Harmony Healthcare International (HHI)

# Documentation Manual

**Facility Name**
Facility Address

DRAFT

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# Documentation Policy and Procedure
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Harmony Healthcare International (HHI)

# Policies

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# Charting and Documentation

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## Policy Statement

All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.



## Policy Interpretation and Implementation

1) Documentation in the medical record may be electronic, manual or a combination.

2) The following information is to be documented in the resident medical record:

    a) Objective observations;
    b) Medications administered;
    c) Treatments or services performed;
    d) Changes in the resident's condition;
    e) Events, incidents or accidents involving the resident; and
    f) Progress toward or changes in the care plan goals and objectives.

3) Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

4) Entries may only be recorded in the resident's clinical record by licensed personnel (e.g., RN, LPN/LVN, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nursing Assistants may only make entries in the resident's medical chart as permitted by facility policy.

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5) Information documented in the resident's clinical record is confidential and may only be released in accordance with state law, the Health Insurance Portability and Accountability Act (HIPAA) and facility policy. Refer all requests for information to the Director of Nursing Services, Nurse Supervisor/Charge Nurse or to the business office.

6) To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries in the resident's clinical records.



7) Documentation of procedures and treatments will include care-specific details, including:

   a) The date and time the procedure/treatment was provided;
   b) The name and title of the individual(s) who provided the care;
   c) The assessment data and/or any unusual findings obtained during the procedure/treatment;
   d) How the resident tolerated the procedure/treatment;
   e) Whether the resident refused the procedure/treatment and what education regarding the refusal was provided;
   f) Notification of family, physician or other staff, if indicated; and
   g) The signature and title of the individual documenting.

| Survey Tag Numbers | F583 – Personal Privacy/Confidentiality of Records<br>F842 – Resident Records – Identifiable Information<br>F636 – Comprehensive Assessments & Timing<br>F755 – Pharmacy Svcs/Procedures/Pharmacist/Records |
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# Charting Errors and/or Omissions

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## Policy Statement

Accurate medical records shall be maintained by this facility.

## Policy Interpretation and Implementation



1) If an error is made while recording the data in the medical record, line through the error with a single line and correct the error.

2) If it is necessary to change or add information in the resident's medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition.

3) Late entries in the medical record shall be dated at the time of entry and noted as a "late entry."

4) No erasures or deletions shall be made in the medical record. Correction fluid shall not be used in the correction of mistakes or errors in the medical record when making original entries.

5) All corrections, changes, or addenda must be signed and dated by the person making such entries.

| Survey Tag Numbers | F842 – Resident Records – Identifiable Information<br>F726 – Nursing Services |
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# Electronic Medical Records

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## Policy Statement

Electronic medical records may be used in lieu of paper records when approved by the Administrator.

## Policy Interpretation and Implementation



1) Electronic records are an acceptable form of medical record management.

2) The Administrator, in conjunction with the Quality Assessment and Assurance Committee, shall review requests for and the implementation of any electronic medical records system.

3) Only authorized persons who have been issued a password and user ID code will be permitted access to the electronic medical records system.

4) The facility will make reasonable efforts to limit the use or disclosure of protected health information to only the minimum necessary to accomplish the intended purpose of the use or disclosure.

5) The HIPAA Compliance Officer, Administrator and Director of Nursing Services maintain a listing of each user ID code. Such listing is confidential and secured.

6) When personnel changes occur, or there is reason to believe that unauthorized access to protected information has occurred, the HIPAA Compliance Officer, Administrator and Director of Nursing Services shall review the security of the information and change user ID codes if necessary.

7) Authorized Federal and State survey agents, etc., as outlined in current regulations, may be granted access to electronic medical records.

# Electronic Medical Records

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8) Our electronic medical records system has safeguards to prevent unauthorized access of electronic protected health information (e-PHI). These safeguards include administrative, technical and physical safeguards that are appropriate for:

   a) The probability and criticality of risks to e-PHI based on a thorough risk analysis conducted by this facility;
   b) The size, complexity and capabilities of this organization; and
   c) The technical infrastructure, hardware, software and security capabilities of this facility.



| Survey Tag Numbers | F842 – Resident Records – Identifiable Information |
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# Electronic Transmission of the MDS

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## Policy Statement

All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records will be completed and electronically encoded into our facility's MDS information system and transmitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current OBRA regulations governing the transmission of MDS data.



## Policy Interpretation and Implementation

1) All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the MDS RAI Instruction Manual, before being permitted to use the MDS information system. A copy of the MDS RAI Instruction Manual is maintained by the Resident Assessment Coordinator.

2) Staff members are trained on updates/revisions to the MDS Form and software upgrades as they are released. Such training is provided by the Staff Development Director and/or computer software vendor.

3) Only personnel authorized to complete portions of the MDS shall have access to the MDS information system. A current listing of employees who have access to the MDS information system shall be maintained. Only the Administrator, Director of Nursing Services and Resident Assessment Coordinator shall have access to this listing. Such listing shall contain each employee's access code and password. Access codes and passwords shall be changed at least twice yearly.

4) Employee access codes and passwords shall be provided by the Resident Assessment Coordinator. Access codes and passwords must be deleted within twenty-four hours of the employee's termination from employment or when the employee no longer has responsibility for completing portions of the MDS. The Resident Assessment Coordinator shall be responsible for providing the Administrator and Director of Nursing Services with a revised access listing.

# Electronic Transmission of the MDS

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5) MDS electronic submissions shall be conducted in accordance with current OBRA regulations governing the transmission of such data.

6) The MDS Coordinator is responsible for ensuring that appropriate edits are made prior to transmitting MDS data and that feedback and validation reports from each transmission are maintained for historical purposes and for tracking.

7) All MDS assessment data will be backed up daily.



| Survey Tag Numbers | F640 – Encoding/Transmitting Resident Assessment<br>F842 – Resident Records – Identifiable Information |
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# MDS Completion and Submission Timeframes

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## Policy Statement

Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.

## Policy Interpretation and Implementation



1) The Resident Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines.

2) Timeframes for completion and submission of assessments is based on the current requirements published in the *Resident Assessment Instrument Manual*.

3) Submission of MDS records to the QIES ASAP is electronic. A hard copy of each record submitted is maintained in the resident's clinical record for a period of fifteen (15) months from the date submitted.

| Survey Tag Numbers | F639 – Maintain 15 Months of Resident Assessments |
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# MDS Error Correction

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## Policy Statement

The Assessment Coordinator and/or the Interdisciplinary Assessment Team will follow the established processes for making corrections to the MDS.

## Policy Interpretation and Implementation



1) Once completed, edited, and accepted into the QIES ASAP system, MDS data may not be changed just because the resident's status has changed during the course of his or her stay at the facility.

    a) Minor changes in condition or status are documented in the resident's medical record and adjustments in care or services are made in accordance with standards of clinical practice.
    b) Major changes in the resident's status may prompt a Significant Change in Status Assessment, as described below.

2) Note that the QIES ASAP system has defined record rejection standards and data that is outside the reference range will not be accepted by the system (e.g., a 4 is entered when only 0-3 are allowable responses).

