Documentation Requirements PC.D25

Regulation(s):	None
L-Tag(s):	None

POLICY: Members of the interdisciplinary group document the interventions provided to the patient/family, their response to care, services provided, and the goals or outcomes achieved.

PROCEDURE:

1. Documentation is completed by all hospice staff and volunteers whenever:
    a. patient/family visits occur;
    b. patient/family phone conversations related to the patient's condition or care occur;
    c. community resource contact related to a patient/family is initiated;
    d. IDG members communicate changes to the hospice plan of care and/or
    e. physician or healthcare provider contact is made on behalf of the patient.

2. All written documentation is completed in black ink.

3. Written documentation must be legible. All documentation, written and electronic must be grammatically correct, accurate, and timely.

4. When an error is made in the clinical record, it may only be corrected by the individual who made the error. Errors are corrected by drawing a single thin line through the error, initialing and dating the error. Whiteout liquid or tape, erasure, or obliteration of the error by multiple cross-outs and/or write-overs is not allowed. When corrections are made on any forms that are signed by a patient/responsible person, they must also initial and date the corrections.

5. Only agency-approved abbreviations may be used. For a complete list of these abbreviations see PC.A10.1 Approved Abbreviations.

6. On paper documentation, the last name of the patient, followed by the complete first name, not just initial, is noted on every page of documentation. The use of nicknames is not allowed in clinical records.

7. The patient's clinical record number is noted on every page of documentation.

Created:	Reviewed:	Revised:	Effective:
6/18	2/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**

8. All documentation contains complete, factual, essential, and accurate information. Staff and volunteers clearly state what was seen (assessment), what was done (intervention) and how the patient/family reacted (outcome).

9. No spaces are left blank on paper documentation tools and forms. A single straight line is drawn through the space that does not apply or "N/A" is written in the space when not applicable.

10. Writing "late entry" with the date and time next to the actual documentation that is being added correctly identifies late entries. Electronic medical records cannot be unlocked or altered. If any entry into the electronic medical record is incorrect, then the record is amended with an updated note explaining the error.

11. All documentation is signed using complete first and last name, credentials and title.

12. The clinical record contains original documents with exceptions allowed for:
    a. facsimiles of physician orders;
    b. admission authorizations signed by the patient's representative if the original documents cannot be obtained; and
    c. copies of clinical records and other documentation from non-hospice providers.

Created:	Reviewed:	Revised:	Effective:
6/18	2/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**