Documentation Mini-Tool Kit

THOSE ESSENTIAL BASICS!

Presented by:
Hospice and Community Care Insurance Services

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Prepared by

To the best of our knowledge, the information contained in this Documentation Mini-Tool Kit reflects current accepted practice standards. All information should be considered in light of the individual patient's condition and the state of practice. The publisher and author disclaim responsibility for any adverse effects from the use of this material.

Introduction

This mini-tool kit is provided to our insured organizations for their use in staff education. It is intended to assist individuals and organizations to reinforce documentation standards and improve this important aspect of care delivery. These tools can be adapted for individual organization use, if needed or desired. Documentation and assessment requirements change over time, and when change occurs, details of documentation might also change. This offering is intended to reflect current industry standards at the time of development, but it remains the organization's responsibility to maintain documentation at the level expected by regulatory and licensing agencies, as well as accrediting bodies. These tools provide additional resources for the enhancement of documentation and ease of use for staff education. All resources are made available for the organization's internal use and can be copied and distributed to the organization's staff. These materials are not to be copied or used in any way for external distribution or mass production.

OBJECTIVES:

Following implementation of these tools, participants will be able to:

1. State why accurate documentation is important.
2. Name the uses of documentation.
3. List elements of documentation.
4. Know three documentation DOs.
5. Name three documentation DO NOTs.
6. Find the organization's listing of approved and not approved abbreviations.
7. Complete the documentation inservice.
8. Participate in the documentation games and activities.
9. Relate references and resources for additional documentation information.
10. Identify their individual role in quality documentation.

TOOL KIT COMPONENTS:

Tool kit resources and components include:

1. **Implementation Guide** - A guide to sequence and time frame for use of the tool kit's components.
2. **Documentation** - An overview of why documentation is important (Handout 2-1), Documentation HOW TOs (Handout 2-2) and Documentation DOs (Handout 2-3).
3. **Documentation DO NOTs** - A Handout (3-1) that includes words and phrases that are considered best not to use in documentation, as well as a handout on specific Documentation DO NOTs (3-2).
4. **Abbreviations, What's Happening** - An Approved and Do Not Use Abbreviation tool/Handout (4-1 - 4-5), incorporating specific abbreviations that are recommended on the JCAHO Official Do Not Use List and selected abbreviations from the Institute for Safe Medication Practices releases.
5. **Paraprofessional/Volunteer Inservice** - A documentation inservice designed for the paraprofessional and personal care volunteers. The inservice includes objectives, content, and a test *(Health Care Aide Educator).*
6. **Documentation Reinforcement Hints** - A collection of resources that includes a sample poster that can be posted in the organization to reinforce the importance of documentation. In addition, the Alphabet Sleuth game/treasure hunt and a Documentation Celebration invitation are provided in this component. All elements are designed to positively reinforce documentation success (Handouts 6-1 - 6-3).
7. **Resources and References** - A listing of additional resources, both published and electronic, for obtaining additional information on documentation are provided in this component, as well as several sample mini-audit tools that can be used for specific focused record audits.
8. **Certificate of Completion** - A sample certificate provided for individualization and use by the organization. This certificate can be copied and presented to all staff participating in the documentation inservice activities and education sessions.

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Implementation Guide

The components of this mini-tool kit are for use by the organization as part of its annual inservice education program. The suggested steps and sequence of implementation are as follows:

1. Review contents of documentation tool kit.
2. Conduct any pre-implementation documentation audits desired, using either agency tools or tools provided within tool kit.
3. Distribute Handout 2-1, Handout 2-2, and Handout 2-3 to all staff and provide inservice on why documentation is important and Documentation DOs to all staff.
4. Distribute Handout 3-1 and 3-2 to all staff and provide inservice on Documentation DO NOTs and words and phrases to avoid at a staff meeting.
5. Distribute Handout 4-1 and add what's happening with abbreviations on the staff meeting's agenda as a discussion item.
6. Bring organization Official Approved Abbreviation List and Do Not Use List to the staff meeting, along with Handout 4-2: Sample Approved Abbreviation Listings and Handout 4-3: Sample Do Not Use Abbreviations Listing provided.
7. Complete abbreviation mini-audits and track and trend findings using audit tools provided (Handout 4-4 and Handout 4-5).
8. Copy and distribute Aide and Volunteer Documentation Inservice.
9. Administer post test to aides and volunteers upon completion of documentation inservice.
10. Score individual aide and volunteers' post tests using answer sheet provided. File scored post test in individual personnel files or annual inservice education folders.
11. Copy and post Memo Handout 6-1 for two weeks. Ask staff for additional items to complete listing.
12. Copy and post Poster Handout 6-2 for two weeks.
13. Initiate Alphabet Sleuth Hunt games starting with Game 1. Establish a three-week time frame for completion.
14. Initiate Alphabet Sleuth Hunt Coverall Game 2. Establish a four-week time frame for completion.
15. Conduct ongoing mini-documentation audits using tools provided in Components 4 and Component 7.
16. Communicate ongoing mini-documentation audit results to all staff.
17. Develop ongoing documentation improvement action plans based upon audit findings.
18. Hold discipline-specific Documentation Milestone Achievement Celebrations. (See Sample Invitation 6-3 provided.)
19. Hold organization-wide Documentation Milestone Achievement Celebration. (See Sample Invitation 6-3 provided.)
20. Assign an individual to continue ongoing:
    - Positive reinforcing of documentation.
    - Referencing of additions to the abbreviations not to use lists and web sites. (See Resources/References provided, Component 7.)
    - Monitoring of changing accreditation and licensing expectations.
    - Communicating of above findings.
21. Complete Certificate of Achievement for each staff participating in documentation inservice and education activities. (See Sample Certificate provided.)
22. Present completed Certificates of Achievement at staff celebration event.
23. File copies of completed certificates in individual staff personnel file or annual inservice education records.

