

Oakridge Homes

Charting/Documentation Guidelines

1. Writing or printing is acceptable
2. Always use black ink pen; never use a pencil, a felt tip or erasable pen. The exception to this is in filling out Program Notes which uses red, blue, and black ink pen as codes (key on each program note).
3. Always write neatly and legibly.
4. Be sure the information is being recorded in the correct chart.
5. Use correct spelling.
6. Do not erase. Do not use White Out. Do not black something out. Place a line through the error, write “error” above the entry with the date and your initials. The original error should be readable.
7. Always chart as soon as possible. Do not leave blank spots for someone else to chart.
8. Always chart the time, date and year that the observation was made.
9. Close each entry with your signature and job classification. You need to use your full name or your first initial and your last name.
10. Never chart for someone else. The only exception to this is if you use the 3rd person approach (i.e. “according to ___” or “it has been reported by ___”)

11. Never leave blank spaces in the Program Records. Draw lines on empty space to prevent illegal entry. If you forget to chart something, go back later and label the charting “late entry”.
12. Consumer records are strictly confidential.
13. Avoid the use of professional jargon and personal opinions.
14. Use terminology that you understand. Avoid using phrases and words that you cannot be accountable for.
15. Do not use vulgar language unless it is a direct quote from the person. Then the language should be in quotation marks.
16. Each new page must be headed correctly with the consumer’s full name.
17. Never write in another consumer’s name in any records that go in a permanent file. (This goes for Program Records, Incident Reports, etc.)
18. When charting, document key facts only. Do not state your opinion or what you think may have happened. Opinions and assessment can go in the Staff Communication Log.
19. Progress Notes should contain documentation of outstanding events. Anything that pertains to the consumer’s psychological, physical, or social well-being must be recorded.

If it is not documented, it was not done!!

Chart:

1. Acute illness, with or without elevated temperature (i.e. vomiting, diarrhea, upper respiratory infection, etc.) Chart on all shifts until condition subsides.
2. Injuries and what was done.
3. Medication changes
4. Behavior changes – be on the lookout for a medical reason
5. Treatments, whether they are a nursing or doctor's order.
Document the effectiveness of the treatment.
6. Seizures
7. Leave and return for vacation or parent visit. Where a consumer went and with whom. Also remember to complete the LOA form before and after.
8. Doctor's visits – the reason, who they saw, where, any diagnosis made, prescriptions, or recommendations.
9. Any unusual event.
10. Anything interesting – good or bad.