

CHAPTER 26

Documentation Principles, Health Records

I. POLICY

Basic documentation principles and record-keeping practices shall be followed to ensure that patient's unit health records (UHR) shall be current and maintained in accordance with laws and acceptable professional principles and practices. Only approved methods for legally correcting UHR deficiencies shall be used when deficiencies are identified by review in the UHR. Health records shall be kept in the normal course of business. Only authorized staff is to document in the UHR. This includes treating health care staff and specific non-treating healthcare staff to include, but not limited to, HRS staff, UM, and clergy.

II. DEFINITIONS

- A. Correctable deficiencies are those deficiencies that can be completed by:
 - 1. The individual responsible for the original entry.
 - 2. Another member of the clinical staff, in the absence of the responsible person, with direct knowledge of the recorded events.
- B. Non correctable deficiencies are entries that cannot be corrected when:
 - 1. Responsible staff is no longer available.
 - 2. There is no other knowledgeable staff with direct knowledge of the events.
 - 3. There are no supporting records available.
 - 4. Significant time has elapsed and recall is impossible.
- C. Amendments to the record are additions that provide:
 - 1. Additional facts not available at the time the original entries were made.
 - 2. Evidence that the information as originally recorded is in error, or incorrectly represents the facts.
 - 3. Explanation or clarification of missing or incomplete entries.
 - 4. An accurate reflection of the sequence of events.
- D. Alteration of the Record is the act of revising, changing or modifying an entry without using acceptable legal methods of health record completion/correction as outlined in this document.
- E. Late Entries are those made at a date and/or time after the fact of the event or observation that exceeds the usual recording time period.
- F. Extraneous Remarks are entries in the record that are not related to the patient, i.e., complaints about other staff, blaming or criticizing others, arguing in the record, flippancy, and other such entries.
- G. Falsification of the Health Record is any entry that is untrue or misleading in order to deceive; willful misrepresentation of events by addition of false information or the removal of original documents.
- H. Obliteration of Health Record Entries is the act of totally destroying and leaving no trace of the original information.

- I. Reconstruction of a Record is the rebuilding of a record from secondary records as much as possible, and is only permitted when the original has been inadvertently destroyed or permanently lost.

III. PROCEDURE

A. Entries to the UHR shall be:

1. Timely
 - a. Record promptly as the events or observations occur, or as soon after the event as possible using the 24-hour clock to time entries.
2. Complete
 - a. Record all entries completely, concisely, and timely. Entries shall address specific documentation requirements and be accurate, timely, specific (definitive), concise, legible, and clear. Additionally, entries shall be:
 1. Descriptive - Write descriptive notes of observations and provision of services. Documentation is required where statutes, regulations and policies are not specific, based on the patient's condition, changes in patient's condition, Medical Staff Bylaws, policies and procedures, acceptable professional standards and clinical judgment.
 2. Record pertinent observations including psychosocial and physical manifestations, patient behaviors, unusual events, and patient's responses.
 - b. Inpatient records shall be completed within fourteen (14) days following discharge of the patient.
3. Chronological
 - a. Record entries in chronological sequence. Should it be necessary to record out of sequence during the episode of care, the actual time of recording shall be entered with the time when the actions actually occurred.
4. Permanent
 - a. Record all entries permanently; entries shall be either typewritten or legibly written in a permanent media (preferably black ink). Do not use felt tip pens. Record allergies in red ink.
5. Authenticated
 - a. Sign, date, and time all entries. Include the full date: month, day and year. Clearly show the professional designation e.g., M.D., RN, MTA, D.D.S., Ph.D.
 - b. Never sign an entry for someone else.
 - c. The printout of a computerized record shall be accepted as the original. These documents, which have been authenticated electronically, do not require additional signatures.
6. Consecutive
 - a. Record entries consecutively without leaving spaces between entries, skipping lines, or leaving a space where someone else can record. Do not leave blank spaces on any form designed for chronological, sequential notes.
 - b. Write "continued" to specify there are additional entries on subsequent pages. There is no requirement to sign each page of a continued document.

