Policy: The Division will establish and maintain uniform documentation procedures in accordance with NRS 433.494.

Purpose: Establish basic documentation guidelines for the Division.

Procedures:

I. Entries in the consumer/medical record shall be:

A. Accurate - Document the facts as observed or reported, e.g., not limited to statement of general appearance including obvious bruising or injury.

B. Timely - Record significant information at the time of the event, as delays can result in inaccurate or incomplete information, e.g., not limited to all restraint and seclusion documentation including physician orders, routine staff observation, and the standard seclusion and restraint documentation packet. All documentation should be completed in a timely manner.

C. Objective - Record the facts and avoid conclusions. Professional opinion must be phrased within the scope of practice for that profession. Written description of any event or any unusual event that leads to the transfer to a hospital or other facility or prior level of care should all be documented.

D. Specific, concise and descriptive - The medical record is a clinical communication tool and record entries should be detailed (not generalized), brief and meaningful without sacrificing essential facts, and thoroughly describe observations and other pertinent information. Include specific patient quotes in medical record entries.

E. Consistent - Entries should not be contradictory.

F. Comprehensive - Record significant information relative to a consumer's condition and course of treatment. Documentation should reflect pertinent findings, services rendered, changes in the condition and the response to treatment. Information in the record should include all medication administration information both oral and intramuscular, including physician orders, justification for the initial medication administration, the first dose review and effectiveness, any changes of increasing or decreasing dosage, including all related services or treatment provided.

G. Legible - All entries should be neat and readable by other persons.

II. Consumer/medical record entries must include both the date and time of the entry and be authenticated by the individual making the entry. All evaluations/examinations must include the date and the time the service was rendered. When information is transcribed, the date dictated and date transcribed is included, along with the initials of the author and transcriptionist.

III. All entries will be made using the CWS electronic medical record.

IV. Remarks that are critical of treatment carried out by others, that may indicate bias against a consumer or that are unprofessional, should not appear in the consumer record.

V. Record entries should be in chronological sequence. Lines or spaces should not remain vacant between record entries on progress notes. A single line should be entered in the blank space. Do not line out vacant lines or physician order sheets.

VI. When corrections are necessary to correct recording errors or inaccuracies, the following procedures should be followed:

A. The recording individual must USE THE APPEND FUNCTION OF CWS TO ENTER THE CORRECT INFORMATION. IF INCORRECT INFORMATION IS INCLUDED IN A CWS ASSESSMENT, THE EDIT FUNCTION SHOULD BE USED TO CORRECT THE ERROR.

B. When information has been omitted, THE APPEND FUNCTION OF CWS WILL BE USED TO INSERT THE ADDED INFORMATION. Late entries should be labeled as such.

C. Late entries must be identified as a "late entry" with the actual date and time the entry was made. The date and time that the entry should have been made must also be documented.

VII. Entries in the consumer record should not personally identify another consumer. When reference must be made about other consumers, use initials, consumer record number or some other form of identification, such as "male peer," "roommate," "mother," etc.

VIII. Unusual occurrences, medication errors, or incidents should be recorded but not labeled as such in the medical record. They shall include a description of the event, remedial actions taken and the consumer's condition following the event. Opinions or conclusions relative to the event **should not be** included in the record entry. When a separate incident report is completed, this should not be referenced in the consumer record. Incident reports will not be filed in the medical record.

IX. When consumer abuse is observed or reported, facts relative to the abuse should be documented in the consumer record, including action taken by the staff. Staff opinions or conclusions **should not be** included in the record entry.

X. Use only facility-approved abbreviations when documenting in the consumer record. Banned abbreviations are never to be used.

XI. For each bill generated from a service provided, there must be a corresponding progress note completed by the clinician or service coordinator describing, in detail, the billable service.

XII. Each Division agency shall develop specific written procedures to implement the provision of this policy or shall incorporate this policy into the agency policy manual.

Administrator

Effective Date: 02/07/92
Date Revised: 7/7/00; 5/11/01; 9/26/01, 12/4/01, 10/13/06; 11/19/07