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HANDOUT 2-1

Documentation Tool Kit

WHY DOCUMENTATION IS IMPORTANT

Documentation…

1. Can be the source of communication among care team members and should be seen as a resource for all care providers
2. Can assist in coordination of care and services
3. Is the primary source of information provided for reimbursement
4. Can result in approval or denial of services and payment or non-payment of services
5. Can form the foundation for making care decisions
6. Is a legal document and a record of quality of care and services provided
7. Is used to defend legal claims against the organization
8. Is one source of information used to conduct utilization and quality audits
9. Can demonstrate the patient's achievement of outcomes and blueprint for care (care plan)
10. Is the visual of the patient and care for others, as it paints the picture of the patient and provides the foundation for other's visualization
11. Can be a safeguard to protect the organization from fraudulent liabilities
12. Can show adherence to regulation requirements
13. Can demonstrate compliance with accreditation standards
14. Can enhance the organization's reputation and public image

Definition of Quality Clinical Record Documentation:

The degree to which the recorded documentation reflects the accuracy and completeness of the care and services provided. This includes recording relevant patient, family and environment of care information. All recorded documentation is recorded in clear and easily retrieved format.

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HANDOUT 2-2

Documentation HOW TOs

DOCUMENTATION ELEMENTS:

Take time to include the basic elements of care in your documentation. These include, but are not limited to:

- Patient Demographics
- Emergency/Family Contact Information
- Environment of Care Assessment
- Patient Assessments and Findings
- Initial and Ongoing Care Plans
- Physician Certification and Orders
- Problems Identified and Actions Taken
- Services Provided: Teaching, Care and Supportive Services
- Patient-Specific Measurable Goals
- Patient Status and Condition Changes
- Goal Achievement Status, Response to Care
- Visit Schedule
- Discharge Planning
- Interdisciplinary Activities/Collaboration

R E M I N D E R A L E R T

Documentation Must Be:

ACCURATE
COMPREHENSIVE
CLEAR
LEGIBLE
PERMANENT

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HANDOUT 2-3

Documentation DOs

All Providers:

1. Do write legibly, using only approved charting forms.
2. Do identify the patient on every charting form.
3. Do document in blue or black ink.
4. Do make corrections by striking a single line through the ~~rong~~ (BG 02/14/2006) wrong entry and placing your initials and the date above.
5. Do write in complete, clear sentences.
6. Do be specific.
7. Do note the time and date of each entry.
8. Do sign each entry.
9. Do spell correctly.
10. Do use good grammar.
11. Do use an addendum if more space is needed.
12. Do avoid tunnel vision – consider the entire patient.
13. Do record the patient's subjective comments that are relevant to care and services.
14. Do use only organization-approved abbreviations.
15. Do include the patient and/or family caregiver's response to care.
16. Do document at the visit or immediately upon leaving the home.
17. Do take credit for all that you do in the home by documenting it.
18. Do record collaboration and communication with other members of the care team.
19. Do take the time to focus on your documentation.

Licensed/Professional Care Providers:

20. Do clearly document the patient's status with every note.
21. Do document discharge planning early in the patient's care.
22. Do remember the limits of your license and document relative to your domain of care.
23. Do include objective data and assessment findings to support the documentation.
24. Do include documentation of patient involvement in care planning.
25. Do document outcome achievements and/or variances in achievement.
26. Do document interdisciplinary activities.

Do add to this list of Documentation DOs based upon your organization's experiences and specific findings.

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HANDOUT 3-1

Documentation DO NOTs

All Providers:

1. Never use liquid correction fluid.
2. Never use pencil.
3. Do not crowd the documentation, but rather add an addendum to the documentation if needed. If an addendum is needed, do not cram it into the record but write an "Addendum to documentation" note.
4. Do not purposefully omit information.
5. Do not alter clinical documentation or any parts of the clinical record.
6. Do not add to someone else's notes.
7. Do not erase any entry.
8. Do not black out any entry.
9. Do not leave blank lines.
10. Do not leave gaps in the record.
11. Never tamper with the documentation or any part of the clinical record. Tampering is:
    - Adding to a clinical note at a later date without indicating that it is a late entry.
    - Placing inaccurate information in a record.
    - Purposely omitting information.
    - Rewriting or altering the documentation.
    - Destroying clinical record notes or other documentation.
    - Adding to someone else's notes without indicating your identity and the date.
12. Do not use abbreviations that are not approved by the organization.
13. Do not rely on your memory to provide complete documentation later in the day.
14. Do not document any care that was not provided. Never chart care, treatments or medications administered in advance.
15. Do not document in public.

