Golden Rules of Documentation

1. If you didn't write it down, then it didn't happen.
2. Date, time, and sign every entry.
3. Chart care as soon as possible after you give it.
4. Write legible every time.
5. Be accurate.
6. You must be objective.
7. If you notify the nurse or supervisor of something important, include it in your entry.
8. Never change what you have documented/charted.
9. Don't chart for someone else or let anyone else chart for you.

One of the most critical responsibilities of all health care professionals is producing proper documentation. Documentation is a clear and accurate method of keeping track of everything that happened during the shift and to communicate with other team members about the client, so they receive the best care.

Documentation has other important functions as well:

- It creates a permanent record of the patient's care.
- It serves as proof of care and services for billing the insurance companies.
- It can be use as evidence in a court of law.

What do CNAs document?

- Level of consciousness
- Measurements of vital signs
- Height and weight
- Intake and output
- Bowel elimination
- Appetite and food intake
- Skin color, condition, integrity
- Activities and care: ambulation, turning and positioning, bathing, etc.
- Patient's response to activities and care
- Changes in patient health

Important Rules of Documentation

- ***"If you didn't write it down it didn't happen."***
  This is one of the most important sayings in health care. Failing to chart care properly can have serious consequences. If not documented there is no proof that the care was given. Whatever we have done for the client has to be written on the daily care record/timesheet. This document is not only to record time but to also show what care was provided to the client. Therefore, if you do it, you chart it. No daily care record should be turned in without anything checked off/documented. It it's turned in like that, it means you did nothing for the client the time you were there.
- ***Date, time, and sign every entry***
  Be sure to put the dates under each day. For an example, for Thursday August 16, put 8/16 directly under Thursday's box.
- ***Chart as soon as possible after you have given care***
  For accuracy and to prevent omissions, care should be charted as soon as possible. Care should never be charted before it's given. In the event something happens and the care was not actually given after it was already charted, then it is fraud.
- ***Write legibly at all times***
  If your notes/documentation cannot be read, then it doesn't do any good.
- ***You absolutely must be objective***
  Do not record your opinion. Document what you observed, what the patient states, but never what you feel. For an example, if you walked in the room and see the patient on the floor, you should document that you walked in the room and saw the patient on the floor.
- ***Never change what you have charted***
  Once an entry is made, it must be permanent. The proper way to make corrections if an error was made is to draw a single line through it and write the correction beside it with your initials. The original documentation should be legible. NEVER erase, scribble over, black out, or use white out.
  The patient's medical chart is the place that legally binds the patient information. It shows we are doing what we are supposed to be doing. It's sometimes used as our communication for others that are caring for the same client. It documents the patient baseline so change can be noticed immediately.

Name:
Date:

Documentation Quiz

1. Name 3 golden rules of documentation.

2. What is one of the most critical responsibilities of healthcare professionals?

3. What is one purpose of documentation?

4. Name 2 things that CNA document.

5. How do we communicate that the client received care?

6. It is not important to write legibly. T or F

7. No entry is permanent. T or F

8. It is okay to document one's opinion. T or F

9. White out is always acceptable. T or F