Documenting and Reporting Patient Status

Charting the care you've given the patient and giving report on the patient's status are vital ways to maintain the chain of communication between all health care team members.

Conscientious documentation and report habits help to assure that the patient's quality of care and safety is maintained.

If it isn't charted, it did not happen. If it isn't reported, you are negligent.

Remember, the chart is a legal document.

General Charting Guidelines

Chart as soon as possible after giving care.

Make sure each page used has the patient's identifying information.

Begin the entry with the complete date and time of its initiation.

Use permanent ink so that entries cannot be erased.

Use black ink – other colors do not Xerox as well.

Write legibly.

Do not leave blank or partially blank lines that would allow insertions or raise the question of whether information has been omitted. Draw a single straight line through any blank areas.

Sign the entry with your complete first name, complete last name, and title.

When documentation continues from one page to the next, sign the bottom of the first page. At the top of the next page, write the date, time and "continued from previous page."

Document objective facts, observations, and data, and what you actually did for the patient. **Don't chart your opinions, assumptions, or make subjective statements.**

It is required by the State of Illionis that all your documentation get turned into the office in a timely matter. It is **MANDATORY** that all your visits notes/time sheets for the previous week be turned in by **3pm on Monday.**

What to Chart

Care given, Procedures
Changes of condition
Unusual occurrences
Incidents
Any call to the family
Intake and output

Errors

Mark through the erroneous lines with one straight line of ink, and initial and date the entry.

Do not use white out, erasers, or scribble through documentation.

Do Not

Never refer to an incident report in the nursing notes.- These are reported to the office and documented on an incident report.

Never document a medication name or type- if you are documenting that you did a medication reminder, then you document it just as that. Reminder Mr. Doe to take his medications.

Never amend someone else's documentation.

Never chart a symptom, problem, or complaint without also charting what you did about it.

Do not use language that is derogatory or suggests a negative attitude toward the patient, such as crazy, nasty, or outrageous.

Do not record staff comments or conflicts.

Do not refer to a second patient by name – this would violate that patient's confidentiality.

Do not document problems with clocking in and out or other software issues.

***The telephony clocking in/out system is additional documentation for that client's chart. The only things that should be documented on any paper documentation or telephony documentation should only be related to patient care. All patient folders are a legal document! If you have problems with the software or any other issue that you need to discuss you need to call the office.**

Giving Report

If your documentation is adequate, the report you give to the next shift or staff member will essentially be a summary of your notes.

Included in your report would be anything that you didn't chart, such as impending visits from other staff members, appointments, or perhaps agency-related information.

Do not leave other staff members guessing. There should never be any unnecessary surprises for anyone who follows your shift.

If you have been unable to perform part of your work, you should have already informed your charge nurse of this, and this information should be given in report too.

Before you leave, ask the replacing staff member if she has any questions for you, and make sure she has truly understood the information you have given.

Calling the Supervisor

The supervisor should be called at any time you have questions about your assignment or the patient's care or status. When in doubt, call. It is better to be safe than sorry. Know who to call and what to do if you cannot reach the supervisor.

Document in the chart when and why you placed the call, and the results of the call.

Never assume anything. If you are uncertain, place the call.

What are some changes in the patient's condition that should be called to the Supervisor?

Changes in the Patient's Condition

New or unusual complaints, symptoms, or observations
Incidents, Falls, or Injuries
Decreased strength or activity tolerance
Decreased mobility
Increased confusion
Signs or symptoms of acute illness
Altered mental status
Altered level of consciousness
New or unusual behavior
Sensory changes
Inadequate or unusual intake or output
Signs and symptoms of dehydration
New or increased pain
Skin breakdown

Absolute Home Care Plus **Policies and Procedures**	
Section 3: Service Delivery and Client Care	
Policy Title: Documentation and Client Records	**Policy Number: 3.140**
	Effective Date: 03/01/2014
	Revision Date:
	Approved By: Monica Armour
	Page Number: Page 1 of 2

PURPOSE

To establish a process for documenting and maintaining client records and to comply with legislative requirements.

POLICY

Absolute Home Care Plus has a policy in place for the construction and maintenance of client files to ensure that required information is documented and consistent record management standards are applied.

PROCEDURES

1. Forms, used for client records, shall be designed in such a way to reduce/eliminate unnecessary searches and to save documentation time.
2. Client records shall be:
   a. maintained for each client receiving home care services;
   b. kept secure and confidential;
   c. accessed only by authorized personnel;
   d. protected from theft, fire and/or water;
   e. kept in good order;
   f. constructed, maintained and used in accordance with statutory requirements;
   g. legible, factual, signed and dated; and,
   h. kept for the obligatory length of time and then shredded.
3. Client records shall include, but not be limited to, the following information:
   a. identifying data (i.e. name, gender, birth date, address, telephone number, next of kin, emergency contact number, etc);
   b. request for service/referral information;
   c. service plan and updates;
   d. service agreement;
   e. delegation of activities to Home Care Workers (if applicable);
   f. financial transactions for handling client's money;
   g. flow sheet;
   h. progress notes;
   i. documentation of all services rendered (hours and dates);
   j. billing documentation;
   k. termination of services documentation; and,
   l. documentation on health care directives (if applicable).

4. All client data listed above shall be kept in a single, individual client file or within a software program.
5. All entries and documents in client files shall be recorded in ink, be typed, or be computer-generated.
6. Staff shall be informed about the types of records to be maintained, the documentation process and record management standards.

GUIDELINES

1. All employees shall follow the Agency's system for recording information for consistency purposes.
2. Personnel shall apply the following standards, when documenting/managing client records:
   a. To identify the client, each page that is indicated shall contain:
      i. client's name;
      ii. current date; and,
      iii. page number.
   b. To keep the record permanent, all entries shall be made using ink or other durable means.
   c. When making corrections, the original notation shall not be erased. Instead:
      i. use a single line to rule out wrong information;
      ii. write "error" and initial beside "error; and,
      iii. insert the correct information right after the error notation;
   d. Employees shall only document the specific care they personally provided to clients.
   e. Only accurate data about what was observed or heard shall be documented. Assumptions shall be avoided.
   f. Abbreviations shall be kept to a minimum, using only those abbreviations recognized by all members of the care team.
   g. Routine events shall always be recorded.
   h. All entries shall be legible.
3. A Master Signature List shall be prepared and kept in the client's records. The list shall contain the:
   a. printed full name and initials of each individual providing care;
   b. professional designation of each individual providing care; and,
   c. signature of each individual providing care.

FORMS

1. Service Plan
2. Service Agreement
3. Flow Sheet
4. Incident Report
5. Financial Transactions Record