Licensed/Professional Care Providers:

16. Do not profess to be an expert of another discipline's domain by limiting your documentation of care to your area of expertise.
17. Do not document "in a vacuum"; reference other discipline's documentation to maintain consistency.

Do add to this list of Documentation DO NOTs
based upon your organization's experience and findings.

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HANDOUT 3-2

Words/Phrases to Avoid AND Replacement Suggestions

WORD/PHRASE TO AVOID	COMMENTS	POSSIBLE REPLACEMENT
Slightly	It either is or is not	A more definitive word
Pink	Very non-descript	Red
Cloudy drainage	Very non-descript	Purulent
Mild	Not measurable	A 0-10 score or other appropriate standardized measurement
Stable	Why is care needed?	Stabilizing
Discomfort	Use a measurement	Pain 0-10
Monitor	Use more active words	Assess, evaluate
Short-winded when up	Use more professional terminology	Extreme SOB with only minimal exertion
Assisted by	Use more professional terminology	Requires the assistance of
Discussed	Use a more skill-oriented term	Educated, Instructed
Encouraged	Use a more skill-oriented term	Taught
Reinforced	Use a more skill-oriented term	Reeducated
Encouraged to keep legs elevated	Use a more skill-oriented term	Instructed in importance of non-weight bearing
Difficulty with	Use a measurement	0-10 measurement of ability/function

Organization can add to this Table based upon organization-specific findings. (Replacement words/phrases should use descriptive, measurable terminology.)

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HANDOUT 4-1

Abbreviations: What's Happening

Approved Abbreviations:

Organizations have long been asked to have a list of approved abbreviations and to keep this list updated. This list also usually includes symbols commonly used in clinical documentation and physician orders. Sample abbreviations commonly included in an organization's approved abbreviations listing and a sample format for this document are provided in Handout 4-2.

Prohibited Abbreviations:

Since 2002 the need to identify problem-prone abbreviations has been suggested. In 2004 the Joint Commission for Health Care Organizations (JCAHO) asked organizations, accredited through them, to comply with development of a list of do not use abbreviations. Initially, the list was to include a minimum number of abbreviations, as well as some specifically-required do not use abbreviations, which must be on the organization's list. Sample abbreviations, including those required by JCAHO, along with examples of others identified by the Institute for Safe Medication Practices are found in Handout 4-3.

IMPLEMENTATION PROCESS:

1. Conduct a Pre-Abbreviation Education clinical and administrative record audit (Handout 4-4, Mini-Abbreviation Audit Tool).
    - Identify commonly used abbreviations and meaning intended.
    - Identify any problem-prone abbreviation use and meaning confusion.
    - Track commonly used and problem-prone abbreviation use for discipline specific or across the organization usage (Handout 4-5, Mini-Abbreviation Audit Tracking/Trending Summary).
2. Compare the abbreviations used and meaning intended with the organization's approved abbreviations and their allowed usage for lack of consistency.
3. Use these examples and the Documentation Tool Kit tools to conduct a staff-wide education session.
4. Follow up with Documentation Reinforcement Hints provided in Tool Kit, Component 6.
5. Reaudit clinical and administrative audits using the above process, tools and forms found in Component 7.

INTRODUCTION TO APPROVED ABBREVIATIONS:

The following Handout 4-2 is a sample from a listing of an abbreviation resource developed for community health, hospice, private duty and home health organizations. It is intended to provide a format and examples, but is not intended to be all-inclusive.

It is recommended that organizations review these examples and develop and/or make current their approved abbreviations and do not use abbreviations and compile an up-to-date list.

Additional idiosyncratic/agency-specific abbreviations found during audits or completion of the Alphabet Sleuth Game (see Documentation Tool Kit Component 6) should be either added to the approved listing or be noted as Do Not Use abbreviations. This exercise should be conducted on an ongoing basis.

At the end of both Approved Abbreviations and Do Not Use Abbreviations, additional space is provided for each letter of the alphabet, to allow for additions to be inserted in pen.

