THE CHARTING RESET

A quick guide to clearer, clinically useful nursing documentation

A strong nursing note tells the clinical story - not just the task.

THE FIVE PARTS OF A COMPLETE CLINICAL STORY

Use these prompts to decide what belongs in your documentation.

01 PRESENTATION

Why is this patient being assessed now? Record the concern, change, onset, or patient statement.

02 ASSESSMENT

Use specific, relevant observations. Support conclusions with documented findings and data.

03 ACTION

Capture the care performed, safety measures, and relevant treatment; use the MAR and flowsheets.

04 RESPONSE

Document reassessment and the observed or patient-reported response at an appropriate interval.

05 COMMUNICATION

Record important escalations, the information shared, orders or directions, and follow-through.

THE RULE THAT MATTERS MOST

Chart what you assessed, did, observed, and communicated - not what you assumed.

Educational resource only. Follow facility policy, EHR workflows, and applicable standards. Do not include patient information on this handout.

REAL-WORLD CHARTING EXAMPLES

Examples of documentation that connects assessment, action, and response.

Illustrative examples only - chart the findings and actions you actually observe and perform.

PATIENT RESPONSE

VAGUE

"Patient okay after medication."

MORE CLINICALLY USEFUL

"Morphine 2 mg IV given at 1432 for 8/10 abdominal pain. At 1505, pain 4/10; RR 18/min, unlabored; patient denies dizziness or nausea."

ESCALATION

VAGUE

"Doctor aware."

MORE CLINICALLY USEFUL

"Provider notified at 0918 of BP 86/52 mm Hg and new dizziness. Order received for 500 mL LR bolus; initiated at 0924. Will reassess BP and symptoms."

PATIENT EDUCATION

VAGUE

"Patient educated."

MORE CLINICALLY USEFUL

"Reviewed discharge instructions, medication schedule, and return precautions. Patient correctly described when to seek urgent care and had no further questions."

PRE-SIGN DOCUMENTATION CHECKLIST

- [ ] Why am I documenting this?
- [ ] What did I actually assess or observe?
- [ ] What action did I take?
- [ ] What was the patient response?
- [ ] Who did I notify and what followed?
- [ ] Does the note tell a clear clinical story?

Educational resource only. Follow facility policy and document care in the approved record.