Name: _____

# The Keys to Correct Documentation

(2 credits)

After completing this section, you should be able to:

1. Define documentation and identify its importance
2. Describe five forms commonly used in documentation
3. Describe legal aspects of documentation
4. List eight reasons for careful documentation
5. List ten guidelines for documentation

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**1. Define documentation and identify its importance**

Documentation means "to give written information that is proof or support of something that has been done or observed." In other words, documentation is the written account of observations; the information the client, resident or family relates or states; the data you collect during care; and the care you provide.

This written report is reviewed by your facility/agency and the supervising nurse. Because you will often spend more time with a resident or client than any other member of the healthcare team, you have more opportunities to relate to that person and his or her family. It is important that you effectively communicate your findings to the other members of the healthcare team.

A medical record, or collection of information about a person in your care, is also called the chart. Written information is called documentation. When you write information in a person's chart, you are recording, charting, or documenting that information. All of these words mean the same thing and can be used interchangeably.

When you write on the medical record, you must accept responsibility for what is documented. For this reason, your writing should be careful, accurate, neat, and clear.

FACT: Legally, a medical record is the record of all care that is provided. If it isn't recorded, legally it didn't happen. If it was recorded incorrectly, it happened as it was recorded. This is why it is so important to be accurate when documenting.

***Directions.*** *Define the following terms.*

1. Medical record _____

2. Chart _____

3. Documentation _____

4. Recording/charting _____

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*Directions. Name four sources of information for documentation.*

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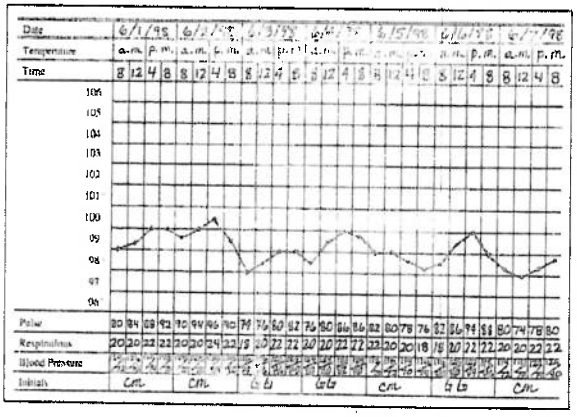
## 2. Describe five forms commonly used in documentation

You may be using documentation skills on several different forms. You will need to become familiar with those specially used by your facility or agency. Your supervisor should review all forms. The following are examples of some forms used by aides and assistants.

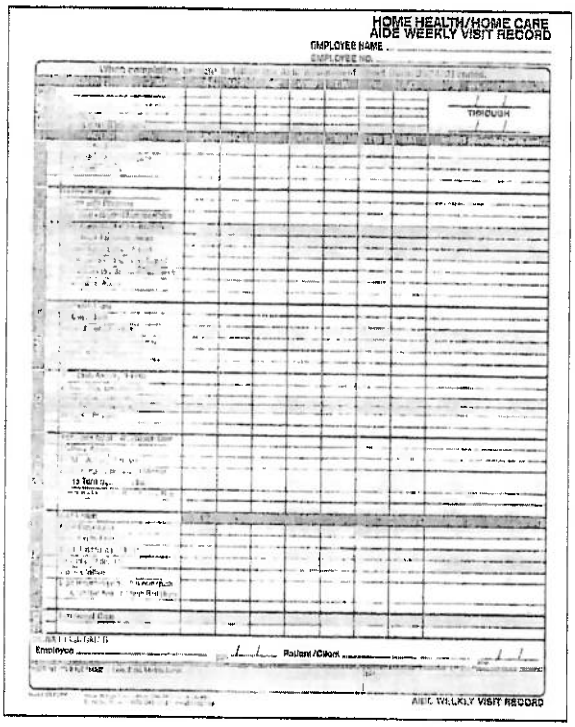
### Graphic Sheet for Vital Signs

This form will often include vital signs, weight, urine output, and bowel movements.