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HANDOUT 4-2

Sample Approved Abbreviations Listing/Format

Abbreviations ©Advantage Health Care Management Resources Press [1994, 1996, 2000, 2004]

A

a	Before
A	Achieved/Atrial
AM	Morning
AP; ap	Apical Pulse
A/R	Apical/Radial
ADL	Activities of Daily Living
ak	Above Knee
APPT	Appointment
APT	Apartment
AROM	Active Range of Motion
Ax	Axillary

Organization Specific:

B

B&B	Bowel and Bladder
BPH	Benign Prostatic Hypertrophy
BBB	Bundle Branch Block
BC	Blue Cross
BC/BS	Blue Cross, Blue Shield
Bilat; Bil	Bilateral
BKA	Below the Knee Amputation
BP; bp	Blood Pressure
BR	Bedrest
BRP	Bathroom Privileges

Organization Specific:

C

c/o	Complained Of
C/R	Closed Reduction
C/S; C&S	Culture and Sensitivity
Ca	Cancer
CABG	Coronary Artery Bypass Graft
CHF	Congestive Heart Failure
CLL	Chronic Lymphocytic Leukemia
CM; C.Mgr.	Case Manager
CAN	Certified Nursing Assistant
CPM	Continuous Passive Motion

Organization Specific:

D

DJD	Degenerative Joint Disease
DM	Diabetes Mellitus
DME	Durable Medical Equipment
DNR	Do Not Resuscitate
DO; D.O.	Doctor of Osteopathy
DPM; D.P.M.	Doctor of Podiatric Medicine
DSD	Dry Sterile Dressing
D/T; dt; d/t	Due To
dgt.; dgtr.	Daughter
diff	Differential

Organization Specific:

E

E-Coli	Escherichia Coli
ED	Emergency Department
e.g.	Example
EKG	Electrocardiogram
ENT	Ears, Nose, Throat
ET	Enterostomal Therapist
ECF	Extended Care Facility
ECG	Electrocardiogram
ESRD	End Stage Renal Disease
ETOH	Ethylalcohol

Organization Specific:

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F

FF	Force Fluids
FMD; F.M.D.	Family Medical Doctor
FWB	Full Weight Bearing
F/H; FH	Family History
f/t	Follow Through
Fam. Hx.	Family History
Fe	Iron
Fib.	Fibrillation
Fo	Fahrenheit
FU; f/u	Follow UP

Organization Specific:

G

GB	Gall Bladder
GI	Gastro Intestinal
GT	Gait Training
G-tube; GT	Gastrostomy Tube
GTT	Glucose Tolerance Test
GU	Genito Urinary
GYN	Gynecology

Organization Specific:

H

H & L	Heart and Lungs
H & P	History and Physical
HME	Home Medical Equipment
HR	Heart Rate
H/A	Headache
H_2O	Water
H_2O_2	Peroxide
HBP	High Blood Pressure/Healthy Beginnings Plus

Organization Specific:

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I

I	Independent
I	Intake/Intact/Instruct
I & D	Incision and Drainage
IC	Intracoronary, Infection Control
IDA	Iron Deficiency Anemia
IDDM	Insulin Dependent Diabetes Mellitus
IDS	Integrated Delivery System
i.e.	For Example
IM	Intramuscular
inc.	Incontinent

Organization Specific:

______________ ______________________________
______________ ______________________________
______________ ______________________________

J

JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JVD	Jugular Vein Distention

Organization Specific:

______________ ______________________________
______________ ______________________________
______________ ______________________________

K

K+	Potassium
K-Wire	Kirshner Wire
Kg; Kilo	Kilogram
KUB	Kidney, Ureter, Bladder
KVO	Keep Vein Open

Organization Specific:

______________ ______________________________
______________ ______________________________
______________ ______________________________

L

L; Lt	Left
LAD	Left Anterior Descending
LAO	Left Anterior Oblique
LCA	Left Coronary Artery
LOA	Level of Activity; Leave of Absence
LOB	Loss of Balance
LOC	Laxative of Choice/Loss of Consciousness
LOS	Length of Stay
LPN	Licensed Practical Nurse
lab.	Laboratory

Organization Specific:

______________ ______________________________
______________ ______________________________
______________ ______________________________

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M

MA	Medical Assistance
MAX (A)	Maximum Assistance
MAX; max	Maximum
MD; M.D.	Medical Doctor
med(s)	Medicine(s), medication[s]
MHMR	Mental Health Mental Retardation
MI	Myocardial Infarction
Min. (A)	Minimum Assistance
MmHg	Millimeters of Mercury
MVA	Motor Vehicle Accident

Organization Specific:

N

N.A.	Nursing Assistant/Not Achieved
N/V/D, N&V&D	Nausea, Vomiting & Diarrhea
NA; na; n/a	Not Applicable
Na; Na+	Sodium
NAS	No Added Salt
NAS-PC	No Added Salt Prudent Cardiac
NC	Nasal Cannula, No Charge
neg.	Negative
neuro.	Neurological
NG; ng; ng(T)	Nasogastric Tube

Organization Specific:

O

O	Output
o	Oral
O_2	Oxygen
O_2 cap	Oxygen Capacity
O_2 sat.	Oxygen Saturation
OOA	Office of Aging
OOB	Out of Bed
ORIF	Open Reduction Internal Fixation
OT	Occupational Therapy
OTR	Registered Occupational Therapist

Organization Specific:

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P

P	Phosphorous, Pulse
PCH	Personal Care Home
PAT	Pre-admission Testing, Paroxysmal Atrial Tachycardia
PCA	Patient Controlled Analgesia
PCN	Penicillin
PD	Private Duty
PEARL	Pupils Equal & React to Light
PEARLA	Pupils Equal & React to Light & Accommodation
PH	Past History
PMH	Past Medical History