3) If an error in data is discovered within 7 days of the completion of the MDS and before submission to the QIES ASAP system (the "encoding and editing period"):

    a) The correction is made to the hard copy of the form using standard editing procedures (cross out, enter correct response, initial and date);
    b) Corresponding corrections are made to the facility's MDS database. (Note: Software used to encode the MDS runs all standard edits as defined in the CMS data specifications); and
    c) The resident's care plan is reviewed and modified as necessary.

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4) If an error is discovered after the encoding and editing period and the record in error is an Entry, Discharge or PPS Assessment, then correct the record and submit to the QIES ASAP system.

5) If an error is discovered after the encoding period and the record in error is an OBRA Assessment, determine if the error is *major* or *minor*.



   a) A *minor* error is one related to the coding of the MDS. For minor errors, correct the record and submit to the QIES ASAP system.
   b) A *major* error is one that inaccurately reflects the resident's clinical status and/or may result in an inappropriate plan of care. For major errors:
      i) Correct the original assessment to reflect the resident's status as of the original Assessment Reference Date and submit the record; AND
      ii) Perform a new Significant Change in Status (if this has occurred) OR a new Significant Correction to a Prior Assessment with a new observation period and Assessment Reference Date.

6) If an error is discovered in a record that has already been accepted by the QIES ASAP system, implement procedures for either Modification or Inactivation of the information in the system within 14 days of the discovery of the error.

7) Modification Requests are used when information in the record contains clinical or demographic errors. [Note: The only MDS items that cannot be altered with a Modification Request are: Type of Provider (A0200), Submission Requirement A0410); and the state-assigned facility submission ID (FAC_ID). These items require a Special Manual Record Correction Request.]

8) To modify errors in Entry, PPS or Discharge records that are not OBRA:

   a) Create a corrected record with all items included, not just the items in error;

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b) Complete the Correction Request Section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a Modification Request.); and
c) Submit the Modification Request record.

9) To modify errors in an OBRA Assessment when the errors are *minor*:



a) Create a corrected record with all items included, not just the items in error;
b) Complete the Correction Request Section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a Modification Request.); and
c) Submit the Modification Request record.

10) To modify errors in an OBRA Assessment when the errors are *major*:

a) Create a corrected record with all items included, not just the items in error;
b) Complete the Correction Request Section (X) items and include with the corrected record (Item X0100 should have a value of 2, indicating a Modification Request.);
c) Submit the Modification Request record; and
d) Perform a new Significant Change in Status Assessment (if this has occurred) OR a new Significant Correction of a Prior Assessment.

11) Inactivation Requests are used when a record has been accepted to the QIES ASAP system but the corresponding event did not occur (e.g., a discharge record was submitted for a resident but there was no discharge).

12) To submit an Inactivation request, complete and submit an MDS record with only Section X items completed.

13) For Manual Record Correction Request instructions, refer to the RAI User's Manual.

# MDS Error Correction

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| **Survey Tag Numbers** | F640 – Encoding/Transmitting Resident Assessment |

# Release of Information

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## Policy Statement

Our facility maintains the confidentiality of each resident's personal and protected health information.

## Policy Interpretation and Implementation



1) Each resident will receive confidential treatment of his or her personal and medical records and may approve or refuse their release to any individual outside the facility, except in case of a transfer to another healthcare institution or as required by current HIPAA law.

2) Medical records are the property of the facility.

3) All information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her legal representative (sponsor), consistent with state laws and regulations.

4) Release of resident information including video, audio, or electronically stored information will be based on the facility's concern for protecting resident rights.

5) Access to the resident's medical records will be limited to the staff and consultants providing services to the resident. (Note: Representatives of state and federal regulatory agencies have access to resident information without the resident's consent.)

6) Resident records, whether medical, financial, or social in nature, are safeguarded to protect the confidentiality of the information. Only those persons concerned with the fiscal affairs of the resident will have access to the resident's financial records as permitted by current HIPAA laws.

7) Closed or thinned medical records are maintained in the Medical Records Department and are available only to authorized personnel. Authorized personnel include, but are not necessarily limited to:

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a) Nursing Personnel;
b) Physicians;
c) Consultants;
d) Support Services (i.e., Dietary, Activities, Social, etc.);
e) Administration;
f) Government Agencies; and/or
g) Resident/Representative (Sponsor).



8) The resident may initiate a request to release such information contained in his/her records and charts to anyone he/she wishes. Such requests will be honored only upon the receipt of a written, signed, and dated request from the resident or representative (sponsor).

9) A resident may have access to his or her records within 24 hours (excluding weekends or holidays) of the resident's written or oral request.

10) A resident may obtain photocopies of his or her records by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request. A fee may be charged for copying services.

11) The facility may recommend that the resident or representative review the active chart in the presence of a knowledgeable staff person who can discuss the information and answer questions capably.

| | |
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| **Survey Tag Numbers** | F551 – Rights Exercised by Representative<br>F573 – Right to Access/Purchase Copies of Records<br>F583 – Privacy and Confidentiality<br>F842 – Resident Records – Identifiable Information |

Harmony Healthcare International (HHI)

# Guidelines

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# Abbreviations and Symbols

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The following list of abbreviations and symbols has been approved by our facility in ordering and charting medications. Abbreviations are acceptable in upper or lower case letters. Personnel authorized to document in medical records should use the following list of approved abbreviations and symbols.

## Symbols



| | |
|---|---|
| Δ | change |
| ↓ | decrease |
| ° | degree |
| ↑ | increase |
| # | number |
| 1° | primary |
| 2° | secondary |

## A

| | |
|---|---|
| A | assessment (POMR) |
| A&P | anterior and posterior; auscultation and percussion |
| A&W | alive and well |
| A/G | albumin to globulin ratio |
| A2 | aortic second sound |
| A2>P2 | aortic sound larger than second pulmonary sound |
| aa | of each |
| AAL | anterior axillary line |
| Ab | abortion |
| abd | abdomen |
| ABE | acute bacterial endocarditis |
| ABG | arterial blood gases |
| AHG | antihemophilic globulin |
| AI | aortic insufficiency |
| AIDS | acquired immunodeficiency syndrome |
| AJ | ankle jerk |
| AK | above knee (amputation) |
| ALD | alcoholic liver disease |
| ALL | acute lymphocytic leukemia |
| ALS | amyotrophic lateral sclerosis |
| AM | morning |
| AMA | against medical advice |
| amb | ambulate, ambulatory |
| AMI | acute myocardial infarction |
| amp | ampule |
| amt | amount |
| ANA | antinuclear antibodies |
| ANS | autonomic nervous system |
| AODM | adult-onset diabetes mellitus |
| AP | anteroposterior; apical pulse |
| approx or ~ | approximately; about |
| appt | appointment |
| AQ;aq | aqueous/water |

