Interim HealthCare of Pittsburgh, Inc. Documentation Policy

GENERAL PRINCIPLES

1. All documentation is **legal** and **confidential**.
2. Documentation must be **legible, clear, complete** and in **blue or black ink**.
3. Record the patient's first and last name on every chart form.
4. Place date and time on every new narrative entry in the date/time column.
5. Complete legible **signature and title** (i.e., RN, LPN, PT) at the end of every narrative note. Where it reads Print name, do Not sign your name. Print your name and discipline.
6. Errors are to have a single line drawn through the error, along with the discipline's initials and date. **Do not** white out or scratch out entries on the clinical record.
7. Document factual and specific information only.
8. Avoid documenting activity of family members except for patient interactions.
9. Do not skip lines of narrative form.
10. Addendums to documentation may be made if recorded as a "late entry".
11. Chart assessment, interventions and response to care provided and treatments (reason and response for PRN medication).
12. If patient or caregiver refuses treatment, document the reason and what effort was made to encourage acceptance of treatment.
13. Document using the nursing process: Assessment, Plan, Intervention and Evaluation. Accurate, pertinent documentation regarding the patient/client.
14. Document only the care that you delivered.
15. Time slips need to have accurate Time In and Time Out, legible name printed with signature and signed by the caregiver (mother, father, trained caregiver i.e., grandmother, brother).