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Learner's Guide: the What, Where, Why, When, and How of Documentation

What is documentation?

Documentation means to write something down.

We write down things we notice about our clients, things they tell us, things we do for them, information we get from checking vital signs or doing a procedure, and anything else that is important for the well-being of our clients. This is sometimes called charting.

Where do we document?

We write information in the client's record, sometimes called a chart, medical record, or file. We also write in logs, in communication books, on activity or flow sheets, in narrative or visit notes, on treatment or medication records, in notes for supervisors, and other places according to company policies and procedures.

Why is documentation important?

- **To communicate.** The main purpose of documentation is to tell other care providers about the person we are caring for. Our care is not complete until the documentation is complete. Keeping a record that describes the client's condition, treatments, and the response to those treatments is one way we show that we have done our jobs. Documenting our care is almost as important as providing the care itself, and failure to document implies failure to provide care. Note: See "Charting by Exception" on page 7.

  <u>The usual rule is, "If it isn't documented, it hasn't been done</u>."

- **To meet legal standards**. Careful documentation is one of the best ways to protect ourselves against someone who might accuse us of being negligent or not providing proper care**.** Documentation provides proof that the company's policies & procedures, safety precautions, and standards of care have been met, and shows that we have done our jobs correctly.

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Legal Significance of the Record

- A client's record provides legal proof of the care your client receives. Poor documentation can make it look like you or your company did not give good care.
- No matter how well you take care of a client, documentation errors can leave you and your company open to a lawsuit. Even misspelled words in a client's record can make it look like you don't know what you are doing.
- In a court case involving a client, the client's record can be admitted as evidence. The record is presumed to be true unless disproved by other evidence.
- If you or your company are ever involved in a lawsuit, the outcome could depend on how you documented, what you documented, and what you didn't document.
- To document properly, you need to understand and follow the standards of your company and your state or province.

Legal Standards for Records

- Client records must not be altered in any way.
- If errors are made, they should be corrected by drawing one line through the error in a way that the incorrect entry can still be read. You should write *"mistaken entry"* by the error and initial it. After that you can write the correct information. In some companies it is not necessary to write *"mistaken entry."* The important thing is that the incorrect entry can still be read, and that you initial your error.
- Never erase or completely scratch out an error. Don't use correction fluid.
- Document only the care *you* provide. *Never* document for someone else.
- Document procedures *after* you perform them, never beforehand.
- Don't mention an incident report in the client's record unless your company or state requires you to do so.
- Client records are confidential. ***Never show anything in a client's record to anyone else unless you have specific permission from your supervisor.*** Only those who take care of the client, or family members with special legal permission, should be able to look at a client's record. If your supervisor asks you to fax something to another care provider, such as to a hospital or doctor's office, protect the confidentiality of the material by checking the number before you dial, checking it on the fax display, and rechecking it before pressing the send button.

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How should we document?

Documentation focuses entirely on the client or possibly the immediate family. It describes events and responses to those events.

Document only facts—not opinions.

- Make neat, legible entries that are easy to read. You should print if your handwriting is hard to read.
- Use permanent black or blue ink. Follow your company's policies.
- Put the date and time on all entries.
- Sign all entries with your first initial, last name **and title**.
- Document errors and corrections appropriately.
- Record accurately and immediately. Entries should be written in the order in which the events occurred.
- Don't skip lines or leave blank spaces.
- If you forget to write something in the record at the time it occurs, you can still write it in the record, but the date and time will be out of order. This is called a late entry. To make a late entry, put the date and time and write *"late entry"* before documenting.
- Describe only what you've seen, heard, smelled and touched.
- Use proper punctuation and grammar.
- Use only those abbreviations that have been approved by your company. Don't make up your own abbreviations.
- Use quotation marks for direct quotes.
- Be complete, but don't be wordy.

Be: **C**hronological **C**omplete **C**oncise **F**actual **L**egal **L**egible **N**eat

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What should we document?