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|---|---|---|---|
| ABO | the main blood group system | ARC | AIDS=related complex |
| ac | before meals | ARDS | adult respiratory distress syndrome |
| ACTH | adrenocorticotropic hormone; Adrenocorticotropin | ARF | acute renal failure |
| ADA | American Diabetes Association | AROM | active range of motion |
| ADH | antidiuretic hormone | AS | aortic stenosis; anal sphincter; arteriosclerosis |
| ALD | alcoholic liver disease | | |
| ADL | activities of daily living | A.S.,A.D.,A.U. | left ear, right ear, both ears |
| ad lib | freely as desired; at pleasure | ASA | aspirin |
| adm | admitted or admission | ASAP | as soon as possible |
| ADR | Adverse Drug Reaction | ASCVD | arteriosclerotic cardiovascular disease |
| AF | acid-fast; atrial fibrillation | | |
| AFB | acid-fast bacteria; acid-fast bacilli | ASD | atrial septal defect |
| AGN | acute glomerular nephritis | ASHD | arteriosclerotic heart disease |
| AHF | antihemophilic factor | ASO | **antistreptolysin O titer** Arteriosclerosis obliterans |
| AHFS | American Hospital Formulary Service | ASPEN | American Society of Parenteral and Enteral Nutrition |
| ATC | around the clock | | |
| ATN | acute tubular necrosis | | |
| AV | arteriovenous; atrioventricular | A wave | atrial contraction waves |
| ax | axillary | | |



## B

| | | | |
|---|---|---|---|
| B&O | belladonna and opium | BE | barium enema; base excess |
| Ba | barium | BEE | basal energy expenditure |
| BAL | British anti-lewisite (dimercaprol) | BEI | butanol-extractable iodine |
| Bands | banded neutrophils | bid | two times a day |
| Baso | basophils | bili | bilirubin |
| BBB | bundle branch block; blood brain Barrier | BIW | twice a week |
| | | BJ | biceps jerk; bone and joint |
| BBT | basal body temperature | BK | below knee (amputation) |

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| | | | |
|---|---|---|---|
| BLB | a type of oxygen mask | C&P | cystoscopy and pyelography |
| BLOBS | bladder observation | C&S | culture and sensitivity |
| BM, bm | bowel movement, basal Metabolism | c/o | complains of |
| | | CA | cancer; carcinoma; carbonic anhydrase |
| BMR | basal metabolic rate | | |
| BP | blood pressure | Ca | calcium |
| BPH | benign prostatic hypertrophy | CAD | coronary artery disease |
| BR | bathroom | cal | calories |
| BRP | bathroom privileges | cap | capsule |
| BS, bs | blood sugar; bowel sounds breath sounds | CAT | computed axial tomography |
| | | cath | catheter; catheterize |
| BSA | body surface area | CBC | complete blood count |
| BSC | bedside commode | CBR | complete bed rest |
| BSI | body substance isolation | CC | chief complaint |
| BSO | bilateral salpingo-oophorectomy | CCR | creatinine clearance |
| BSP | bromsulphalein | CCU | coronary care unit; critical care unit |
| BT | breast tumor; brain tumor | | |
| BTL | bilateral tubal ligation | CDC | Centers for Disease Control |
| BTFS | breast tumor frozen section | CDH | Chronic Disease Hospital |
| BU | Bodansky unit | C diff | Clostridium difficile |
| BUN | blood urea nitrogen | CEA | carcinoembryonic antigen |
| BVL | bilateral was ligation | Ceph floc | cephalin flocculation |
| BW | body weight | CF | complement fixation |
| Bx | biopsy | CFT | complement-fixation test |
| | | cg | centigram |
| **C** | | CHD | childhood disease; Congenital heart disease; coronary heart disease |
| C | Centigrade; Celsius; calorie; gallon; carbon | CHF | congestive heart failure |
| c | with | CHO | carbohydrate |
| C 1,2,3,4,5,6,7 | cervical vertebra | cho | cholesterol |
| C&A | clinitest and acetest | CI | color index; contraindication |

# Abbreviations and Symbols

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| | | | |
|---|---|---|---|
| CLL | chronic lymphocytic leukemia | CVA | cerebrovascular accident; costovertebral angle |
| cl liq | clear liquid | | |
| Cm | centimeter | CVP | central venous pressure |
| cm3 | cubic centimeter | CX | cervix; cervical |
| CN | cranial nerve | CXR | chest x-ray |
| CNS | central nervous system | cyl | cylinder; cylindric lens |
| CO | carbon monoxide | cysto | cystoscopy |
| CO2 | carbon dioxide | | |
| COAG | chronic open angle glaucoma | **D** | |
| COAP | cyclophosphamide, oncovin ARA-C, prednisone compound | d | day |
| comp | compound | d/c | discontinue/discharge |
| cong | congenital | D&C | dilation and curettage |
| COP | cyclophosphamide, oncovin, prednisone | D51/2NS | 5% dextrose in half normal saline (0.45%NaCl) |
| COPD | chronic obstructive pulmonary Disease | D5LR | 5% dextrose in lactated ringer's solution |
| CP | cerebral palsy; cleft palate | D5NS | 5% dextrose in normal saline (0.9%NaCl) |
| CPAP | continuous positive airway pressure | D5W | 5% dextrose in water |
| CPK | creatinine phosphokinase | DAT | diet as tolerated |
| CPR | cardiopulmonary resuscitation | db, dB | decibels |
| CPT | chest physiotherapy | DD | differential diagnosis |
| CR | cardiorespiratory | DDD | degenerative disc disease |
| CRF | chronic renal failure | Decub | decubitus |
| CRP | C-reactive protein | DIC | disseminated intravascular coagulation |
| CS | coronary sclerosis | | |
| C sect | Cesarean section | diff | differential |
| CSF | cerebrospinal fluid | dil | dilute |
| CT | computed tomography; circulation time | DJD | degenerative joint disease |
| | | dl | deciliter |
| CV | cardiovascular | DNR | do not resuscitate |

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|---|---|---|---|
| DM | diabetes mellitus; diastolic murmur | EEG | electroencephalogram |
| DOA | dead on arrival | EENT | eye, ear, nose, and throat |
| DOB | date of birth | EFA | essential fatty acid |
| DOE | dyspnea on exertion | e.g. | for example |
| DP | dorsalis pedis (pulse) | EH | enlarged heart |
| DPT | diphtheria-pertussis-tetanus | elix | elixir |
| dr | dram | EM | electron microscope |
| DRGs | diagnosis related groups | EMG | electromyogram, electromyography |
| drsg or dsg | dressing | | |
| DSD | dry sterile dressing | ENG | electronystagmography |
| DT | delirium tremens | ENT | ear, nose, throat |
| DTR | deep tendon reflex | EOM | extraocular movements |
| DUB | dysfunctional uterine bleeding | Eos | eosinophil |
| Dx | diagnosis | epith | epithelial |
| | | EPS | extrapyramidal symptoms |
| **E** | | equiv | equivalent |
| | | ER | emergency room |
| E | **enema** | ERCP | endoscopic retrograde choledochopancreatogram |
| EBL | estimated blood loss | | |
| EBV | Epstein-Barr virus | ERG | electroretinogram |
| EC | enteric coated | ESR | erythrocyte sedimentation rate |
| ECCE | extracapsular cataract extraction | | |
| ECF | extracellular fluid; extended care Facility | ESRD | end stage renal disease |
| | | EST | electroshock therapy |
| ECG, EKG | electrocardiogram | et | and |
| ECHO | echocardiography | ETOH | alcohol |
| ECT | electroconvulsive therapy | EUA | examine under anesthesia |
| ECW | extracellular water | eval | evaluation |
| EDC | estimated date of confinement (obstetrics) | exam | examination |
| | | ext | extract |
| EDD | estimated date of delivery (obstetrics) | Ext Rot | external rotation |

