MDS Alert

Tool: 10 Rules for Defensive Documentation

1. Have a purpose to your entry.
2. Be descriptive.
3. Be concise and precise.
4. Don't leave the next reader in suspense and wondering what happened.
5. Don't leave problems of last shift unaddressed.
6. Describe resident responses and reactions to therapy, med changes, and other aspects of care.
7. Include signature, date, and time.
8. Use legible handwriting, and never skip lines.
9. Make sure every entry corresponds with the resident's care plan.
10. Remember that the chart is a legal document and that it reflects on you and your abilities as a nurse.

Source: Karen Merk, R.N., B.S., Clinical Risk Manager for **GuideOne Risk Resources for Health Care**. For tools you can use to audit your documentation, go to www.goriskresources.com.