- Vital signs such as blood pressure, temperature, pulse, and respiration are usually documented on a graph or form. Follow your company's policies.
- If you assist a client with medications, you will document what you do on a medication record. Follow your company's policies to do this correctly.
- If you perform or assist with a treatment or procedure, you will document this in the appropriate place. Sometimes procedures are recorded on a graph or checklist. Sometimes they are written in narrative form, which means you write a description of what you did. These descriptions are called narrative notes, and they are usually written on lined paper.
- Describe the client's responses to procedures, treatments, and medicines. For example, document if a client requires more assistance than usual during personal care. Document whether or not the client's headache gets better after taking medicine. Always report unusual or unfavorable responses.
- If a client refuses to let you do something that is part of the client's plan of care, write down that the client refused and why.
- Record the things you do. Document safety measures you use to protect the client. For example, "Provided standby assist to transfer to wheelchair."
- Name the people you notify of a client's condition. If you report a problem to a client's family member or to your supervisor, write it down.
- Document activities of daily living (ADLs) according to your company's policies and procedures.
- Describe things you observe and things clients tell you, and document to whom you report this information. For example, if a client tells you that he or she is depressed, tell your supervisor, and document what the client told you and the name of the person you reported it to.
- Document all communications with other care providers. Document telephone calls to family members, physicians, nurses, supervisors, and other agencies or facilities. Write the name and title of the person you talk to, the date, the time, the nature of the conversation, and any changes in care that result from the conversation.

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Documenting Incidents and Accidents

- An incident is anything that occurs which is out of the ordinary. Common incidents are client falls and employee back injuries.
- Most companies want incidents documented on a special "Incident Report" or other specific form.
- You must report all incidents and accidents to a supervisor as soon as possible. Your supervisor should decide when an incident report is needed, and will guide you in documenting your information on the form if necessary.
- Do not place blame on anyone when you write about an incident or accident.
- Know your company's policies and procedures for incidents, and know your responsibility in meeting them.

Documentation Don'ts:

- Never write in the wrong client's record. Always check the name.
- Never use stick-on notes. They can end up on the wrong chart.
- Never falsify any part of any record ever; it is a criminal offense.
- Never alter a medical record.
- Never sign for anyone else, ever!
- Never chart ahead of time.
- Never make references to errors or incidents unless your company's policy requires it.
- Never enter opinions. Stick to the facts. Be accurate, factual, and truthful.
- Never enter degrading comments about the client. For example, don't say anything like, "Client is stubborn and unpleasant."
- Never squeeze an entry into the margin or over an existing entry.
- Never chart company problems. For example, don't say anything like, "Client fell because we were too short of staff." Problems like this should be told to your supervisor, not written in the client's record.

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When should we document?

It is best to complete documentation immediately, or as soon after the event or procedure as possible. Document while things are still fresh in your memory.

Document according to the plan of care

- The care you give each client, and the documentation of that care, must match the client's plan of care.
- If your care varies from the plan, document the reason.
- Even if you only give certain kinds of care to a client when he or she requests it, the plan of care should say that it is OK to give that care as requested (prn).

Documentation Systems

There are many types of documentation systems. Whatever system you use in your company, it should convey the four important points in this word:

PART

Problem: write what you saw or heard.
Action: write what you did.
Response: write what the client did or said in response.
Tell: write who you notified.

(Credit for this acronym goes to Sandra Petersen, RN, MSN, who urges her workers to do their PART when they document. Ms. Petersen's workers carry this reminder with them on a laminated card.)

Charting by Exception

Some companies use a system called "charting by exception." This means that routine events and procedures are not written down. Only unusual or out of the ordinary things are documented. If nothing is written down, it is assumed that everyday things such as personal care and activities of daily living were done according to the plan of care. This is not allowed in certain situations. Your supervisor will tell you if you should document this way.

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Commonly Used Abbreviations

Your company might use some of these abbreviations, or it might prefer different or additional ones. Your supervisor can tell you which abbreviations are approved for your use. Notice that some abbreviations mean more than one thing. “R” can mean rectally, respirations, or right. Such abbreviations are only understood in context—the meaning depends on where and how they are used. Notice also that most abbreviations can be written in capital letters (upper case) or small letters (lower case) without changing the meaning. Sometimes abbreviations are circled, such as circling the “L” or “R” for left or right.