# Abbreviations and Symbols

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## F

| | |
|---|---|
| F | Fahrenheit; fair; female |
| F/U | follow-up |
| FANA | florescent antinuclear antibody Test |
| FB | finger breadths; foreign body |
| FBS | fasting blood sugar |
| FDA | Food and Drug Administration |
| Fe | iron |
| FeSO4 | ferrous sulfate |
| FEV | forced expiratory volume |
| FEV1 | forced expiratory volume in one Second |
| FF | filtration fraction |
| FFA | free fatty acids |
| FH | family history |
| FHR | fetal heart rate |
| fl, fld | fluid |
| fl dr | fluid dram |
| fl oz | fluid ounce |
| FP | family practice; family planning |
| FRC | functional residual capacity |
| Freq | frequency |
| FROM | full range of motion |
| FSH | follicle-stimulating hormone |
| ft | feet; foot |
| FT | facilitation techniques |
| FTA | fluorescent treponemal antibody |
| FTT | failure to thrive |
| FUO | fever of undetermined/unknown origin |
| FVD | fluid volume deficit |
| FWB | full weight bearing |
| Fx | fracture; fraction |

## G

| | |
|---|---|
| G | gravida; good |
| G/C | gerichair |
| G/T | gastrostomy tube |
| G-P- | gravida-; para- (e.g. G-2, P-1) |
| G6PD | glucose-6-phosphate dehydrogenase |
| GA | gastric analysis; general appearance |
| Gal | gallons |
| GB | gallbladder |
| Gc, GC | gonococcus; gonorrhea |
| GE | gastroesophageal |
| GERD | gastroesophageal reflux disease |
| GFR | glomerular filtration rate |
| GI | gastrointestinal |
| Gm, gm | gram |
| GP | general practitioner |
| gr | grain |
| grav I, II, III, etc. | pregnancy one, two, three, etc |
| GTT | glucose tolerance test |
| gtt | drop |
| Gt. Tr. | Gait training |
| GU | genitourinary |
| GYN, Gyn | gynecology; gynecological |

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## H

| | |
|---|---|
| H | hypodermic; heroin |
| H, hr | hour |
| H+ | hydrogen ion |
| H&H | hematocrit and hemoglobin |
| H&P | history and physical examination |
| h/o | history of |
| H2O | water |
| H2O2 | hydrogen peroxide |
| HA | headache |
| HAA | hepatitis-associated antigen |
| HAV | hepatitis A virus |
| HBAg | hepatitis B antigen |
| HBP | high blood pressure |
| HBV | hepatitis B virus |
| HCFA | Health Care Financing Administration |
| HCG | human chorionic gonadotropin |
| HCl | hydrochloric acid |
| Hct | hematocrit |
| HCTZ | hydrochlorothiazide |
| HCVD | hypertensive cardiovascular Disease |
| HDL | high-density lipoprotein |
| HEENT | head, eyes, ears, nose, throat |
| Hg | mercury |
| Hgb | hemoglobin |
| HHA | home health aide |
| HHD | hypertensive heart disease |
| HIV | human immunodeficiency virus |
| HLA | human lymphocyte antigen |
| HO | house officer |
| HOB | head of bed |
| HOH | hard of hearing |
| HOPI | history of present illness |
| HP | hot packs |
| HPF | high power field |
| HPI | history of present illness |
| hs | bedtime |
| HSA | human serum albumin |
| HSV | herpes simplex virus |
| HSV2 | herpes simplex virus, type 2 |
| ht | height |
| HTN | hypertension |
| HTVD | hypertensive vascular disease |
| HVZ | herpes varicella zoster |
| Hx | history |

## I

| | |
|---|---|
| I&D | incision and drainage |
| I&O | intake and output |
| IASD | **interatrial** septal defect |
| IBC | iron-binding capacity |
| IBI | intermittent bladder irrigation |
| IBS | irritable bowel syndrome |
| IBW | ideal body weight |
| IC | inspiratory capacity |
| ICCE | intracapsular cataract extraction |
| ICM | intracostal margin |

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| | | | |
|---|---|---|---|
| ICF | intermediate care facility; Intracellular fluid volume | IUD | intrauterine device |
| | | IV | intravenous |
| ICP | intracranial pressure | IVC | intravenous cholangiogram |
| ICS | intercostal space | IVP | intravenous pyelogram |
| ICU | intensive care unit | IVPB | intravenous piggyback |
| ICW | intracellular water | IVSD | intraventricular septal defect |
| ID | initial dose; intradermal | IVU | intravenous urogram |
| IDDM | insulin-dependent diabetes mellitus | | |
| IDR | interdisciplinary review | **J** | |
| IDU | idoxuridine | | |
| IE | immunoelectrophoresis | TJC | The Joint Commission on Accreditation of Healthcare Organizations |
| Ig | immunoglobin | | |
| IgA, etc. | immunoglobulin A, etc. | | |
| IHSS | idiopathic hypertrophic sub-aortic Stenosis | J.M. | joint mobilization |
| | | JRA | juvenile rheumatoid arthritis |
| IM | intramuscular | J. tube | jejunostomy tube |
| Imp | impression | JVD | jugular vein distention |
| IMV | intermittent mandatory ventilation | JVP | jugular venous pressure |
| in | inch | | |
| Incont | incontinent | **K** | |
| inf | infusion | | |
| inhal | inhalation | K | potassium |
| inj | injection | KC | kilo calorie |
| instill | instillation | KCL | potassium chloride |
| int | internal | kg | kilogram |
| Int Rot | internal rotation | KJ | knee jerk |
| IOL | intraocular lens | Km | kilometer |
| IOP | intraocular pressure | KO | keep open |
| IP | intraperitoneal | KP | keratic precipitates |
| IPPB | intermittent positive pressure Breathing | 17-KS | 17-Ketosteroids |
| | | KUB | kidneys, ureters, and bladder (radiograph) |
| IQ | intelligence quotient | | |
| ISW | interstitial water | KVO or TKO | keep vein open or to keep open |
| Ith | intrathecal | | |

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## L

| | |
|---|---|
| L, l | liter |
| L, L, lt | left |
| L1, 2, 3, 4, 5 | lumbar vertebra 1-5 |
| L&A | light and accommodation |
| L&W | living and well |
| LA | left atrium |
| lab | laboratory |
| lac | laceration |
| lap | laparotomy |
| lat | lateral |
| LATS | long-acting thyroid stimulator |
| Lb | pound |
| LBBB | left bundle branch block |
| LCM | left costal margin |
| LD | longitudinal diameter (of heart) |
| LDH | lactic dehydrogenase |
| LDL | low density lipoproteins |
| LE | lower extremities; lupus Erythematosus |
| LFT | liver function test |
| LGV | lymphogranuloma venereum |
| LH | left hyperphoria |
| LHF | left heart failure |
| LHT | left hypertropia |
| Liq | liquid; fluid |
| LKS | liver, kidneys, and spleen |
| LLB | long leg brace |
| LLE | lower left extremity |
| LLL | lower left lobe (lung) |
| LLQ | lower left quadrant (abdomen) |
| LMCA | left middle cerebral artery |
| LMD | local medical doctor |
| LML | left middle lobe (lung) |
| LMP | last menstrual period |
| LNMP | last normal menstrual period |
| LOA | leave of absence; left occipital anterior |
| LOC | level of consciousness; loss of consciousness |
| LOM | limitation of movement |
| LOP | left occipital posterior |
| LP | lumbar puncture |
| lpf | low power field |
| LR | lactated ringer's solution |
| LS | lumbosacral; lumbar spine |
| LSB | left sternal border |
| LTG | long-term goal |
| LUE | left upper extremity |
| LUL | left upper lobe (lung) |
| LUQ | left upper quadrant (abdomen) |
| LV | left ventricle |
| LVH | left ventricular hypertrophy |
| LWCT | Lee-White clotting time |
| lymph | lymphocytes |
| lytes | electrolytes (Na, K, Ca, Cl, Mg, HCO3, PO4) |

