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FREE GUIDE FOR BEDSIDE NURSES

25 Phrases That Weaken Your Chart

And the exact words to write instead, built from what actually gets read out loud in depositions.

> NURSING NOTE · 0247
>
> Pt **appears intoxicated**, uncooperative with assessment. **Will continue to monitor.**

I break down malpractice cases so you don't become one.

START HERE

Why this matters

You are not going to be asked about your patient. **You are going to be asked about your chart.** And you are going to be asked years after you last thought about that shift.

4.2

Average years for a malpractice claim with an indemnity payment to close

NSO/CNA, 5TH ED., 2025

38.0%

Of license protection matters allege professional conduct, the largest single category

NSO/CNA, 5TH ED., 2025, FIG. 20

14.0%

Allege scope of practice, the second most common

NSO/CNA, 5TH ED., 2025, FIG. 20

Source. CNA and Nurses Service Organization, *Nurse Professional Liability Claim Report: 5th Edition*, August 2025. Available at nso.com/claimreport. Figures describe closed claims in the 2025 dataset and are not predictions about any individual nurse.

Good charting is not writing *more.* It is writing what can be verified.

The one rule underneath all 25

Chart **what you observed**, **what you did**, **who you told**, and **when**. Everything defensible fits in those four boxes. Almost everything that gets highlighted in a deposition is something that did not.

01 Read the dark line first. If you have charted it this month, you are normal. That is the point.

02 The grey paragraph is what an attorney does with the phrase, the part nursing school skipped.

03 The blue box is a sentence you can type. Adapt the details, keep the structure.

04 Pick **three** to change this week. Not twenty five.

SECTION 01

The judgment phrases

These are conclusions, not observations. They tell a jury what you ***thought about*** the patient rather than what you saw. They are also the phrases most likely to be enlarged on a courtroom screen, because they make a sympathetic patient look judged.

01

DON'T CHART

"Patient appears intoxicated."

A medical conclusion you are not licensed to make, and one you cannot support without a level. On cross: *"Nurse, are you qualified to diagnose intoxication?"*

→ CHART INSTEAD

Odor similar to alcohol noted on breath. Speech slurred. Unsteady gait, required 2-person assist to chair. Pt unable to state year. Provider notified 0214.

02

DON'T CHART

"Drug-seeking behavior."

The most damaging phrase in a chart when the patient turns out to have had a real pathology. It documents your bias and nothing else.

→ CHART INSTEAD

Pt requested pain medication at 0400, 0430, and 0510. Reports pain 9/10, unrelieved by current regimen. Provider notified 0515. No new orders received.

03

DON'T CHART

"Uncooperative." / "Difficult."

Vague, judgmental, and it invites the follow-up question of what *you* did about it.

→ CHART INSTEAD

Pt declined AM medications. Stated: "they make me sick." Education provided re: purpose and risk of omission. Refusal documented. Provider notified 0830.

04

DON'T CHART

"Noncompliant with treatment."

Assigns blame, and it is usually clinically wrong. It hides the access barrier that is the actual finding.

→ CHART INSTEAD

Pt reports not taking metoprolol × 6 days. States prescription ran out and pharmacy is 40 min away without transport. Case management consulted 1100.

05

DON'T CHART

"Manipulative." / "Attention-seeking."

Zero clinical content, permanent record, and it will be read to a jury in the voice of someone who didn't care.

→ CHART INSTEAD

Pt activated call light 6× between 2200 to 2300, each time requesting staff remain in room. States "I'm scared to be alone." Anxiety discussed. Provider notified.

SECTION 02

The vague phrases

These feel like documentation but contain no verifiable fact. Under cross-examination they collapse into "so you don't actually know." A phrase that

collapses is worse than a blank space, because you signed it.

06

DON'T CHART

"Confused."

Meaningless without a baseline. If the patient has dementia it's normal; if they were oriented ×4 an hour ago it's an emergency. The word alone can't tell the difference.

→ CHART INSTEAD

Oriented to person only. Unable to state location or year. Baseline per daughter at bedside: oriented ×4 this AM. Provider notified 1340. Neuro checks q1h initiated.

07

DON'T CHART

"Will continue to monitor."

You just promised an action with no defined interval, and created a duty you now have to prove you met. This phrase has ended more cases than any other on this list.