Times

ASAP: As soon as possible
PRN: As needed
AM: From 12 midnight to 12 noon (morning)
PM: From 12 noon to 12 midnight (afternoon and evening)
HS: At bedtime
QD: Every day
TID: Three times a day
BID: Twice a day
QID: Four times a day
QOD: Every other day
QOW: Every other week
QH: Every hour
Q4H: Every four hours (any number of hours can be used)
X: Times
AC: Before meals
PC: After meals
p: After

Parts of the Body

O: Oral or orally
PO: By mouth
R: Rectal or rectally
PR: By rectum or per rectum
Ax: Under the arm
OD: Right eye
OS: Left eye
OU: Both eyes
UE: Upper extremity (arm)
LE: Lower extremity (leg)
RL: Right leg
LL: Left leg
RA: Right arm
LA: Left arm
SL: sublingual (under the tongue)
SQ: subcutaneous (under the skin)

Activities and Observations

R or Rt.: Right
L or Lt.: Left
B/L: Bilateral (both sides)
s (often written with a line over it): without
c (often written with a line over it): with
U/O: Urine output
Rx: Prescription or therapy
Sx: Symptom
NPO: Nothing by mouth
P: Pulse
R: Respirations
T: Temperature
BP: Blood pressure
VS: Vital signs
TPR: Temperature, pulse, and respirations
BM: Bowel movement
I & O: Intake and output
ADL: Activities of daily living (bathing, toileting, dressing, grooming, eating, etc.)
BS: Blood sugar
FBS: Fasting blood sugar
SOB: Short of breath

Occupations and Therapy

OT: Occupational therapy or therapist
PT: Physical therapy or therapist
ST: Speech therapy or therapist
SN: Skilled nurse (may be LPN, LVN, or RN)
RN: Registered nurse
LPN: Licensed practical nurse
LVN: Licensed vocational nurse
MSW: Medical or Master social worker
MD: Medical doctor
DO: Doctor of osteopathic medicine

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Documentation Test

I understand the information presented in this in-service. Signature of Student _____

Name: _____ Date: _____ Score: _____

Directions: Circle the correct answer.(s) (10 correct answers required)

1. To save time when you are busy, it is OK to document care on everyone before you provide care to anyone. True or False

2. When a client refuses care, you don't have to document anything because you did not give any care. True or False

3. Write the four important points of documentation (worth four points):

   P_____ A_____ R_____ T_____

4. What basic information should be included when you document in the record?
   a. The date.
   b. The time.
   c. Your name and title.
   d. The day of the week.
   e. All of the above.

5. From a legal standpoint, if you do something and do not document it, the care
   a. was done.
   b. was not done.
   c. was done by yourself and a co-worker.
   d. was only half done.

6. You made an entry on the wrong record. How should it be corrected?
   a. By erasure.
   b. With correction fluid.
   c. By drawing a single line through the incorrect entry, writing "mistaken entry," then signing with your first initial, last name and title.
   d. By scratching it out and writing "error" over it.

7. The care you give and document should match the plan of care. True or False

8. It is permissible to enter documentation in the margin. True or False

9. The first thing you should do before beginning to document is make sure you have the right record. True or False

10. It is a criminal offense to alter a client's record. True or False

11. Instead of writing opinions about people or events, we should document only the _____.

Name of TE Grading Test: _____ Date:_____ 30 minutes credit

This completed document serves as the Certificate of Completion.

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Documentation

Client Records—Your Best Friend or Worst Enemy

Learning Objectives

Participants in this activity will be able to:
1. Explain the reasons for careful documentation.
2. Protect against legal problems.
3. State what, where, why, when, and how to document.
4. Discuss documentation don'ts.
5. Recognize acceptable abbreviations.

Teaching Plan

This lesson is designed to teach workers to document carefully. To use this lesson for self-study, the learner should read the materials, do the activity, and take the test. For group study, the leader should give every learner a copy of the Learner's Guide and use the suggested activities to teach the lesson.

The Lesson

Write on a board or flipchart: "What? Where? Why? When? How?" Tell your workers that they are going to learn some answers to these questions about writing in client's records as they study documentation principles in this lesson.

Have your learners take turns reading the information in the Learner's Guide, either silently or aloud to the class. Discuss each section before going on to the next one. Clarify anything about the way you want your workers to document that is different from the information in this lesson.

Bring all the forms your workers use. Go over your company's forms, abbreviations, and requirements. Have the workers fill out the more common forms as practice. Review their work and make suggestions or corrections.

Activity

After reviewing the lesson material, give every worker a client record. Instruct the group to review the records and try to find errors in documentation. Have learners share their findings with the group. Reward those who find errors with a candy bar or other small prize. Remind them to do their PART (see p. 7).

Conclusion

Have the learners take the test, and then grade the test together. Hand out certificates to those who give at least 10 correct answers. Test answers: 1. False; 2. False; 3. Problem, Action, Response, Tell; 4. a, b, & c; 5. b; 6. c; 7. True; 8. False; 9. True; 10. True; 11. Facts.