EMR: Rules of Good Documentation Cheat Sheet

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RULE #1: MAKE IT COMPLETE!

Complete documentation is thorough and follows your workplace policies. In general, your documentation will be complete if you include:

- The correct date and time.
- The client's correct name.
- The tasks you perform with each client and how the client responds to your care.
- Any changes you notice in a client's condition.
- Any care that was refused by the client.
- Any phone calls or oral reports you made about the client to a supervisor. (Include the supervisor's name.)
- Your signature and job title.
- Note: Check with your supervisor about how to complete the specific forms used in your workplace.

RULE # 2: KEEP IT CONSISTENT!

Documentation is consistent when it remains true to:

- The client's care plan.
- Physician and nursing orders.
- The observations that your coworkers have made about the same client.
- Your workplace policies. Your documentation will be consistent if you:
- Use workplace-approved medical terms and abbreviations.
- Perform your care according to each client's care plan. If you are unable to follow the care plan on a particular day, document the reason why.
- Tell your supervisor right away if you notice changes in a client's condition so that your observations can be shared with other members of the health care team. This keeps your coworkers from documenting incorrect information.

For example, you take your client's BP and it's suddenly very high. If you don't inform the nurse, she may document that the client's vital signs are normal. This can cause confusion and have a negative effect on client care.

- If you make home health visits, be sure your documentation matches the visit frequency ordered by the physician.

RULE #3: KEEP IT LEGIBLE

RULE #4: MAKE IT ACCURATE

Documentation is accurate when it is true. Your documentation will be accurate if you:

- Use appropriate medical terms and abbreviations that have been approved by your workplace.
- Use correct spelling and proper English.
- Double check that you've written down the correct client name (and ID number, if required).
- Handle errors correctly. (See page 10.)
- Record only the facts...not your opinions about those facts. For example, if your client seems dizzy and confused, don't write what you guess to be true, like "Client acts like she's on drugs". Instead, stick to the facts, like "Client is unable to stand up without assistance and called me by her mother's name several times".
- Record what a client tells you by quoting his exact words. For example: If your client says, "I want my daughter to visit", don't put what he said in your own words such as "client misses his daughter". That's not really what he said!

RULE #5: FINISH ON TIME!

Documenting on time means writing information down as it happens and turning in your paperwork when it is due. Your documentation will be on time if you:

- Write information down immediately. For example, if you take a client's vital signs, document them right away. Don't wait until you finish your care and leave the room. The longer you wait, the more likely you are to forget some of the details.
- Be sure you make note of exact times on your documentation. Don't guess at the time or put a general time frame like "Day Shift".
- Note the time of your arrival and your departure from each client's home (if you make home health visits).
- Use the proper time format according to your workplace policy. For example, some health care organizations use a twelve hour clock, noting whether it's AM or PM. Others use a twenty-four hour clock—also called military time. Using military time, 6:00PM is written as 1800.
- Most home health aides are required to document their care on visit notes. If you care for clients in their homes, be sure to complete your visit notes at the time of each home visit. Don't wait until the end of the day to fill out visit notes on all your clients. Be sure to meet the deadlines for turning in your visit notes at the office. (Remember: completing visit notes on time helps you and your workplace get paid!)

Remember, the purpose of documentation is to communicate with other members of the health care team. (If you are the only person who can read your handwriting, your documentation won't communicate anything to anybody!)

- Use a black or blue ballpoint pen. (The ink from felt tip pens tends to "bleed".)
- Watch your handwriting . . . messy documentation could come back to haunt you in a lawsuit.
- Print with block letters. Cursive handwriting tends to be hard to read and should not be used in a medical chart. Flow sheets are often used as a quick way to document vital signs, weights and other tasks. If you use flow sheets, make sure they are legible. Here are a couple of tips:
- Fill out the flow sheet properly. For example, do you circle numbers or words on the flow sheet? Or, are you supposed to make marks like X's or checkmarks?
- Don't try to cram long narrative documentation onto a flow sheet.