Organization Specific:

Q

Qns	Quantity Not Sufficient
Qs	Quantity Sufficient, As Much As Required
QR	Quiet Room
qt.	Quart
quad.	Quadriplegic

Organization Specific:

R

R	Resistance, Respiration, Return Demonstration
R; Rt	Right
RD; R.D.	Registered Dietitian
r; R	Rectal
R/O	Rule Out
RA	Right Atrium, Rheumatoid Arthritis
RBBB	Right Bundle Branch Block
Rbc	Red Blood Cell(s)
RC	Respiratory Care, Roman Catholic
resp.	Respiration

Organization Specific:

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S

s/s	Signs and Symptoms
sang.	Sanguinous
SASH	Saline Antibiotic Saline Heparin
sat.	Saturated
SBE	Subacute Bacterial Endocarditis
SBO	Small Bowel Obstruction
sed. Rate	Sedimentation Rate
SGOT	Serum Glutanic Oxaloacetic Transaminase
SL; s/l	Sublingual
SNF	Skilled Nursing Facility

Organization Specific:

T

T&A	Tonsillectomy & Adenoidectomy
TAH	Total Abdominal Hysterectomy
TB	Tuberculosis
TBA	To Be Admitted; To Be Announced
Tc; t.c.	Telephone Call
To; t.o.	Telephone Order
TIA	Transient Ischemic Attack
TSH	Thyroid Stimulating Hormone
T; temp.	Temperature
Tab	Tablet

Organization Specific:

U

U/A	Urinalysis
UC	Ulcerative Colitis
UE	Upper Extremity
UR	Utilization Review
URI	Upper Respiratory Infection
USP	United States Pharmacopoeia
UTI	Urinary Tract Infection
UV	Ultraviolet

Organization Specific:

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V

VC	Vital Capacity
VD	Venereal Disease
v.o.; vo	Verbal Order
v/s	Vital Signs
VDRL	Venereal Disease Research Laboratories
vol.	Volunteer
vss	Vital Signs Stable

Organization Specific:

W

w/c; wc	Wheelchair
W/E; WE	Weekend
w/o	Without
WB	Weight Bearing
WBAT	Weight Bearing as Tolerated
WBC	White Blood Cells
wgt.	Weight
WN	Well Nourished
WNL	Within Normal Limits
wt.	Weight

Organization Specific:

X

X	Times, Except

Organization Specific:

Y

Yr	Year
Yrs	Years

Organization Specific:

Z

Z	Dram

Organization Specific:

Symbols

↓	Decreased
↑	Increased
=	Equals
#	Pound[s]

Organization Specific:

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HANDOUT 4-3

Sample "DO NOT USE" Abbreviations Listing/Format*

*(*Required by JCAHO, as selected from ISMP List Distributed November 2003)*

ABBREVIATION	MEANING	MISTAKEN FOR	RECOMMENDED ALTERNATIVE
IU	International unit	IV (intravenous) or 10 (ten)	International Units
q.d. or QD	Every day	q.i.d., especially if the period after the "q" or the tail of "q" is misread	Daily
q.o.d. or QOD	Every other day	q.d.(daily) or "q.i.d. (four times daily) if the "o" is poorly written	Every other day
U or u Dose Designations and Other Information Intended Meaning	Mistaken as the number 0 or 4, causing a 10-fold overdose or greater (e.g., 4U seen as "40" or 4u seen as "44")	cc so dose given in liquid/volume rather than units (e.g., 4u seen as 4cc)	Unit or unit
5.0 mg (Trailing zero after decimal)	5 mg	50 mg if the decimal point is not seen	Never use trailing zeros for whole number dosages
.2 mg (No leading zero before decimal)	0.2 mg	2 mg if the decimal point is not seen	Always use the zero before a decimal point
MgSO4	magnesium sulfate	morphine sulfate	Magnesium Sulfate
MS, MSO4	morphine sulfate	magnesium sulfate	Morphine Sulfate

(Note: Plus a minimum of three additional required if accredited by JCAHO.)

Organization Specific:

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HANDOUT 4-4

Abbreviation Mini-Audit Tool

Location Found / Date	Abbreviation Used	Interpreted Intended Meaning	Approved Abbreviation	Approved Meaning	Follow-Up Actions Taken

Mini-Audit Comments:

Mini-Audit Date: ___________ Conducted by: ____

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HANDOUT 4-5

Abbreviation Mini-Audit Tracking/Trending Summary

Incidence of Misused Abbreviations Found (Number)	Add to Approved List? (Yes/No) Date Completed	Add to Do Not Use List? (Yes/No) Date Completed	Staff Education Provided? (Yes/No) Date Completed	Other Actions Needed/Taken? (Yes/No) Date Completed

Summary Comments:

Summary Date: ___________ Completed by: ____

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Health Care Aide EDUCATOR

Barbara Stover Gingerich, Editor An ADVANTAGE HOME Consultants Publication

Editorial Comments

Taking up your pen to record your care is a very important part of your job. You can talk with other members of the care team about the patient and care that you have provided, but what you document on the aide plan of care or aide work plan is the permanent record of your care. Your documentation lets other members of the care team know that you have provided the care to the patient that you have been asked to provide. A nurse or social worker, or any other care team member, who reads the patient's clinical record can refer to your documentation to see about the patient's personal care. So remember to take time to not only reflect upon what you write down and record and also remember to take the time to write clearly and to record correct and accurate information. This inservice talks about the importance of documentation and about some things to remember to do and some to remember not to do when you document. Take time to complete the inservice and the pre and post test, and as always be sure to clarify anything in this inservice that you do not understand.