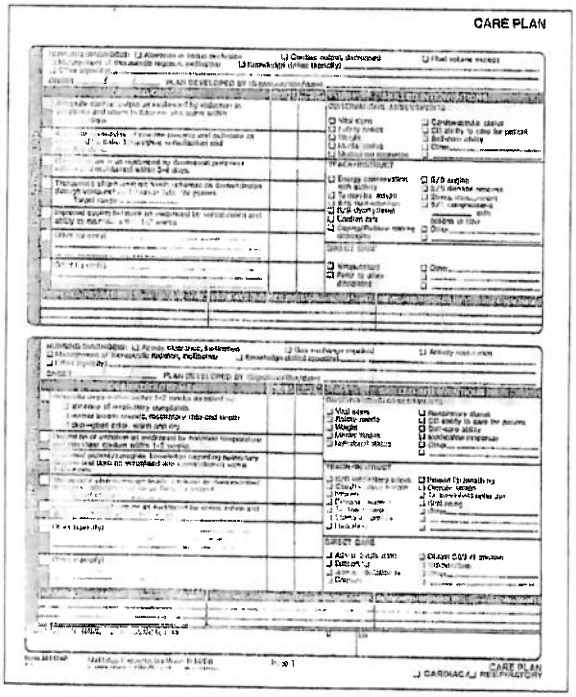

### Activities of Daily Living (ADL) Checklist

ADL sheets come in many styles. These list daily functions such as personal care, exercise, toileting, ambulation and activities, and diet.




### Care Plan

This form lists the client's/resident's problems, goals, procedures, and treatments that have been ordered. It is developed by a nurse and changes as the person's condition changes. This form should be updated at supervisory visits every two weeks or as orders change.



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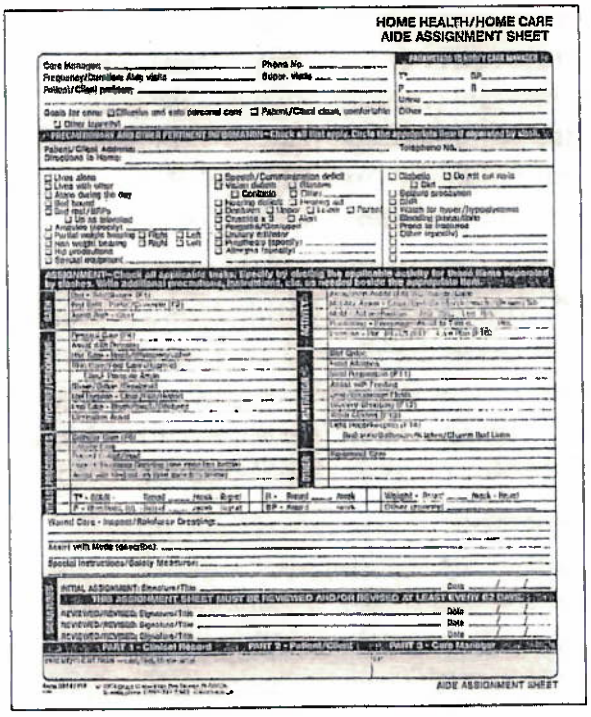
### Visit Form/Activity Sheet

This is a daily checklist and narrative form that accounts for what is done on the visit. It usually has a time in and a time out section, as well as a section for progress notes and comments. You must document all client/resident changes.

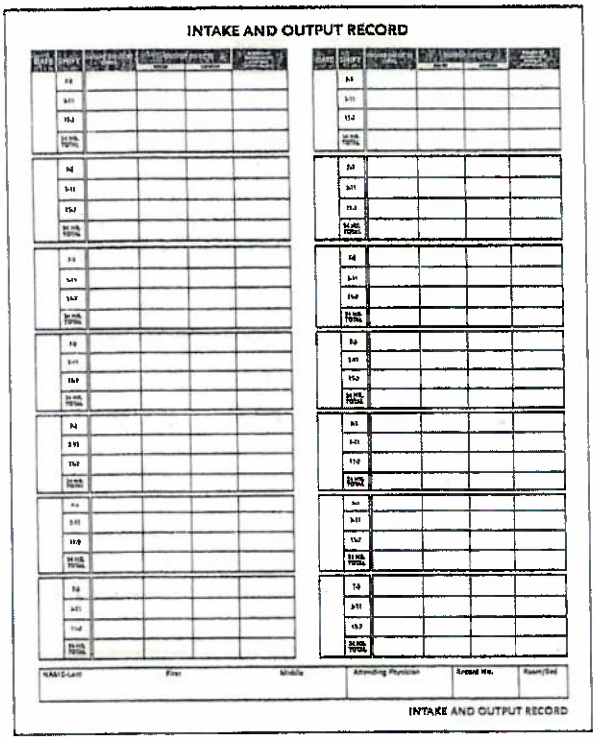
No matter how you are required to do written notes or charting, your documentation should follow all the guidelines we will discuss, including the date and signature.


