ALLEGHENY VALLEY SCHOOL

Celebrating 50 Years of Caring
1960 - 2010

An NHS Company
HUMAN SERVICES

Documentation

The Key to Safe and Effective Services

Documentation for DSPs

Objectives:

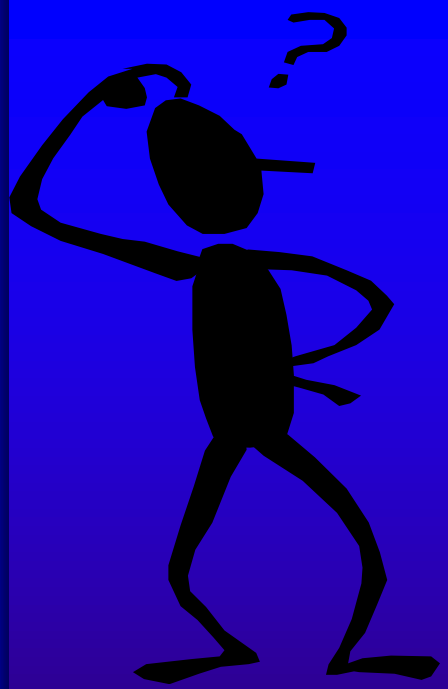
- To learn the proper way to document during your work day
- To understand the necessity and accountability associated with your documentation

Documentation

The process of providing written details or information about something- in this case, about the services that you provide

Purposes of Documentation

- Communication
- Accountability
- Quality improvement
- Legislative requirements
- Data Collection
- Funding
- Resource management

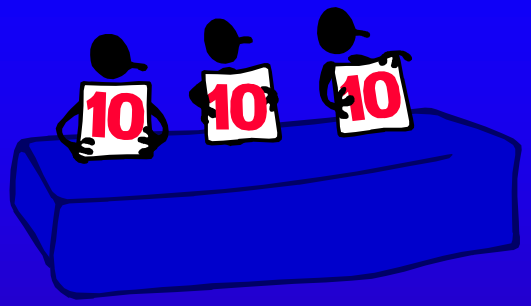


Knowing what to write, when to write it, why to write it, and how to write it is what makes the difference between a person who is poor at documentation and a person who is great at documentation.

Why is this important? Poor documentation can lead to poor care, services and legal risk, while concise and appropriate documentation promotes quality care, services and protection from legal action.

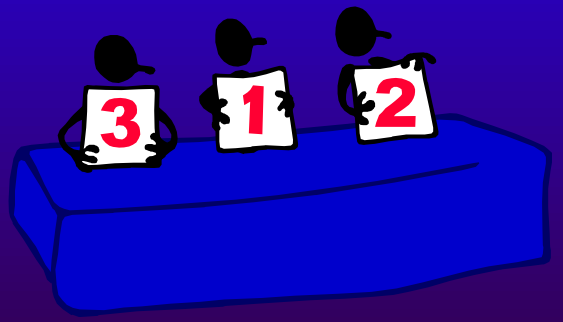
So what makes the difference between a chart

that is a



and a chart

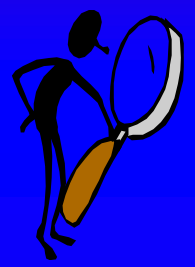
that is a



Good Records are ACCURATE

- **Content must be kept up to date and accurate at all times**
- **Documentation should be chronological and relevant – use "late notes" when necessary**
- **Incomplete records may lead to improper care and injury which may lead to legal action**
- **Take care when choosing descriptive words, using abbreviations, entering numbers, and recording events**
- **All forms or pages must include the person's name and a specific identifier such as date of birth (not SSN)**
- **Sign (name and position) and date all entries, including "continued" pages**

