PROCEDURE: *D-04*	Title: *Recording of Patient Information*
	Type: Clinical Procedures
	Subsection: D-Documentation
	Authority: Executive Director with Medical Director
	Related Documents:

Policy

The recording of information of a patient's chart should be uniform throughout the Hospice.

Purpose

To chart appropriately and accurately on a resident's chart.

D-04.01 Recording Patient Information

1. All entries are to be written in black when on a paper chart.
2. Write legibly.
3. Write accurately with clarity and absence of ambiguity.
4. Events are to be recorded chronologically with date and time noted in the margin.
5. Information is to be recorded as soon as possible.
6. All entries must be signed with initials and status by the person who made the entry.
7. Use consistent terminology throughout the Hospice. Only approved abbreviations are permitted (see list of approved abbreviations).
8. If an error is made, a singe line is crossed through the error and the word "error" is noted above this with your initials and date. Do not obliterate the writing. White out is not permitted.

D-04.02 Review Cycle

Clinical Policies shall be reviewed in the odd year.

Original Approval:	04-2004
Reviewed On:	
Revised On:	04-2013