to testify in court regarding an incident that occurred at work, so it is important that the patient’s chart reflects accurate information about what took place. It is important to remember that patient charts are legal documents, so they must be treated as such every time you are making an entry. There are even courses that are now emerging within the nursing field to address this important topic. One of those that is widely recommended is called *Charting with a Jury in Mind*. As we continue to see a rise in new graduate nurses entering the workplace, it is important to educate them immediately on the proper way to chart to protect their hard-earned license.

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