## M

| | |
|---|---|
| M | male |

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| | | | |
|---|---|---|---|
| m | meter; murmur | ML | midline |
| M1 | first mitral sound | ml | milliliter |
| m2 | square meters of body surface | mM | millimole |
| MA | mat activities | mm | millimeter |
| MAL | midaxillary line | mm3 | cubic millimeter |
| MAP | mean atrial pressure | mm Hg | millimeters of mercury |
| MAR | medication administration record | MMT | manual muscle test |
| MAT | multifocal atrial tachycardia | MN | midnight |
| max | maximum | mod | moderate |
| MCA | middle cerebral artery | MOM | milk of magnesia |
| MCH | mean corpuscular hemoglobin | MR/MI | mental retardation/ mental illness |
| MCHC | mean corpuscular hemoglobin Concentration | MRI | magnetic resonance imaging |
| MCL | midclavicular line | MRSA | Methicillin Resistant Staphylococcus Aureus |
| MCP | metacarpophalangeal joint | MSD | musculoskeletal disorder |
| MCV | mean cell volume; mean corpuscular volume | MSL | midsternal line |
| MDS | Minimum Data Set | MSQ | mental status quotient |
| MED | minimum effective dose | M.T. | mobility training |
| Meds | medications | MVA | motor vehicle accident |
| mEq | milliequivalent | MW | molecular weight |
| MF | myocardial fibrosis | | |
| MG | myasthenia gravis | **N** | |
| Mg | milligram; magnesium | | |
| MGF | maternal grandfather | N | nitrogen; normal |
| MGM | maternal grandmother | N&T | nose and throat |
| MH | marital history; menstrual history | N&V, N/V | nausea and vomiting |
| MI | myocardial infarction | N/C | no complaints |
| MIC | minimum inhibitory concentration | NA, N/A | no answer; not applicable |
| MICU | medical intensive care unit | Na | sodium |
| min | minutes | NAD | no acute distress |
| MJT | Mead Johnson tube | Neg | negative |

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| | | | |
|---|---|---|---|
| NF | nursing facility | O | objective data (POMR) |
| NG, NGT | nasogastric and nasogastric tube | O&P | ova and parasites |
| NICU | neonatal intensive care unit | O2 | oxygen |
| NIDDM | non-insulin dependent diabetes Mellitus | OA | osteoarthritis |
| | | OB | obstetrics; occult blood |
| NIH | National Institutes of Health | OB/GYN | obstetrics and gynecology |
| NKA | no known allergies | OBRA | Omnibus Budget Reconciliation Act |
| NKDA | no known drug allergies | | |
| NM | neuromuscular | OBS | organic brain syndrome |
| nm | nanometer | OBT | obtained |
| NMR | nuclear magnetic resonance | OC | oral contraceptive |
| NNO | no new orders | OD | right eye (oculus dexter); optical density; overdose |
| no. | number | | |
| noc | night | OL | left eye (oculus laevus) |
| NPN | nonprotein nitrogen | OM | otitis media |
| NPO | nothing by mouth | OOB | out of bed |
| NR | no refill | OOBBRP | out of bed with bathroom privileges |
| NS | normal saline (0.9% sodium chloride solution) | | |
| | | OOP | out on pass |
| NSFTD | normal spontaneous full-term Delivery | OR | operating room |
| | | ORIF | open reduction and internal fixation |
| Nsg | nursing | | |
| NSR | normal sinus rhythm | OS | left eye (oculus sinister) |
| NSS | normal saline solution | os | mouth |
| Nt | nasogastric tube | OSHA | Occupational Safety and Health Administration |
| NTG | nitroglycerin | | |
| NVD | nausea, vomiting, diarrhea; neck vein distention | OT | occupational therapy |
| | | OTC | over-the-counter |
| NWB | non-weight bearing | OU | both eyes (oculi uterque) |
| NYD | not yet diagnosed | oz | ounce |



## O

## P

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| | | | |
|---|---|---|---|
| P | pulse; plain (POMR) | PE | physical exam; pulmonary embolism |
| P | after | PEEP | positive end expiratory pressure |
| P&A | palpitation and auscultation; Percussion and auscultation | PEFR | peak expiratory flow rate |
| P&R | pulse and respiration | PEG | pneumoencephalography |
| P/D | protective device | per | through, by way of |
| P/M | perceptual-motor | PERRLA | pupils equal, round, react to light, and accommodation |
| PA | posterior/anterior | PET | positron emission tomography |
| PAC | premature atrial contraction | PG | prostaglandin |
| PaCO2 | partial pressure of carbon dioxide (arterial blood) | PGF | paternal grandfather |
| Pap smear | Papanicolaou smear | PGM | paternal grandmother |
| PaO2 | partial pressure of oxygen (arterial blood) | pH | hydrogen ion concentration (acidity and alkalinity) |
| Para I,II, (etc) | unipara, bipara, etc. (pregnancy one, two, etc.) | PH | past history |
| PAT | paroxysmal atrial tachycardia | PI | present illness |
| path | pathology | PICC | peripherally inserted central catheter |
| PBI | protein-bound iodine | PID | pelvic inflammatory disease |
| pc | after meals | PIE | pulmonary infiltration with eosinophilia; acronym for "Problem, Intervention, and Evaluation" |
| PCA | patient-controlled analgesia | PIP | proximal interphalangeal joint |
| PCG | phonocardiogram | PKU | phenylketonuria |
| PCN | penicillin | PM | postmortem |
| PCO2 | partial pressure of carbon dioxide | pm | afternoon |
| PCP | pulmonary capillary wedge Pressure | PMH | past medical history |
| PCV | packed cell volume (hematocrit) | PMI | point of maximal impulse |
| PCWP | pulmonary capillary wedge Pressure | | |
| PD | interpupillary distance; postural Drainage; peritoneal dialysis | | |
| PDR | Physician's Desk Reference | | |