Barbara Stover Gingerich RN, MS, FACHE
Editor

Educational Inservice
Documentation: What To Do

Learning Objectives

Upon completion of this in-service, the health care aide will be able to:

1. Identify three abbreviations not to use when documenting.
2. List at least three elements of quality documentation.
3. Describe two to do's of quality documentation.
4. State two ways to keep documentation confidential.
5. Identify three things not to do when documenting.
6. Name at least two reasons why quality documentation is important.

Why Document

Documentation has always been an important part of care. In fact a saying in the healthcare industry at one time was, "if it wasn't documented, it wasn't done". As a health care paraprofessional, you are asked to provide personal care and are provided a care plan that reflects the patient's personal care needs. This plan lets you know what care you are to provide and is developed by a healthcare professional, usually a registered nurse. If you have questions about the patient or the care you have been asked to provide, it is important that you ask the nurse or the patient's case manager these questions. That way you will understand what care you are to provide and how to document the care.

Admission Assessment and Care Planning

Home Health

In home health care agencies the initial admission visit is usually completed by a registered nurse. During this initial visit, the nurse completes a lot of assessments. One of these assessments, is the Outcomes Assessment and Information Set [OASIS] that is completed. Included in this OASIS is lots of questions about the patient's ability to do common tasks, called activities of daily living.

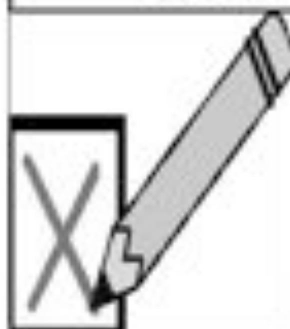
These questions are answered at the time of admission and also at the time of discharge from the organization. During the admission visit, the patient is asked how he/she was able to perform these tasks before they became sick with their present illness. This OASIS is not a tropical paradise, but rather it is a labor intensive collection of information used to plan care and obtain reimbursement for services.

Hospice

The hospice patient's admission assessment is multidisciplinary in approach. The nurse and the social worker complete admission assessments and an initial multidisciplinary plan of care is developed. The patient is included in the care planning process and ongoing interdisciplinary team meetings are held to discuss the patient's ongoing and changing care needs. The Interdisciplinary Team [IDT] maintains an up to date multidisciplinary care plan for each hospice patient.

It is important that you use the organization's forms

Documentation Format



and tools in documenting care. Many time the aide's documentation format is a checklist. This checklist has blocks that need to be marked with a check or an x to indicate that the care plan was followed and the care was done. There is a lot of thought and planning that has gone into that checklist care plan and it is important that you understand how the plan of care was developed.

The nurse develops the aide plan of care that you are expected to follow when providing care to the patient. It is important that you provide the care that is checked on the plan of care and that you check that you did provide the care. Should the patient refuse certain items on the plan of care, you must report to the nurse that the patient refused these items and document that the care was refused by the patient. However, it is the patient's right to refuse care. It is always important to report what care the patient is refusing to the patient's case manager. If the patient's safety within the care setting is at risk because of the care that is being refused, this must be communicated to the office at once.

Importance of Accurate Documentation

The documentation that your organization completes on its patients must be accurate. This is important because documentation is used for:

- Recording information
- Communicating care provided
- Determining changing care needs
- Coordinating care needs

(continued on page 3)

(continued from page 2)

- Defending legal claims
- Avoiding fraudulent liabilities
- Receiving payment for services
- Avoiding service denials
- Meeting regulatory requirements
- Achieving accreditation status
- Demonstrating patient care outcomes

Quality Documentation

Documentation should demonstrate the C's of quality. Quality documentation shows:

- Consistency in care
- Clarity of care
- Changes in care needed and provided
- Comprehensiveness
- Care team involvement
- Clinical findings
- Confidentiality

Importance of Confidentiality

The Health Insurance Portability and Accountability Act (HIPAA) placed new emphasis on keeping the patient's health care information confidential. Confidentiality has always been important when you provide and document care, but it is even more important since this act went in to effect. In addition to documenting accurately and completely, you must also keep your documentation, as well as your care confidential.

Keeping Documentation Confidential Hints

Here are some hints on how to keep your documentation confidential.