HOME HEALTH/HOME CARE AIDE ASSIGNMENT SHEET

AIDE ASSIGNMENT SHEET

### Intake and Output Record

This form tracks intake of fluids and output of urine. Output also includes vomitus and feces (including diarrhea).


INTAKE AND OUTPUT RECORD

INTAKE AND OUTPUT RECORD

***Directions.*** *Name the five different types of documentation forms discussed and briefly describe them.*

1. _____

2. _____

3. _____

4. _____

Name: _____

5. _____

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6. Compare the type of form(s) you use in your present job. How is it/are they different from any of these? What is the same about your form? What do you especially like about the paperwork at your job?

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### 3. Describe legal aspects of documentation

The medical chart is a legal document and is confidential. What is written in the chart is considered in court to be what actually happened. If you gave a resident a bath and took his temperature, but never documented it, you could not necessarily prove that you actually performed the care. In the event of a malpractice case, the medical record may be used to provide the court with evidence about a person's condition and treatments. In a malpractice case, the jurors usually view the medical record as the best evidence of what really happened. In general, if something does not appear in a person's medical chart, it did not legally happen. Failing to document your care could cause very serious legal problems for you and your employer. It could also cause harm to your resident or client.

For this reason, all of your documentation should be done neatly and legibly. Illegible handwriting is handwriting that cannot be read or understood by others. Sometimes it is sloppily written, and many times misspelled words and poor grammar are used. Illegible or poorly written documentation makes you look careless and distracted. Take the time to make all of your notes look neat and clear.

You should also try to avoid words that are unnecessary or very long. When you abbreviate (shorten) a word, use only those abbreviations that are approved by your employer. You may use phrases instead of complete sentences to save space.

DO NOT cover any errors with correction fluid, erase the error, or scratch out the error so that it cannot be read. Draw one line through it, and write the correct word or words. Put your initials and the date.

Remember: If you did not document it, legally it did not happen. This also means that you should not let anyone else document the care you provide, and you should not document the care provided by someone else. The following mistakes in documentation can cause legal problems:

- Inaccurate documentation
- Incomplete documentation
- Failure to record prevention efforts (particularly falls, side rails, restraints, burns, smoking, and any potential for client/resident self- injury)
- Failure to record treatments and care
- Failure to record the client/resident's refusal of care, or the refusal of their families to accept provided care
- Incomplete incident reports

Name: _____

- Tampering with the medical records
- Failure to record client/resident's or family's failure to follow orders
- Failure to document potentially risky situations

### Reimbursement

Another important aspect of documentation is reimbursement. In health care, sometimes private insurance or Medicare repays (or reimburses) the facility or agency for the cost of caring for the person. That means that Medicare, Medicaid, or an insurance company pays your employer back for the salary it pays to staff or for supplies the patient uses, etc. The basis of this system of repayment is the documentation that appears on the medical record. If payment is denied, this may be because the documentation was not complete. Reimbursement can also be denied for poorly documented care. The evaluation of the patient's status and charting of care are vital to the reimbursement system.

Your observations can "trigger" a reassessment in your patient's care plan. This can affect cost and reimbursement, but most importantly, it can impact the quality of the care we provide. Today, reimbursement for both long-term care and home care is often based on the person's diagnosis. Your documentation is vital for planning the course of care. Knowing exactly the status of those in our care contributes to planning the most efficient (lowest cost) way to provide quality care.

***Directions.*** *Answer the questions below.*

1. What does the phrase, "If you did not document it, legally it did not happen" mean?

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2. List the nine mistakes in documentation that can cause legal problems.

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### 4. List eight reasons for careful documentation

Reasons for careful documentation include the following:

1. Documentation gives written evidence of care given, the patient's response, and the effect of the care.

Name: _____

2. Documentation plans for future care and changes in plan of care so all members of the team can be informed and kept current.
3. Documentation serves as a communication tool. When you document, remember that you alone are responsible for noting what you observe.
4. Documentation can be reviewed and evaluated for quality assurance.
5. Medicare and insurance companies require documentation for reimbursement (payment).
6. Documentation is a legal paper and may be used in a court of law.
7. Health caregivers can look for areas needing to be recalled from the past.
8. Documentation allows for continuity of care or focusing on resident/client goals from all those involved in the case. A complete record allows caregivers to know what has happened in the past and what should happen in the future.