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| | | | |
|---|---|---|---|
| PMN | polymorphonuclear neutrophil | PUD | peptic ulcer disease |
| PMR | polymyalgia rheumatica | pulm | pulmonary |
| PMS | premenstrual syndrome | PUO | pyrexia of unknown origin |
| PMT | premenstrual tension | pv | per vagina |
| PND | paroxysmal nocturnal dyspnea; postnasal drip | PVC | premature ventricular contraction |
| PNX | pneumothorax | PVD | peripheral vascular disease |
| PO, po | per mouth, orally | PWB | partial weight bearing |
| PO2 | partial pressure of oxygen | PZI | protamine zinc insulin |
| POMR | problem-oriented record | | |
| pos | positive | **Q** | |
| postop | postoperative; after surgery | | |
| PP | postpartum; postprandial | q | every |
| PPD | purified protein derivative | q2h,q3h,(etc.) | every 2, 3 hours, etc. |
| PPF | plasma protein fraction | qam | every morning |
| PPL | penicilloyl-polylysine conjugate | qh | every hour |
| PPN | peripheral parenteral nutrition | qhs | every night at bedtime |
| ppm | parts per million | qid | four times a day |
| PR | per rectum | qn | every night |
| PRBC | packed red blood cells | qns | quantity not sufficient |
| PRE | progressive resistance exercise | qs | quantity sufficient |
| preop | preoperative; before surgery | qt | quart |
| PRN, prn | when **required,** as often as necessary | quant | quantity |
| PROCTO | proctoscopic; proctology | | |
| PROM | passive range of motion | **R** | |
| psych | psychiatry | | |
| PT | physical therapy/prothrombin time | **R; resp** | respirations; respiratory |
| pt | patient; pint | R&M | routine and microscopic (urinalysis) |
| PTA | prior to admission | | |
| PTB | patellar tendon bearing | RAD | radiation absorbed dose |
| PTT | partial thromboplastin time | RBBB | right bundle branch block |
| PU | pressure ulcer | RBF | renal blood flow |

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| | | | |
|---|---|---|---|
| RAI | radioactive iodine uptake/ Resident Assessment Instrument | RSB | right sternal border |
| | | RSR | regular sinus rhythm |
| RBC | red blood cell; red blood count | RSV | Rous sarcoma virus |
| RCM | right costal margin | rt; R | right |
| RD | right deltoid muscle | RTA | renal tubular acidosis |
| RDA | recommended daily allowance | RTN | renal tubular necrosis |
| RDS | respiratory distress syndrome | RUE | right upper extremity |
| rec | recreation | RUL | right upper lobe (lung) |
| rehab | rehabilitation | RUQ | right upper quadrant (abdomen) |
| REM | rapid eye movement | | |
| req | requisition | RV | right ventricle |
| RF | rheumatoid factor | RVH | right ventricular hypertrophy |
| Rh+ | positive Rhesus factor in blood | Rx | prescription; take; treatment |
| Rh- | negative Rhesus factor in blood | | |
| RHD | renal hypertensive disease; Rheumatic heart disease | **S** | |
| RISA | radioactive iodine serum albumin | S | subjective data (POMR) |
| RLE | right lower extremity | s | without |
| RLL | right lower lobe (lung) | S/A | sugar and acetone |
| RLQ | right lower quadrant (abdomen) | S/O, S.O. | standing order |
| RMCA | right middle cerebral artery | S/P | status post |
| RML | right middle lobe (lung) | S1 | first heart sound |
| RNA | ribonucleic acid | S2 | second heart sound |
| RO, R/O | rule out | SA | sinoatrial |
| ROM | range of motion | SB | sternal border |
| ROS | review of systems; review of symptoms | SBE | subacute bacterial endocarditis |
| RPF | renal plasma flow; relaxed pelvic Floor | SC, SQ | subcutaneous |
| | | SCM | sternocleidomastoid |
| RQ | respiratory quotient | SDAT | senile dementia Alzheimer's type |
| RR | recovery room; respiratory rate | | |
| RS | Reiter's syndrome | Segs | segmented neutrophils |

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| | | | |
|---|---|---|---|
| Sed rate; SR | sedimentation rate (erythrocyte) | SSS | sick sinus syndrome; specific soluble substance; short stay surgery |
| SEM | systolic ejection murmur | | |
| SGOT | serum glutamic oxaloacetic transaminase | ST | speech therapy |
| SGPT | serum glutamic pyruvic transaminase | staph. | staphylococcus |
| | | stat | immediately; at once |
| SH | social history; serum hepatitis | STD | sexually transmitted disease; |
| sib | sibling | | skin test dose |
| SICU | surgical intensive care unit | strep. | streptococcus |
| SIDS | sudden infant death syndrome | STS | serologic test for syphilis |
| sig | to write on label | supp | suppository |
| SL | sublingual | surg | surgery |
| SLB | short leg brace | susp | suspension |
| SLDH | serum lactic dehydrogenase | SV | stroke volume |
| SLE | systemic lupus erythematosus | SVC | superior vena cava |
| SM | sensory motor | SVT | supraventricular tachycardia |
| SMA | serial multiple analysis; simultaneous multiple analysis | Sx | symptoms |
| | | syr | syrup |
| SMIG | sensory motor integration group | Sz | seizure |
| SNF | skilled nursing facility | | |
| SOAP | subjective, objective, assessment and plan | T | |
| SOB | shortness of breath | T | temperature |
| sol | solution, dissolved | T&A | tonsillectomy and adenoidectomy |
| sos | if it is needed | | |
| spec | specimen | T&C, T&CM | type and crossmatch |
| sp gr, SG | specific gravity | T1 | first thoracic vertebra |
| ss | one-half | T3 | triiodothyronine |
| SSE | saline solution enema; Soapsuds enema | T4 | tetraiodothyronine; thyroxin |
| | | T-7 | free throxine factor |
| SSKI | saturated solution potassium iodide | TAB | typhoid and paratyoid A and B |
| SSPE | subacute sclerosing panencephalitis | | |

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| | | | |
|---|---|---|---|
| tab | a medicated tablet | TP | total protein; thrombophlebitis |
| TAH | total abdominal hysterectomy | TPI | Treponema pallidum immobilization |
| TAO | thromboangitis obliterans | TPN | total parenteral nutrition |
| TAP, T/P | turn and position | TPR | temperature, pulse, respirations |
| TAT | tetanus antitoxine; thermatic apperception test | TRA | to run at |
| TB | tuberculosis | TRIG | triglycerides |
| TBG | thyroxin-binding globulin | T-set | tracheotomy set |
| tbsp | tablespoon | TSF | triceps skin fold |
| TBW | total body water | TSH | thyroid stimulating hormone |
| TD | transverse diameter (of heart) | tsp | teaspoon |
| TEDS | elastic stockings | TST | triple sugar iron test |
| TENS | transcutaneous electrical nerve stimulation | TT | treatment team |
| TF | tube feeding | TUR | transurethral resection |
| TG | triglyceride | TURP | transurethral resection of the prostate |
| TIA | transient ischemic attack | TV | Trichomonas vaginalis; tidal volume |
| TIBC | total iron building capacity | Tx | treatment |
| tid | three times a day | | |
| tinct, tr | tincture | | |
| TIW | three times a week | | |
| TKO | to keep open | | |
| TL | team leader | | |
| TLC | total lung capacity; thin layer chromatography; tender loving care (informal); total lymphocyte count | **U** | |
| | | U&C | urethral and cervical |
| | | UA; U/A | urinalysis |
| TM | tympanic membrane | UCHD | unusual childhood diseases |
| T max | maximum temperature | UE | upper extremities |
| TMJ | temporomandibular joint | UGI | upper gastrointestinal (series) |
| TNS | transcutaneous nerve stimulation | | |
| T.O.; T/O | telephone order | ung | ointment |