1. Keep any written information that you have on the patient covered.
2. Do not allow anyone to look over your shoulder when you are documenting.
3. Do not post the patient's documentation or care plan where it is visible in the home.
4. Do not show anyone your documentation.
5. Do not answer questions from friends or family about your patient or your documentation.
6. Do not share your documentation with others.
7. Do not document in public places, such as McDonald's.
8. Keep any patient specific information covered and out of sight.
9. If you are uncertain about what or how to document, discuss your uncertainty with your supervisor at the agency.
10. Do not ask questions about documentation over a public telephone.
11. Document in a private location.

Abbreviations Not to Use

The Institute for Safe Medication Practices has released a list of abbreviations that they recommend **NOT** using when documenting. When you document your care, it is important that you do **NOT** use these potentially "confusing" abbreviations. Abbreviations that you should **NOT** use include the following:

1. D/C- This might be either discontinue or discharge and should not be used in clinical documentation.

(continued on page 4)

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Health Care Aide EDUCATOR

To the best of our knowledge, the information contained in this in service reflects current accepted practice standards. All information should be considered in light of the individual patient's condition and state practice acts. The publisher and author disclaim responsibility for any adverse effects from the use of this material.

(continued from page 3)

2. OJ– This might be used to mean orange juice, but should not be used because it could be read as OD or OS meaning the right or left eye.

3. cc– this means cubic centimeters, but can be mistaken to be u, which means units.

4. HS or hs – These can be confused to mean either bedtime or half strength so neither abbreviation should be used in the record.

5. BT- This might be misread to mean twice a day, instead of what is meant, i.e. bedtime.[1]

These are some examples that apply to aide documentation that are abbreviations **NOT** to be used. It is important that you ask your supervisor if there are other abbreviations that you are not to use and for a copy of a list of abbreviations that it is permissible for you to use.

Documentation Do's

- Take credit for all the care that you provide
- Document right away, either in the home or immediately upon leaving the home
- Use black ink
- Use permanent ink
- Be specific
- Be objective
- Identify the time and date of each entry
- Avoid confusing abbreviations
- Provide only the care listed on your aide plan of care
- Write clearly and legibly
- Follow the organization's policy on noting documentation errors
- Use good grammar
- Spell correctly
- Date, time and sign each entry

Documentation Do Not's

- Change documentation.
- Tamper with documentation
  - For example, adding a note later and not indicating it was added later
  - Making a correction and not following the correct method for correcting
- Purposefully omit information
- Document in pencil
- Use correction fluid (white out)
- Destroy clinical documentation or any parts of the clinical record
- Add to someone else's notes
- Rely on your memory
- Erase any entry
- Leave blank lines
- Leave gaps in the record
- Use abbreviations, unless they are approved

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TEST

Documentation: What To Do

Please circle ALL correct answers to the questions.

1. From the the following list,.choose the abbreviations that are not to be used in documenting.
   A. OJ B. HS
   C. BT D. ROM

2. Choose the documentation DO NOTs from the the following examples.
   In documenting you do not:
   A. Omit information
   B. Erase any entry
   C. Use pencil
   D. Leave blank lines

3. Accurate documentation is important because it can be used for:
   A. Defending legal claims
   B. Avoiding fraudulent liabilities
   C. Talking with the neighbors
   D. Receiving payment for services

4. The aide can keep documentation confidential by:
   A. Keeping the documentation covered and out of sight
   B. Asking documentation questions from pay phones
   C. Documenting patient care while having a cup of coffee in McDonald's
   D. Sharing documentation with family

5. Which of the following are important TO DOs of documentation that the aide should follow?
   Do:
   A. Document right away
   B. Document in pencil
   C. Spell correctly
   D. Sign your name and designate your position

6. Quality documentation has which of the following elements/characteristics?
   A. Consistency
   B. Confidentiality
   C. Clinical findings
   D. Erased words
   E. Whited out corrections

Date ____________ Name ____

Score ____________

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TEST ANSWER SHEET

Documentation: What To Do

1. A, B, C

2. A, B, C, D

3. A, B, D

4. A

5. A, C, D

6. A, B, C

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HANDOUT 6-1

MEMO

The New Documentation Focus
– The New Way –

OLD WAY THINKING	NEW WAY THINKING
Good Enough	Can Be Better
Blame Others	Examine Your Own
Focus on Support Needs	Focus on What You Can Do
Count or Correct the Errors	Change How You Document
React to Errors in Documentation	Plan How to Prevent Errors in Documentation
Perceive What Errors Exist	Complete Audits to Quantify What Errors Exist
Responsibility is Others’	Responsibility is Each Individual’s

Organization to individualize and add to the above handout.

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HANDOUT 6-2

POSTER

We Need YOU To Document Right!

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ALPHABET SLEUTH HUNT GAME

Hunting Rules:
Each participant must maintain his or her own "caught" list and verify the "found" items with the organization's approved and disallowed abbreviation list. The provided game tally sheets are to be used to record findings.

Hunting Season:
Begins Midnight on __________ and extends until midnight on____________.

Hunting Grounds:
Documentation completed between ___________ and __________.

Tally Sheets:
The attached tally sheets are to be used for the completion of the hunt.

