MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

CHARTING RULES TO OBSERVE

Effective Date: January 31, 2019 **Policy**: HI-03

I. PURPOSE: To provide general rules for charting that will assist personnel in correctly transcribing information to the staff progress notes, nurses' notes, graphic sheets, and nursing activity flow sheets.

II. POLICY: The medical record is a written ***legal*** record of the patient's hospitalization from admission to discharge, is a permanent part of the hospital records, and should be accurate, complete, legible, concise, and neat.

The current medical record is hard copy, but as Montana State Hospital transitions from a paper medical record to an electronic health record (EHR) the media used to capture documentation will reflect the change. Policies and Procedures appropriate for an EHR environment will be instituted as new documentation (charting) processes are developed (e.g. electronic signature; amendments, corrections, and deletions in the EHR).

III. DEFINITIONS:

A. ***Authentication***: Proof of ownership by written signature.

IV. RESPONSIBILITIES:

A. All Clinical Staff documenting in patient record are required to follow charting rules.

V. PROCEDURE:

A. Charting Rules:

1. All documentation will be completed in black ink.

2. Capitalize, punctuate, and spell correctly.

3. Only standard accepted abbreviations may be used per MSH Policy HI-01, Abbreviations.

4. All entries must be neat, legible, dated, timed, and authenticated.

5. The person documenting must write their signature consisting of first name or initial, full last name, and title. When documenting during a specified time; i.e., one shift, one signature is sufficient.

6. The signature should follow last recorded sentence and should be placed on same line as last entry.

7. *Charting continued on a new page*: Bottom of page requires signature and "continued" or "cont." stated. The *next page* requires new heading including "continued" or "cont."

8. Record information in the proper column, on the correct form of the correct chart.

9. Use adequate space for wording: ***Do not leave any blank lines or columns***.

10. Never erase or obliterate an error. Errors are marked by crossing through words with one horizontal line, marked error, and initialed.

11. If pertinent documentation is missed or not entered in a timely manner a "Late Entry" should be used to record the information by entering the current date and time in the next available space and writing "Late entry for (date and time missed)." To add information to an existing entry, write the date and time of the new entry on the next available space and include: Addendum or Add. Sign the entry as usual.

12. If it is necessary to copy a page, the original should be retained with the copied sheet and marked with a large X across face. The copied sheet should be marked "recopied" across the top and properly signed and dated.

13. If quoting the patient, state exact words and place in quotation marks.

14. Ditto marks are not to be used in charting.

15. Record ***after*** an intervention has taken place, not before.

16. Keep record intact. Do not remove documents from the record for charting purposes.

B. Observations:

1. All pertinent subjective and objective information should be recorded accurately and as soon as possible.

2. The person caring for the patient is responsible for documenting their own observations and care/interventions provided.

3. Describe any response which is not customary for the patient.

4. Record positive as well as negative behaviors.

5. Use simple, descriptive terms which can be understood by all care givers.

6. Do not document another patients' behaviors in this patient's medical record (unless necessary to explain what the patient is responding to). Do not document another patient's name in this patient's medical records; use patient's medical record number as an identifier.

7. It is not necessary to quote profane or obscene words when documenting.

VI. REFERENCES: CMS Condition of Participation 482.24 C (l).

VII. COLLABORATED WITH: Director of Nursing, Rehabilitation Department Manager, Medical Director, and Director of Health Information.

VIII. RESCISSIONS: HI-03, *Charting Rules to Observe* dated May 6, 2015; HI-03, *Charting – Rules to Observe* dated November 9, 2009; HI-03, *Charting – Rules to Observe* dated October 30, 2006; HI-03, *Charting – Rules to Observe* dated September 1, 2002; HI-03, *Charting – Rules to Observe* dated February 14, 2000; HOPP 13-05C.R. 012479, *Charting – Rules to Observe*, May 1983.

IX. DISTRIBUTION: All hospital policy manuals.

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Director of Health Information.

XII. ATTACHMENTS: None.

Signatures:

Kyle Fouts
Interim Hospital Administrator

Thomas Gray, MD
Medical Director