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| | | | |
|---|---|---|---|
| UIBC | unsaturated iron-binding capacity | VSD | ventricular septal defect |
| URC | utilization review coordinator | VT; Vtach | ventricular tachycardia |
| URI | upper respiratory infection | | |
| US | ultrasound | **W** | |
| USP | United States Pharmacopeia | | |
| UTI | urinary tract infection | W | white; widow |
| | | W/A | while awake |
| **V** | | W/C | wheelchair |
| | | W/U | work-up |
| V | vein | W/V | weight/volume |
| V&T | volume and tension | WBC | white blood cell' white blood count |
| VA | visual acuity | | |
| VAD | vascular access device | WDWNWF | well-developed, well-nourished, white male |
| Vag hyst | vaginal hysterectomy | | |
| VA, VAH | Veterans' Administration Hospital | WFL | within functional limits |
| VC | vena cava; vital capacity | WN | well nourished |
| VCU | voiding cystourethrogram | WNL | within normal limits |
| VD | venereal disease | WP | whirlpool |
| VDA | visual discriminatory acuity | WR | Wasserman reaction |
| VDRL | Venereal Disease Research Laboratory | wt | weight |
| VF; Vfib | ventricular fibrillation | **X** | |
| vit | vitamin | | |
| VLDL | very low-density lipoprotein | x | times |
| VMA | vanillylmandelic acid | XR | x-ray |
| VNA | visiting nurse association | | |
| V.O.; V/O | verbal order | **Y** | |
| VP | venous pressure | | |
| VPC | ventricular premature contraction | y/o; y.o. | year old |
| VRE | Vancomycin Resistant Enterococci | yd | yard(s) |
| VS | vital signs (TPR, BP) | | |

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## Titles of Disciplines

| | | | |
|---|---|---|---|
| ACSW | Academy of Certified Social Workers | NA | nursing assistant |
| ART | accredited record technician | NC | nurse clinician |
| BSN | baccalaureate in science of nursing | NP | nurse practitioner |
| BSW | baccalaureate in social work | OTR/L | registered and licensed occupational therapist |
| CAN | certified nursing assistant | OTS | occupational therapy student |
| COTA | certified occupational therapy assistant | PA | physician's assistant |
| COTA/L | certified and licensed occupational therapy assistant | PD | doctor of pharmacy |
| | | PTA | physical therapy student |
| DDS | doctor of dental surgery | RD | registered dietician |
| DMD | doctor of dental medicine | RN | registered nurse |
| DPM | doctor of podiatry medicine | RNC | registered nurse; certified |
| Dr | doctor | RNCNA | registered nurse; certified in nursing administration |
| Ed. D | doctor of education | | |
| LBSW | baccalaureate in social work, Licensed | RNNP | registered nurse, nurse practtioner |
| **LPN** | **licensed practical nurse** | | |
| MD | medical doctor/ medical director | RPh | registered pharmacist |
| MSW | masters in social work | RPT | registered physical therapist |
| MT (ASCP) | registered medical technologist | SPT | student physical therapist |
| TRD | therapeutic recreation director | **SLP** | **speech language pathologist** |

# Guidelines for Charting and Documentation

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## Personnel Authorized to Record Data

1. Physicians (i.e., M.D., D.O., Dentist, Podiatrist, Ophthalmologist, Psychiatrist, etc.)
2. Physician's Assistants
3. Nurse Practitioners/ Clinical Nurse Specialists
4. Nurses/Nursing Assistants
5. Dietitian/Food Service Supervisor
6. Therapists/Therapy Assistants
7. Activity/Social Services
8. Pharmacists
9. Others as approved by the Administrator



## Purpose

The purpose of charting and documentation is to provide:

1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., and the progress of the resident's care;
2. Guidance to the physician in prescribing appropriate medications and treatments;
3. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident;
4. Nursing service personnel with a record of the physical and mental status of the resident;
5. Assistance in the development of a Plan of Care for each resident;
6. A legal record that protects the resident, care providers, and the facility; and
7. A source of all resident charges.

## General Rules for Charting and Documentation

1. Chart all pertinent changes in the resident's condition, reaction to treatments, medication, etc., as well as routine observations.

# Guidelines for Charting and Documentation

Policy & Procedure

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2. Be concise, accurate, and complete and use objective terms. Avoid brief, monotonous, and meaningless entries.
3. Document only the facts. Do not document interpretive statements or opinions, unless authorized or designated to do so.
4. Use only approved abbreviations and symbols. Do not use slang or "texting" language.
5. Chart as often as necessary and as the need arises.
    a. Medicare—Chart daily. All three shifts must chart. (e.g., vital signs, eating, condition of the resident, etc.)
    b. Medicaid—Chart at least monthly. Include a nursing summary of the condition of the resident, treatment, program of care, etc.
    c. New Admission—Chart on all three shifts for the first seven (7) days.
6. Document assessments, interventions, treatments, outcomes, etc.
7. Chart all entries legibly.
8. All entries must reflect the date, the time and the signature and title of the person recording the data.
9. Charting Errors
    a. Do not erase any error. Erasures of any type may not be made in the medical record.
    b. If an error is made while recording data in the medical record, line through the error with a single line and then record the correct data.
    c. Correction fluid may not be used in the correction of errors in the medical record.
    d. Do not leave blank lines. Draw a single line through a blank line.
    e. If the record is copied over, the nurse copying the record and the Charge Nurse must sign a statement that indicates the chart has been copied over and include that statement in the medical record. All corrections or changes must be signed and dated by the person making such entries.
10. Late Entries:
    a. If a chart entry must be made late, enter the current date and time and indicate that it is a "late entry." Document information, and include the date of the intervention (treatment, etc.).
11. Refusal of Treatments

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Documentation pertaining to a resident's refusal of treatment should include:

a. Date and time treatment attempted;
b. Treatment attempted;
c. Resident's response and reason(s) for refusal;
d. Name of person attempting to administer the treatment;
e. Documentation that the resident was informed of the purpose of the treatment and the consequences of not receiving the care;
f. Documentation each time the resident refuses his/her treatment, the resident's condition and any adverse effects due to such refusal;
g. Date and time physician was notified of the resident's refusal of treatment in addition to the physician's response;
h. All pertinent observation(s); and
i. Signature and title of person recording the data.

12. Miscellaneous Documentation

Documentation should also include:

a. Any time the physician or family is called about the resident and their response;
b. Each time a physician visits the resident;
c. Whenever appointments are cancelled, rescheduled, and missed. Document the reason(s);
d. Whenever the level of care changes;
e. Whenever a bed/room change is made; and
f. Whenever PRN medications are given and the reason for such medications (Note: Document any side effects of the medications.).



## Nursing Summaries and/or Assessments

When charting nursing summaries or making assessments, include (as they may apply) the following information:

1. Ambulation Status:

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Mode, amount and type of assistance needed, tolerance level, and transferring capabilities (e.g.., Bedfast, bed to chair, walks with or without assistance, uses wheelchair or walker, how long up, etc.).

2. Activities:

Discuss the resident's participation and his or her input. Discuss whether or not the resident participates in lone or group activities.