Good Records are COMPREHENSIVE



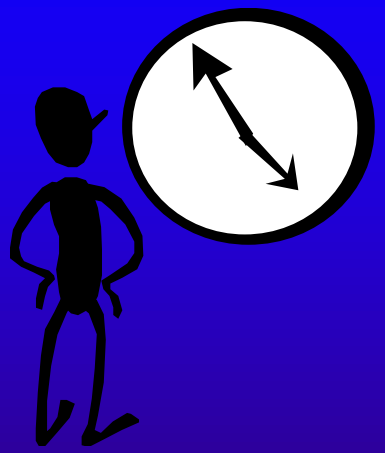
- **Contains complete details necessary to the care of the individual it represents**
- **Non-compliance with recommended therapies and treatments, such as a failure to keep appointments, must be documented**
- **Record both negative and positive responses, complaints, and events**
- **Fill in all the blanks – if you leave it blank legally it means you did not address the issue**
- **Document telephone conversations and messages**
- **Never file any record without reviewing it to be sure the content is complete and relavent**

Good Records Are OBJECTIVE

- **Records must be factual (objective) rather than subjective (reflecting opinions as opposed to facts)**
- **Avoid writing extra remarks and "editorializing" events – your words may come back to haunt you. Never write anything you would not feel comfortable "testifying" about.**
- **Only facts and clinical observations are appropriate to include in the chart – nonprofessional opinions endanger the credibility of the record. Do not record information you did not observe, hear or witness in some way**
- **Never name another service recipient in an individual's chart – use another identifier such as initials or record number**

Good Records are TIMELY

- **Record events as they occur or become known to you**
- **Delaying documentation risks confusion about the event you are recording and/or failure to note important facts and observations**
- **Proofread documents that are based on your dictated or handwritten reports and prepared on a computer or typewriter for accuracy**



Good Records Are LEGIBLE

- **Records must be clean, clear, legible and concise**
- **Permanent (non-erasable)**
- **You are writing for others as well as yourself**
- **Never scribble out an entry – if an error is made be sure to correct it appropriately**
- **Documentation should be made in black ink for copying purposes**

Good Records Are UNALTERED

- **NEVER alter any entry in the individual's record**
- **Make corrections, when needed, according to policy**
- **If you want to further explain a note after it is written or add information that was never written after the fact, do it as a *late note***
- **NEVER use White Out**

Review

Careful Documentation Includes:

- **legible writing in the specified color of ink**
- **correct grammar and spelling**
- **correct recording of time**
- **proper identifying information on each and every page**
- **allowing no blank spaces between entries and signatures**

Review

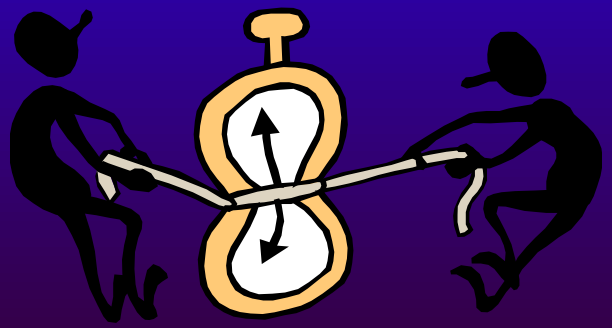
Careful Documentation Includes:

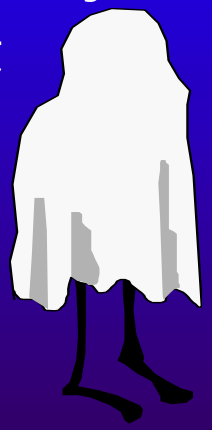
- **making sure that all areas of a form are addressed even if that means just putting a line through the area or marking it as “n/a” for not applicable**
- **charting promptly after provision of care or service**
- **avoiding the use of abbreviations wherever possible, and only choosing approved abbreviations when they are used**

Review

Careful Documentation Includes:

- **recording facts and not opinions**
- **if it is necessary to make a late entry identify it as such and don't try to hide it or squeeze it in**





Day in the Life

- Exercise to document a day in the life of a service recipient

Confidentiality

- People are protected by HIPAA and Confidentiality Policy
- Written release of information is necessary for any communication to occur
- Information can never be released over the phone or to other individuals' circle of support
- Information is only shared on a need to know basis
- Any request for copies or verbal information should be handled by the assigned supervisor- never respond or copy and hand information to anyone