Sullivan County Department of Public Health

Title: Documentation Guidelines **Number**: DP-06 **Page Number:** 1 of 2	Original Approval: 5/00 Reviewed/ revised: 10/02, 10/03, 11/05, 12/08, 8/16, 3/24

Statement/ Purpose:
To record pertinent and appropriate information in accordance with professional standards.

Authority:

Application:
All SCDPH Certified Home Health Agency Staff

Terminology:

Responsible Party:
Public Health Director

Cross-Reference:
Abbreviations, Patient complaints,

Procedure:
1. All visit documentation is completed on the day of the home visit.
2. Original physician orders are never altered.
3. Documentation should include correct grammar and spelling.
4. Only approved abbreviations are to be used.
5. All entries must include date and time.
6. Document all calls to Supervision, MD, family, etc.
7. Ensure that patient's name and date of birth are on all paper forms included in the record.
8. Document that name and title of staff member that a specific event or change of condition is reported to.
9. Complaints must be documented in the clinical record and also on the agency's Complaint Report (see policy re: Patient Complaints).
10. Never destroy or discard any part of the medical record.
11. Do not document in advance to save time.
12. Avoid charting any judgements or labeling people. Chart only the behaviors that are observed. Document exactly what is said; use quotes.
13. To correct mistaken entries in the paper chart, draw a single line through the entry so that it is still readable. Write the words "mistaken entry" or abbreviation, M.E. Date and initial these. DO NOT USE THE WORD "ERROR."
14. To correct electronic document errors and late entries, annotate the appropriate form and document the correction and mistaken entry. For late entries, label the entry "Late Entry" or abbreviate L.E., and record the

time and date it should have been made.

15. To process requests made by a patient or legal representative to correct/amend the medical record: All requests for correction/amendment made by patients/legal representatives will be forwarded to the Privacy Officer. The Privacy Officer will inform the requestor that the Agency's Request for Correction/Amendment of Health Information Form (attachment) must be completed. The form will be reviewed by the Privacy Officer, Director, and attending physician. Comments will be added as appropriate. The completed Request for Correction/Amendment of Health Information Form will become a part of the patient's permanent medical record.