3. Bowel and Bladder Continence:

Specify the level of continence, any problems, progress, or deterioration.

4. Care Plans:

Reflect the effectiveness of each part of the care plan and the status of the goals.

5. Communication:

Describe the resident's method of communication. (e.g., verbal, non-verbal, response to stimulation, ability to make needs known, etc.)

6. Exercise/ Range of Motion:

Describe the location, description and severity of any range of motion problems or limitations. Describe the types of exercise (range of motion). Is it active or passive? Is it performed alone or in group therapy?

7. Impairments:

Describe any impairment in the resident's speech, hearing, or sight.

8. Management/Behavior:

Describe any problem(s) noted during the month and the frequency of such problem(s). Indicate if the resident was belligerent, friendly, cooperative, etc.

9. Use of PRN Medications:

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Summarize the use of PRNs with reason for usage, effects, and frequency of use. Discuss the effects of new medications/dosage changes as well as medications that require monitoring or observation.

10. Mental Status:
Describe the resident's orientation and any programs used (i.e., Reality Orientation). Indicate if the resident was confused, disoriented, alert, lethargic, restless, weak, fatigued, semi-comatose, comatose, etc.



11. Nutritional Status:
Document the diet, appetite, food consumption, eating habits, assistance needed and where, diet normally consumed, weight variations, hydration status, fluid intake, tolerance of tube feeding, etc.

12. Oral Hygiene:
Describe the teeth, gums, and tongue.

13. Personal Care/ ADLs:
Includes dressing, bathing, grooming, oral hygiene; assistance needed, etc. Describe the type and amount of assistance required, if any, and the level of self-care.

14. Skin – Hair – Scalp – Nails:
Dry, moist, scaly, etc. Be descriptive of lesions, edema; etc. Include locations, size, depth, color, amount, consistency, odor of drainage, and status of tissue and surrounding area. Indicate type of treatment and how often treatment is administered.

15. Toileting Habits:
The presence of indwelling catheter, incontinence of bowel and/or bladder, chronic constipation, laxative (routine or PRN).

16. Unusual Occurrence/ Significant Events:
Describe the condition(s) of the past month. Indicate whether the condition(s) improved or worsened. (i.e., Decubitus, UTI, cold symptoms, refusal of medications, treatments, food, bath, activities, etc.)

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17. Visits:
Indicate whether or not the resident's physician and family members visited during the month.

18. Vital Signs:
Indicate what resident vital signs were documented.

## Physician orders



The following information is provided to assist in recording physicians' orders.

1. Supervision of a Physician:

    a. Each resident must be under the care of a licensed physician authorized to practice medicine in this state and must be seen by the physician at least every thirty (30) days for the first ninety (90) days after admission and at least once every sixty (60) days thereafter.
    b. Physicians' orders must be signed by the physician and dated when such order was signed.
    c. Current lists of orders must be maintained in the clinical record of each resident.
    d. Orders must be written and maintained in chronological order.
    e. Physician orders must be reviewed and renewed every 30 days for SNF residents (Note: This may be changed to every 60 days after the first 90 days of the resident's admission, provided that change is approved by the attending physician).
    f. Physician orders are needed for leaves of absences; PT, ST, and OT evaluations and therapy; consultation from other physicians; diet; activity; X-ray; lab work; transfers; discharges; etc. Therapy orders are to be renewed every 30 days and may be recorded on therapy notes.

2. Content of Orders:

    a. Medication Orders:

Specify the type, route, dosage, frequency, and strength of the medication ordered (i.e., Dilantin 100 mg po TID). A placebo is considered a medication and must also have specific orders.

b. PRN Medication Orders:

Specify the type, route, dosage, frequency, strength, and the reason for administration (i.e., Tylenol 250 mg po PRN mild pain or temp ≥ 101°).

c. Oxygen Orders:



Specify the rate of flow, route, and rationale (i.e., 2-3 L/min per nasal cannula PRN SOB).

d. Nasogastric Tube:

Specify the type of feeding, amount, frequency of feeding, frequency for tube change, and rationale if PRN.

e. IV Orders:

Specify the type of solution, rate of flow, and volume to be infused (i.e., 1000cc D5W IV @ 50cc/hr. DC when infused).

f. Restraint Orders:

Specify the type, reason, frequency of check and release, duration of use, and purpose of restraint.

g. Treatment Orders:

Specify what is to be done, location and frequency, and duration of the treatment.

h. Commercial Supplements:

Specify the type, amount, and frequency (i.e., Ensure 3 oz. TID between meals).

i. Foley Catheter:
   i. If PRN, specify why it is needed.
   ii. Specify the size (i.e., #18 Fr foley catheter to straight drain) and the frequency of change.
   iii. Catheter care - specify what is to be done or "according to facility procedure."

3. Telephone/Verbal Orders:

   a. Telephone/verbal orders may be accepted from a licensed physician or dentist only by a licensed nurse.

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b. Such orders must be countersigned by the issuing physician/dentist within forty-eight (48) hours after issuing the order.

4. Standing Orders:

   a. Standing orders should be recorded as a telephone order. Record on the order sheet.
   b. Sign as follows: "Standing Order, Dr._____/ (your name and title)."



5. Automatic Stop Orders:

   a. Utilize the same procedure as with telephone and standing order. Sign as follows: "Automatic Stop Order/ (your name and title)."
   b. Never just "drop" an order. Always write an order to discontinue any order.

Survey Tag Numbers: F842 - Medical Records

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## Official "Do Not Use" List[1]

| Do Not Use | Potential Problem | Use Instead |
|---|---|---|
| U Unit | Mistaken for "0" (zero) the Number "4" (four) or "cc" | Write "unit" |
| IU (International Unit) | Mistaken for IV (intravenous) Or the number 10 (ten) | Write "International Unit" |
| Q.D., QD, q.d., qd (daily) | Mistaken for each other | Write "daily" |
| Q.O.D., QOD, q.o.d, qod (every other day) | Period after the Q mistaken for "I" and the "O" mistaken for "I" | Write "every other day" |
| Trailing zero (X.o mg)* | Decimal point is missed | Write X mg |
| Lack of leading zero (.X mg) | | Write 0.X mg |
| MS | Can mean morphine sulfate or magnesium sulfate | Write "morphine sulfate" Write "magnesium sulfate" |
| $MSO_4$ and $MgSO_4$ | Confused for one another | |

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Additional Abbreviations, Acronyms and Symbols

(For **possible** future inclusion in the Official "Do Not Use" List)

| Do Not Use | Potential Problem | Use Instead |
|---|---|---|
| > (greater than) | Misinterpreted as the number | Write "greater than" |
| < (less than) | "7" (seven) or the letter "L" Confused for one another | Write "less than" |

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| Do Not Use | Potential Problem | Use Instead |
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| Abbreviations for drug names | Misinterpreted due to similar Abbreviations for multiple drugs | Write drug names in full |
| Apothecary units | Unfamiliar to many practitioners Confused with metric units | Use metric units |
| @ | Mistaken for the number "2" two | Write "at" |
| cc | Mistaken for U (units) when poorly written | Write "mL" or "ml" or "milliliters" ("mL" is preferred) |
| Mg | Mistaken for mg (milligrams) Resulting in one thousand-fold overdose | Write "mcg" or "micrograms" |