Charting and Documentation

Policy Statement

All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

Policy Interpretation and Implementation

1. Documentation in the medical record may be electronic, manual or a combination.

2. The following information is to be documented in the resident medical record:
   a. Objective observations;
   b. Medications administered;
   c. Treatments or services performed;
   d. Changes in the resident's condition;
   e. Events, incidents or accidents involving the resident; and
   f. Progress toward or changes in the care plan goals and objectives.

3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

4. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy.

5. Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse or to the business office.

6. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records.

7. Documentation of procedures and treatments will include care-specific details, including:
   a. The date and time the procedure/treatment was provided;
   b. The name and title of the individual(s) who provided the care;
   c. The assessment data and/or any unusual findings obtained during the procedure/treatment;
   d. How the resident tolerated the procedure/treatment;
   e. Whether the resident refused the procedure/treatment;
   f. Notification of family, physician or other staff, if indicated; and
   g. The signature and title of the individual documenting.

References		
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