

Documenting

General Guidelines for Recording

8. **Sequence:** documenting events in the order in which they occur; for example, record assessments, then the nursing interventions, and then the client's responses.

Out-of-sequence entries must be acknowledged. See next slide.

9. **Accuracy:** the client's name and identifying information should be written on each page of the clinical record. Accurate notations consist of facts or observations rather than opinions or interpretations. It is more accurate, for example, to write that the client "refused medication" (fact) than to write that the client "was uncooperative" (opinion). A legal nightmare!

Er Documentation Guidelines

G Thomas



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