*Directions. List the eight reasons for careful documentation.*

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2. _____
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6. _____

Name: _____

7. _____

8. _____

**5. List ten guidelines for documentation**

Guidelines for documentation include the following:

1. Report objectively, be specific and describe each complaint or situation. You may use phrases instead of complete sentences.
2. Write neatly and legibly, with a black pen only.
3. Start all writing with the complete date (day, month, year) and the time. Finish all entries with full signature and title.
4. Avoid words open to interpretation such as "good" or "normal," and do not leave spaces.
5. Chart every two hours in sequence and only for your actions (if appropriate).
6. Use quotation marks when reporting what the patient said and only use acceptable abbreviations.
7. Record all attempts to notify supervisor. If you leave a message, document with whom, the time, and the date.
8. Do not erase errors. Draw a line through the wrong entry, and write the correct word or words. Put your initials and the date. Do not use correction fluid.
9. Never chart a procedure or any care until after it has been completed.
10. Some facilities use military time as part of their documentation policy. Regular time uses the numbers 1 to 12 to show each of the 24 hours in a day. In military time, the hours are numbered from 00 to 23; midnight is expressed as 00 (although it can also be written as 24), 1 a.m. is 01, 1 p.m. is 13, and so on.

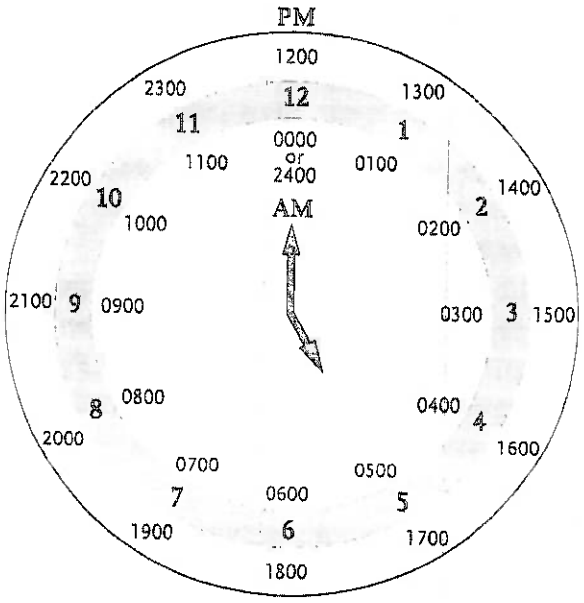
    Both regular and military time list minutes and seconds the same way. The minutes and seconds do not change when converting from regular to military time. The abbreviations a.m. and p.m. are used in regular time to show what time of day it is. However, these are not used in military time, since specific numbers show each hour of the day.

    To change the regular hours between 1:00 p.m. to 11:59 p.m. to military time, add 12 to the regular time. For example, to change 3:00 p.m. to military time, add 3 + 12. The time is expressed as 1500 (fifteen-hundred) hours. To change 4:22 p.m. to military time, add 4 + 12. The minutes do not change. The time is expressed as 1622 hours.

Name: _____

Midnight is the only time that differs. Midnight can be written as 0000, and it can also be written as 2400. This follows the rule of adding 12 to the regular time. Follow your facility's or agency's policy on whether or not to use military or regular time when documenting.

*Directions. Change the following to military time.*




1. 1:15 p.m. _____
2. 3:45 p.m. _____
3. 6:00 a.m. _____
4. 9:20 p.m. _____
5. 11:45 p.m. _____

*Change the following to regular time.*

6. 0800 hours _____
7. 1653 hours _____
8. 1904 hours _____
9. 0130 hours _____
10. 2121 hours _____

11. Briefly list ten guidelines for documentation.

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*Directions. Read the following scenarios and document them in the space below.*

12. Mr. J was walking in the hallway when he slipped and fell. The floor was clear and clean, but his slippers

Name: _____

were not appropriate. He complained of pain in the lower lumbar region of his back. The physician was called and ice packs and bed rest were ordered.

How would you document this?

13. Your client or resident, Ms. P, refuses to help with her bath. Her orders state self-care with minimal assistance because the occupational therapist (OT) is trying to encourage Ms. P to do more for herself. What would your action and documentation be?

14. Your client or resident complains of pain in his left side at 9:00 a.m. At 11:00 a.m. you discover he meant his right side. How would you document this?

***Directions.*** *Answer the following questions.*

15. How do you remember important information about your patients in order to document that information accurately?

16. Do you rely on your memory or carry a notebook?

Name: _____

17. Do you have any "cheat sheets" or a guideline handbook with you as you work?

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