→ CHART INSTEAD

Will reassess neuro status q1h per protocol. Next assessment due 0300.

08

DON'T CHART

"Tolerated well."

Tolerated what, measured how, against what baseline?

→ CHART INSTEAD

Ambulated 30 ft with front-wheeled walker, 1 assist. SpO2 94% on RA throughout. HR 88 to 96. Denied dyspnea or dizziness. Returned to chair.

09

DON'T CHART

"Patient stable." / "No acute distress."

Physician shorthand that means nothing in a nursing note. Chart the observations that led you there instead.

→ CHART INSTEAD

VS 1400: BP 118/72, HR 78, RR 16, T 98.2, SpO2 97% RA. Alert, oriented ×4. Denies pain. Skin warm and dry.

10

DON'T CHART

"Family updated."

Which family member, on what, by whom? And were they even the person authorized to be told?

→ CHART INSTEAD

Spoke by phone 1420 with daughter Jane Smith (documented HCP) re: change in condition. Questions answered. States she will arrive by 1600.

SECTION 03

The assessment phrases

Your assessments are the timeline. In a pressure injury, fall, or failure to rescue case, the measurements and the trend *are* the evidence. Number 15 is the single most common damaging finding in real records.

11

DON'T CHART

"Wound care performed per orders."

Copies the order instead of documenting the assessment. In a pressure injury case, the measurements are the entire timeline.

→ CHART INSTEAD

Sacral wound: 3.1 × 2.4 cm, 0.2 cm depth, pink granulation, scant serous drainage, no odor. Peri-wound intact. Cleansed NS, hydrocolloid applied.

12

DON'T CHART

"Repositioned." / "Turned."

Doesn't establish to what, from what, or that it happened on schedule.

→ CHART INSTEAD

Turned from supine to L lateral 0200. Pillows to back and between knees. Heels floated. Sacrum blanchable, no redness.

13

DON'T CHART

"Educated pt." / "Verbalized understanding."

Understanding of *what*? "Verbalized understanding" alone is the most-copied and least defensible phrase in nursing documentation.

→ CHART INSTEAD

Instructed on s/s of infection at incision site: redness, drainage, fever >100.4. Pt correctly repeated all three and named who to call. Written instructions given.

14

DON'T CHART

Copy-forward assessments.

The EHR makes it one click. It also produces yesterday's lung sounds on a patient extubated this morning, which makes every other entry you made look unreliable.

→ DO INSTEAD

Re-assess and re-enter. If a finding is genuinely unchanged, say so explicitly: "Lung sounds unchanged from 0800 assessment: clear bilaterally."

15

DON'T CHART

Chart vitals, then never mention them again.

The most common finding in real records, and almost nobody teaches it. Documented-but-not-acted-on is ***worse*** than undocumented: it proves you knew.

→ CHART INSTEAD

VS 0400: BP 88/52 (down from 112/68 at 0000), HR 118. Trend reviewed. Provider notified 0410. Orders received to recheck q30min and hold AM antihypertensives.

SECTION 04

The timing problems

Your EHR timestamps every keystroke and keeps an audit trail of every edit. This is the cluster nobody teaches, and the one that turns a defensible nurse into a nurse whose ***honesty*** is the issue. That is a much worse case.

16

DON'T CHART

Block charting the whole shift at 0700.

The metadata shows twelve hours of assessments entered in nine minutes. A jury doesn't need a nursing background to understand what that means.

→ DO INSTEAD

Chart in real time where you can. Where you can't, chart as soon as you can and label it honestly (see #17).

17

DON'T CHART

An unlabeled late entry.

Late entries are normal, expected, and completely acceptable ***when labeled.*** Unlabeled, the same entry looks like concealment.

→ CHART INSTEAD

Late Entry 03/19 1830: Refers to assessment performed 03/18 approx. 1400. Pt ambulated to bathroom with 1 assist, no distress. Entry delayed due to unit emergency.

18

DON'T CHART

Editing or deleting a prior entry.

The audit trail records it, always. This is the fastest route from ***defendant*** to ***dishonest defendant***, and juries forgive clinical error far more readily than concealment.

→ DO INSTEAD

Never edit. Add an addendum: "Addendum 03/19 1830: Entry of 03/19 0600 listed L leg; correct site is R leg."

19

DON'T CHART

Charting ahead, before the care happens.

