

Documentation in the Medical Record

Just the facts.....just the facts

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The medical record....

- Serves as the legal record substantiating health care services provided to a client
- Provide supporting documentation for reimbursement of services provided
- Entries should be factual information for safe, effective continuity of client care

The cardinal rule.....



If you did not write it,
you did not do it

A client medical record...

- “Contains all information regarding the care and treatment of a client.”
- Does not contain
 - Notes related to policy, legal issues, personnel issues, procedural advise, opinions about the quality of care or adverse events

Procedural advise

- Established methods of conducting business, i.e. administrative rules and regulations

Adverse Event

- An incident in which the potential or actual harm/injury resulted to a person receiving health care

The TB record.....

- Is a case management record
- Is not a Document by Exception (DBE) record
- Following instructions and guidelines published by TB Control
- DBE forms should not be included in the TB record

Specific Procedures and Guidance

Specific Guidance

- Each page or sheet must contain the client's identification information
 - Double sided forms must have label on both sides
- All entries should be objective and factual
- All entries should be legible!



Specific Guidance

- Mark each entry with date.
 - Time may also be needed to establish chronology
 - Emergency events, resuscitation, CPR, times medications are given
- All entries made with indelible pens using blue or black ink
- Entries documenting allergies to medicines, food or latex should be in prominent place and written in indelible red ink

Specific Guidance

- Avoid making subjective, derogatory or discriminatory entries into a medical record
- Any subjective statements made by the client or family should be documented and placed in "quotation marks"

Specific Guidance

- A signature should include first name, last name and title
 - Jane Moore, RN, Director, TB Control
 - Olive Oyl, ORW
- Initials may be used on certain forms – flow sheets, DOT record
 - Must have signature sheet
 - Must complete signature lines of DOT sheet

Specific Guidance

- Do not leave blank spaces between entries.
- Draw diagonal lines through all blank spaces after an entry
- All dated entries should be in consecutive order

Specific Guidance - Changes

- Do not use corrective paper, white out, correction tape
- Strike errors with a single line and initialed. Do not write "error".
- A new entry that was missed should be entered as "late entry". Also enter the current date and time. The entry must be signed
- To add an addendum to a previous entry, state "addendum to note of [date]". The new entry must also include the date and time of the new entry with a full signature

Specific Guidance - Numbers

- No trailing zeros in whole numbers
 - 1.0 mg should be 1 mg – easy to confuse with 10 mg
- For numbers less than 1, use a zero before the decimal point
 - .5 mg should be 0.5 mg – easy to miss the decimal point
- Use a comma for numbers above 1,000

Specific Guidance - Interpreter

- First name, last name and title of interpreter must be included in the record
- If language line, use name of language line, interpreter's number and full name and title of staff using service
- If more than one staff person used an interpreter, each will have to sign his/her portion of the medical record entry requiring the use of the service.

Abbreviations

To Shorten or not to shorten
That is the question..

Approved Abbreviations and Symbols for Use in Medical Records

- Part of agency policy on documentation in the medical record
- If there is no abbreviation listed next to a word – there is no abbreviation...write it out!!!!
- Some well loved abbreviations are now listed as “Words for Which Substitutions are not Permissible”
- **WHEN IN DOUBT – WRITE IT OUT!**

Commonly Used in TB

Abbreviation	Word
B6	pyridoxine
DCLS	Division of Consolidated Laboratory Services (state lab)
DOB	date of birth
G or Gm	gram
HIV	Human immunodeficiency virus
IGRA	Interferon gamma release assay (QuantiFERON GOLD inTube or T Spot-TB)
mg	milligram
ml	milliliter
mm	millimeter

Commonly Used in TB

Abbreviation	Word
M.tb	Mycobacterium tuberculosis
MTD	Mycobacterium tuberculosis detection or mycobacterium tuberculosis direct test
N/A	not applicable
neg	negative
PPD	purified protein derivative
TB	tuberculosis
TST	tuberculin skin test
LTBI	latent tuberculosis infection
X	times
wk	week

A Change

- Twice weekly (two times a week)
 - OLD – unacceptable – BIW – do not use
 - NEW – acceptable – 2 X wk
- Three times a week
 - OLD – unacceptable - TIW – do not use
 - NEW – acceptable - 3 X wk



Words with No Acceptable Abbreviation

- Daily
- Discharge
- Discontinue
- Positive
- Every
- Every day/daily
- Without
- One-half



Medication Abbreviations

- For now are not addressed in the abbreviation list
- Continue to use standard medications abbreviations for TB medication as published in CDC guidelines
 - Isoniazid – INH
 - Ethambutol – EMB
 - Rifampin – RIF
 - Pyrizinamide – PZA
 - Rifabutin – no abbreviation
 - Rifapentine – no abbreviation



Handouts

- Documentation in the Medical Record
 - VDH Agency Policy
 - Effective Date 3/26/12
- Approved Abbreviations and Symbols
 - Revised May 2011
 - Incorporated as part of Documentation in the Medical Record

Read them - understand them - ask questions


