SELF-STUDY PROGRAM

0723H: Documentation Basics

Everyday you provide care to your residents. As you provide this care you interact with various people who need information about your clients condition. These people could be other caregivers, doctors, nurses, pharmacists, and therapists. The resident's medical record, especially the care plan, is where you need to store this critical information so you can communicate accurate information to these people.

Documentation is the process of recording information about the person's health status. If there are changes in a person's health condition (either declines or improvement), your documentation must include your responses (interventions) to those changes and the resident's response to your interventions. Documentation is an ongoing process that starts the moment a person enters into your care until the time they leave.

Here are some general guidelines to use whenever documenting in a resident's records.

General documentation guidelines:

1. Make sure you have the correct resident's record before you begin writing.
2. Write clearly. Print if your handwriting is hard to read.
3. **Do not use pencil**. Your documents are considered permanent records and documents written in pencil can be changed. Use a permanent black or blue ink pen.
4. Document completely, concisely and accurately:
   - » Write short, clear sentences, e.g. "Mrs. Smith did not eat any food today" or "Mrs. Smith had pain in her stomach that lasted all morning."
   - » Use simple, precise words; and
   - » Don't be afraid to use "I" , e.g. "I called the nurse at 3pm to tell her that Mrs. Smith was not eating, had no bowel movements for 3 days and was complaining of stomach pain."

Documenting

- Document any precautionary or preventive measures used/taken.
- Document throughout the day, so information is not forgotten.
- If you remember an important point after you've completed your documentation, write the information with a notation that it is a "late entry." Include the date and time of the late entry. For example, ("Late entry, 7pm: "Mrs. Smith did drink 2 glasses of juice today.")
- Never use whiteout or erase an entry. If you make a mistake, draw a single line through the entry, write "mistaken entry." Don't use the word "error," as the word can indicate that a mistake was made in the care given, not in the documentation. Write in the correct entry as close to the mistaken entry as possible and sign your name.
- Fill in all empty lines or spaces with a single line to prevent writing by someone else. If a space is empty write in Not Applicable or NA.
- Avoid using vague terms like, "appears to be" or "apparently." These terms make you appear as if you are not sure what you are describing or doing.
- If you make a mistake in delivering care, document the error, the resident's outcome and who was contacted to help fix the situation.
- Try to write as specifically as possible. Phrases such as "drainage on bed" or "a large amount" are vague and open to various interpretations.
- If you are recording what someone else said, heard, felt, or smelled use quotations and give credit to the individual who said or expressed it.
- Don't record your opinions. Use examples of what you observed, or what actions you took or what the resident stated.
- Don't use language that suggests a negative attitude toward someone, such as "stubborn", "lazy", "mean", or "resistive."

Documenting healthcare professionals

When you need to record your interactions with the doctor or other healthcare professionals, here are some guidelines to follow:

- Record each phone call to or from a healthcare provider, including date and time and who you spoke with.
- Document information from appointments with care providers such as doctors, home health nurses, therapists, etc.
- If you are waiting for a return phone call, document each time you contacted the office. If it is evident the call is not going to be returned and the person needs additional help, contact other resources to help the client.

Documenting medications

Here are some guidelines to use when documenting medications:

- Document the time you gave a medication. If the resident has unusual or unexpected reactions to the medication, document these and any action you took in response.
- Document a resident’s refusal to allow a treatment or take a medication. Write the reasons why the person refused and use the person’s own words in quotations if possible. Document that you reported the refusal to the prescriber.
- If you don’t give a medication, circle the time, initial and date and give the reason for the omission.

- Don’t write a symptom, such as “c/o pain,” without also documenting what you did about it.
- If you give a PRN (as needed) medication follow the instructions and document the effectiveness, e.g. PRN for pain-document when the pain subsided.

Documenting your care

Remember, your documentation could possibly be your only memory of events that took place months, or even years, earlier. Here are some additional guidelines to remember when documenting the care you give:

- Write often enough to tell the whole story.
- Do not use shorthand or abbreviations that aren’t widely accepted. If you need to, write out everything in order to provide a clear picture.
- Do not alter a person’s record. This is fraud. For example, don’t add information at a later date without indicating the correct date; don’t date the entry so that it appears to have been written at an earlier time; don’t add inaccurate information; and never destroy records. Records should be disposed of per institutions policy.
- Don’t write ahead of time. Something may happen and you may be unable to actually give the care that you have written about.
- Make sure your handwriting is readable. Information that is documented is only useful if people can read it. When spelling words you are unsure of

(e.g. medical condition) use a dictionary to ensure the correct spelling.

- Avoid writing “oops,” “oh no,” “sorry,” or drawing happy and/or sad faces in the record.
- The record is not the place to discuss staffing problems, staff conflicts, or casual conversations.

Your documentation is an important communication tool. It provides information about a person status to other caregivers, therapists, consultants and medical professionals. It allows you, the care provider, to clearly show what steps/actions you have taken to provide your resident with the best possible care. Providing people with current, accurate information on your clients is just as important as the care you’re delivering.

ADDITIONAL DHS RESOURCES

DHS's Safe Medication Administration: https://tinyurl.com/ODHSSafeMeds
DHS's Ensuring Quality Care tools and resources: www.tinyurl.com/APD-EQCTools-Resources

TRAINING CREDIT

To receive a certificate for training hours you will need to take a test. 100 percent accuracy is required to receive a training certificate. Tests are open book. Tests cannot be taken with assistance. Tests results will be sent via email from afhtraining.spd@dhsoha.state.or.us.

All tests are graded in the order received. Processing tests can take up to 8 weeks.

ORDERING TESTS

Fill out the test order form and submit payment to SOQ-Self-study Program, PO Box 14530, Salem OR 97309. Test order form is found at: www.tinyurl.com/DHS-AFHTraining. The test order form contains all self-study courses available.

Tests are valid for 30 days from the date of purchase. Once a self-study test is ordered it is not transferable to another individual. **No refunds will be given.**

Questions or inquires?

Send questions or inquiries to: ahftraining.spd@dhsoha.state.or.us

You can get this document in large print, braille or a format you prefer. Contact the Safety, Oversight and Quality Unit at 1-800-282-9092.