Falsification, even when the care happens two minutes later, and even when everyone on your unit does it. This is a license matter, not a lawsuit matter.

→ DO INSTEAD

Chart after. Every time. Without exception.

20

DON'T CHART

Charting under another nurse's login.

Every entry made under your credentials is legally yours. You will be asked about entries you never wrote and will have no way to disclaim them.

→ DO INSTEAD

Never share credentials, in either direction. Lock your workstation. This one is not negotiable regardless of how your unit actually operates.

SECTION 05

The escalation phrases

This cluster protects you more than any other. In most cases where a nurse is

found liable, she ***did*** escalate. She just didn't document it in a way that survived.

21

DON'T CHART

"MD notified." / "Provider aware."

Doesn't establish who, when, what you communicated, or what came back. Turns your strongest defense into a bare assertion.

→ CHART INSTEAD

Dr. Chen paged 0212 re: SBP 78/40, HR 132. No response. Repaged 0230. Spoke 0238; reported VS, mentation change, UOP 15 mL/2 hr. Orders received: 500 mL NS bolus, repeat lactate.

22

DON'T CHART

Nothing, after a provider declines to act.

This is the most common gap in real cases. The nurse escalated, got nothing back, and stopped. The chart shows only silence.

→ CHART INSTEAD

Reported SBP 78/40 and HR 132 to Dr. Chen 0238. No new orders received. Charge nurse Rodriguez notified 0245. Rapid response activated 0252 per protocol.

23

DON'T CHART

"Patient refused."

Incomplete refusal documentation. Was the risk explained? Did they have capacity? Was the provider told?

→ CHART INSTEAD

Pt declined 0900 metoprolol. Risks explained incl. rebound tachycardia. Pt states: "I want to talk to my doctor first." Alert, oriented ×4, able to explain decision. Provider notified 0915.

24

DON'T CHART

"Assignment unsafe" as an opinion, in the chart.

A staffing conclusion in the patient's permanent record helps nobody and may not belong there at all. That objection goes through your facility's process, not the chart.

→ DO INSTEAD

Chart only objective patient facts. Raise the staffing concern via your facility's documented process (ADO/ODP form, chain of command) and keep your own dated record of who you told and when.

25

DON'T CHART

Delegation without documenting what you checked.

You remain accountable for the delegation decision. Scope of practice is 14% of license protection matters, the second most common allegation.

→ CHART INSTEAD

Ambulation delegated to CNA Martinez 1400; pt's activity order and gait status reviewed with CNA prior. CNA reported completion 1425; pt reassessed by RN 1430, no change.

BONUS

The escalation script

Screenshot this one. When something is wrong and you are not being heard, follow it in order and chart each step as you go.

01 **Page, and note the time.** Not "I paged." The actual minute.

02 **Repage at your protocol interval.** Chart both attempts.

03 **Use SBAR when you reach them** and chart what you reported, not just that you called.

04 **Say the sentence.** "I am concerned about this patient and I need you to come evaluate them."

05 **Go up the chain.** Charge nurse, supervisor, rapid response. Chart every rung by name and time.

06 **Activate rapid response if criteria are met.** You do not need permission.

WHAT THAT LOOKS LIKE IN THE CHART

Dr. Chen paged 0212 re: SBP 78/40, HR 132, new confusion. No response. Repaged 0230. Spoke 0238, reported VS, mentation, UOP 15 mL/2hr. No new orders. Stated concern and requested bedside evaluation. Charge nurse Rodriguez notified 0245. Rapid response activated 0252 per protocol. Pt to ICU 0335.

KEEP THESE

Two more worth saving

Before you delegate, four questions

1. Is this within that person's scope in **my state**? **2.** Is this patient stable and predictable enough? **3.** Has this person demonstrated competence in it? **4.** Can I supervise and reassess afterward? Any "no" means you do not delegate it, and you chart that you verified.

If you are ever asked about a chart

Slow down. You have the **right to an attorney** in a board matter, at your own expense. Check whether your liability policy includes **license defense**, because many employer policies do not cover board actions at all. Do not submit a written response alone.

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WHERE TO START

Pick three. Start Monday.

You were never taught this. That is not your failing. It is a gap in how we train nurses.

But it is yours to close now, and it is closeable in a week.

MORE CASE BREAKDOWNS

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