Tally Sheet Completion:
The anonymity of the individual documenting items found is to be maintained. The codes provided are to be used for the completion of the tally sheets. Incomplete sheets will not be considered for trophies, prizes and/or rewards.

Submission:
Completed tally sheets can be turned in by:

- Submitting with payroll sheets
- Handing to your immediate supervisor
- Giving to the Quality Improvement/Utilization Review Staff

All completed entries must be submitted no later than _________________________.

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Game 1

ALPHABET SLEUTH HUNT
TALLY/ENTRY SHEET

Game Objective:
Locate abbreviations being used that are not on the organization's approved abbreviation list or that are from the DO NOT USE abbreviation list.

Scoring:
- 2 points for abbreviations used that are not on approved abbreviations list.
- 5 points for abbreviations used that are on the DO NOT USE abbreviations list.
- Highest scoring tally sheet wins.

ABBREVIATION FOUND	RECORD IDENTIFIER	LOCATION (See codes below)	DATE ABBREVIATION USED	VERIFICATION **N/O -** Not on Approved List **D/N -** On Do Not Use List

Record Identifier: Record Number, Section, as applicable

Location Codes: **CR** - Clinical Record
PO - Physician Orders
MS - Medication Sheet
O - Other

Form Completed by: ___________________________ Date Submitted: ___/____/_______

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Game 2

ALPHABET SLEUTH HUNT COVERALL TALLY/ENTRY SHEET

Game Objective:
Locate a misused abbreviation for each letter of the alphabet. (Can either be an abbreviation that is not on the approved list or an abbreviation that is being used that is on the do not use abbreviation list.)

Scoring: Most letters of the alphabet found wins.

ABBREVIATION FOUND	RECORD IDENTIFIER	LOCATION (See codes below)	DATE ABBREVIATION USED	VERIFICATION **N/O -** Not on Approved List **D/N -** On Do Not Use List
A				
B				
C				
D				
E				
F				
G				
H				
I				
J				
K				
L				
M				
N				
O				
P				
Q				
R				
S				
T				
U				
V				
W				
X				
Y				
Z				

Record Identifier: Record Number, Section, as applicable

Location Codes: **CR** - Clinical Record
PO - Physician Orders
MS - Medication Sheet
O - Other

Form Completed by: ___________________________ Date Submitted: ___/____/_______

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HANDOUT 6-3
INVITATION

Proclaiming the Quality Documentation Celebration!

Hear Ye! Hear Ye!

Date: ________________________________

Time: ________________________________

Location: ______________________________

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Focus:
THERAPY DOCUMENTATION

Time Frame: __**1st** __ **2nd** __ **3rd** __ **4th Quarter** **Year:** ___________

Clinical Record #	Discipline PT- OT- ST-	Abbreviations Found	On Approved List - Y = Yes N = No	Actions Taken: A-Add to List E-Educate C-Confer with Discipline	Action Date: Other Comments:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

General Comments:

Date: ____________________ Completed by: ____

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Focus:
AIDE/NURSING/SOCIAL WORK DOCUMENTATION

Time Frame: **__1st __ 2nd __ 3rd __ 4th Quarter** **Year: __________**

Clinical Record #	Discipline Aide Nursing Social Work	Abbreviations Found	On Approved List - Y = Yes N = No	Actions Taken: A-Add to List E-Educate C-Confer with Discipline	Action Date: Other Comments:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

General Comments:

Date: ____________________ Completed by: ____

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Focus:
PASTORAL CARE/VOLUNTEER/OTHER DOCUMENTATION

Time Frame: **__1st __ 2nd __ 3rd __ 4th Quarter** **Year: __________**

Clinical Record #	Discipline Pastoral Care Volunteer Other	Abbreviations Found	On Approved List - Y = Yes N = No	Actions Taken: A-Add to List E-Educate C-Confer with Discipline	Action Date: Other Comments:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

General Comments:

Date: ____________________ Completed by: ____

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Mini-Audit Tools

Focus:
DOCUMENTATION: LEGIBILITY, SIGNED, DATED

Discipline Audited: ___________________

Time Frame: __**1st** __ **2nd** __ **3rd** __ **4th Quarter** **Year:** ___________

Clinical Record #	Notes Legible	Notes Signed	Notes Dated	Actions Taken: E-Educate C-Confer with Discipline	Action Date: Other Comments:
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

General Comments:

Date: ___________________ Completed by: ____

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Focus:
DOCUMENTATION: CORRECTIONS, REVISIONS AND LATE ENTRIES

Discipline Audited: ________________________

Time Frame: **__1st __ 2nd __ 3rd __ 4th Quarter** **Year: ___________**

Clinical Record #	Corrections Present: Y = Yes N = No	Corrections Made Correctly: Y = Yes N = No	Late Entries Present: Y = Yes N = No	Late Entries Made Correctly: Y = Yes N = No	Actions Taken: E-Educate C-Confer with Discipline	Action Date: Other Comments:
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

General Comments:

Date: ____________________ Completed by: ____

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Certificate of Achievement

Presented to

For Completion of the
Documentation Mini-Tool Kit Components

Signature Date

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