7. Legible
 - a. Record legibly, including signatures.
8. Patient Identifiable
 - a. The patient's addressograph imprint shall be used on each UHR form. If an addressograph is not available, the clinician shall enter patient identifiers on each form. This shall include the patient's name (last, first, middle), CDC number, and date of birth. A two-sided form shall have identifying information on both sides.
- B. Obliteration of Data shall not occur
 1. ORIGINAL ENTRIES IN THE PATIENT HEALTH RECORD SHALL NEVER BE ALTERED, DESTROYED, OBLITERATED, OR REMOVED FROM THE RECORD.
 2. Do not obliterate, erase, alter or destroy any portion of the health record. DO NOT USE LIQUID ERASER (White Out).
- C. Corrections, Amendments, and Late Entries shall conform to the following:
 1. Correction of Documentation Error:
 - a. Draw one horizontal line through each word, phrase, or line of material to be corrected (do not obliterate the error).
 - b. Designate the entry as an error, and label as "mistaken entry" or "ME."
 - c. Date and sign the error correction entry.
 - d. Record the correct information.
 - e. If replacing a statement:
 1. Add a note, if applicable, stating why the previous entry is being corrected.
 2. Enter the correction in chronological order.
 3. Use an asterisk (*) next to the date of the incorrect entry.
 4. Add another asterisk to indicate the location of the correction, or bracket entries in error.
 5. Record the date, name and title of the person entering the correction.
 2. Amendments to the Record
 - a. Amendments shall be completed by:
 1. Original author.
 2. Clinical staff with personal knowledge of care.
 3. Administrative staff qualified to do so.
 4. Patient (all patient requests for amendments to the record shall be referred to the Health Record Services (HRS) Supervisor). Refer to policy: "Request by Patient to Amend Unit Health Record".
 - b. Process the amendment as follows:
 1. Identify the entry to be amended.
 2. Record the reason for the amendment.
 3. Document the statement of facts.
 4. Date and time the amendment using the 24-hour clock.
 5. Sign with full name and classification title.
 6. Identify the location of secondary records that substantiate the amendment.
 3. Late Entries:

- a. Record late entries as follows:
 1. Identify the late entry by placing an asterisk (*) before the text, and stating at the beginning of the entry, "late entry" for date and time. Clearly identify the date and time of the entry as well as the date and time of the actual occurrence. (Example: 3/10/95 1015 recording for 3/3/95 0900).
 2. Insert a second asterisk (*) in the margin at the point the entry would have been written, if it were timely.
- D. Errors
 1. Errors of omission or missing items/elements
 - a. The following errors of omission shall be corrected by the author:
 1. Signatures and titles of unsigned entries.
 2. Dates, if the author recalls the dates when the notes were written.
 3. Required reports by the responsible person, e.g., physical examinations, assessments, nursing assessment. Identified missing and/or late reports shall be completed with the current date. Fill out forms completely.
 - b. There shall be no postdating of entries.
 2. Errors of commission when recording an entry:
 - a. Errors of commission shall be corrected by the authors or other health care staff:
 1. If non-clinical information.
 2. When transcribing information recorded elsewhere in the record, recording patient allergies onto the front of the folder.
 3. When identifying each page in the record.
 - b. HRS staff may write information in the record if information is known as accurate, such as a name, California Department of Corrections (CDC) number, or when transcribing information recorded elsewhere from one document to another such as diagnoses or procedures.
 - c. All entries shall be dated and signed by the author with classification title, e.g., Health Record Technician (HRT II).
- E. Record:
 1. The inpatient status, and the patient's method of discharge, or transfer, e.g., ambulatory, wheelchair, or escorted. Accurately record the time of transfer and arrival from one patient care area of the institution to another.
 2. All treatments, observations during treatments, and results of treatments.
 3. Precautionary or protective measures taken for the patient.
 4. Date, time and method of admission of the patient to emergency by the Registered Nurse and Medical Technical Assistant.
 5. Assessment of the patient's condition upon admission to the emergency or inpatient status and the patient's condition when transferred to another treatment area.
 6. Significant observations relative to the patient's complaints or diagnosis.
 7. Initial treatment prior to arrival in the patient care area.
- F. Other Documentation Principles:
 1. Ditto Marks:

- a. DO NOT USE ditto marks to indicate "same as above." This practice leads to more than one interpretation of data recorded, and ditto marks are easily altered.
2. Non-clinical Remarks:
 - a. AVOID extraneous, flippant or funny remarks. Write entries in the record that are patient related. The UHR shall not be used to settle grudges, complain about staff performance, criticize or argue. Avoid other remarks that "red flag" non-clinical issues.
3. Symbols and Abbreviations:
 - a. Use symbols and abbreviations only from the HCSD-approved symbols and abbreviations list. Each symbol and abbreviation shall have only one meaning. Abbreviations and abbreviated forms of words shall not be used to diagnose or order medications as these are subject to more than one interpretation.
4. Incident Report:
 - a. Do not record the fact that an incident report notification was completed or submitted. The general information recorded on the incident report notification shall be supported by clinical entries written in the patient's progress notes.
5. Initials:
 - a. Initials may be used where called for on a specific form, or by instructions, if there is full signature on the page which identifies the initials. (Example: medication administration is initialed, and the initial is identified by a signature on the medication administration record).
6. Countersignatures:
 - a. Countersignatures shall be used only when the Health Care Services Division policies and procedures specify the use of countersignature, e.g., to reflect direct supervision.
7. Prerecording of Events:
 - a. Do not document before an event occurs.