

8.18.2 DOCUMENTATION

Policy: Title X clinics must establish a medical record for every client who obtains clinical services. Documentation must be made on the same day services are rendered and must document all services provided to clients. The medical record provides a permanent and continuous record of family planning services, outcomes, and appropriate referrals.

Procedure:

Guidelines for chart documentation:

1. Each page in the record contains the client's name, date of birth and/or chart number.
2. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier or initials. If using initials in a chart, there must be a signature page with the person's full signature.
3. All entries are dated.
4. Document all clinic services and procedures provided to the client to include telephone contacts.
5. Chart using blue or black ink.
6. Remember the first rule of charting. If it's not documented – it wasn't done.
7. Document pertinent current and past findings.
8. Documentation must be complete, legible and accurate.
9. Avoid altering medical records.
10. When correcting a one or two word error in a chart – a good rule to remember when making corrections on a medical chart is to use the mnemonic SLIDE:
 - a. SL - Single line through the mistake
 - b. I - Initial the entry as an error
 - c. D - Date the entry
 - d. E - Note "error" in the area
11. Correct paragraph errors by making a single line of black/blue ink through the paragraph in error, enclosing the paragraph in brackets, writing "error" beside the brackets, and noting the initials of the individual who made the error.
12. Avoid use of ditto marks.
13. Draw lines through blank spaces.
14. Charting must be easy to understand and specific.
15. Significant illnesses and medical conditions are indicated on the problem list. Past medical history is easily identified and includes items noted in the comprehensive health history.
16. Medication allergies and adverse reactions are prominently noted in the record. If the client has no known allergies or history of adverse reactions, this is appropriately noted in the record.
17. The history and physical examination identifies appropriate subjective and objective information pertinent to the client's presenting complaints.
18. Laboratory and other studies are ordered, as appropriate.
19. Working diagnoses are consistent with findings.
20. Treatment plans are consistent with diagnoses.
21. Encounter forms or notes have a notation, regarding follow-up care, calls, or visits when indicated.
22. The specific time of return is noted in weeks, months, or as needed.
23. Unresolved problems from previous visits are addressed in subsequent visits.
24. If a consultation is requested, there is a note from the consultant in the record.
25. Record and report follow-up of abnormal lab values, vital signs or physical exam findings.
26. Document physician orders carried out at the clinic.
27. Chart objectively. State facts, not conclusions.

28. Do not chart "education given." Charting must be specific and documented. "Education given per protocol," may be documented, if a detailed protocol exists. It is important to list specific pamphlets given to the client and the names of films viewed by the client during his/her education session. If a "client education/information packet" is used for every client, document this packet was given. The contents of the packet must be included in the local clinic's policy manual or protocols and updated as necessary.
29. Document action taken to protect or inform the client. Document a client's understanding of instructions given, his/her ability to repeat the instructions given and his/her ability to do a return demonstration. (This is very important when documenting a client's understanding of his/her method of choice).
30. Consultation, laboratory and imaging reports filed in the chart are initialed by the licensed provider in the practice to signify review.
31. Clinics using electronic health records will be trained on the correct use of the software and procedures to chart according to the guidelines above.
32. If the reports are presented electronically or by some other method, there is also representation of review by a practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
33. Do not deliberately chart inaccuracies or false statements.
34. The integrity of the medical record must be preserved.
35. Avoid ambiguous abbreviations. Avoid using abbreviations on the Joint Commission's Official "Do Not Use" list. (Go to http://www.jointcommission.org/facts_about_the_official/