CHARTING RULES

OPS.063

Approved By:	**Chief Operations Officer**	Adopted Date:	**Unknown**
Distribution:	**Providers, Site Administrators, Medical Records**	Revision Date(s):	**9/03, 11/03, 6/01/12**

PURPOSE:

To define general guidelines for entries in the chronological record of care in ODCHC clinical charts.

POLICY:

Ink Color	Paper Chart: All entries will be made using black or blue ink. Pencil and/or other ink colors are not acceptable. Electronic Record: System designates font color
Patient Identifier	Paper Chart: Each page must have both of the following: • Full Name • Medical Record Number **or** Date of Birth Electronic Record: EMR displays and prints patient's name, DOB, and/or MRN number.
General Guidelines for Paper or Electronic Chart Notes	• All patient contacts that involve the delivery of clinical advice will be recorded in the clinical record, regardless of whether the contact was in person, by telephone or by email. • All chart notes will be recorded during or directly after the provision of care. • For chart notes that are dictated, the following minimum information must be recorded in the chart for use until the transcribed note is received and filed: o diagnosis o any prescriptions or procedures ordered o any follow-up instructions given
Paper Chart Filing Order	In the chronological record of care, all entries will be filed in date order, with most recent on top. Entries may be placed out of date sequence only in the event that an approved form is used. Out of order entries will be placed immediately under the page on which the entry would have appeared chronologically, and a notation will be made in the chronological record to identify the out of sequence form.
Paper or Electronic Chart Entry Identification	Each entry must be identified with the following: • Date of Entry • Identification of the individual making the entry. See "Signatures" for minimum requirements of signature format.
Alert Stickers/Flags	Alert stickers may be used to flag charts that require special attention or handling, with the following condition: • No specific diagnostic or clinical information may appear on the exterior of a chart. If an alert sticker is used (Allergy, Pre-Med, Alert, Registry, etc), it must never identify patient specific clinical information.
Document review	The following documents require provider review and co-signature: • Referral results / consultation notes • Records of diagnostic procedures • Health histories • Assessment tools See "Signatures" for minimum requirements for signature format.
Signatures	Signatures must be legible. The minimum requirements for a chart note signature are: • First Initial, Last Name and Title
Abbreviations	ODCHC will maintain a list of approved abbreviations as an attachment to this policy. Chart notes should not use abbreviations that are not on the approved list.

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Entry Correction	No entry will be effaced in any manner, either by use of erasure, correction fluid, or superimposition of another document. A correction to a previously made entry will be denoted as follows: • single line drawn through the erroneous entry (the erroneous entry must still be legible) • initials and date of the individual making the correction by the line through • reference to date of new entry if applicable
Late Entries	A late entry is defined as an entry made more than 24 hours after the provision of care. Date any late entry with the date the entry was written, followed by the statement "Late Entry for visit of {date of visit}". If there is an extenuating circumstance that led to the late entry, such as loss or destruction of a dictation tape, indicate that as well.
Addenda	An addendum is defined as an entry made to add new information to the clinical record. All addenda must be noted with the date of entry and be located at that date in the chronological record of care. The addendum should reference the date of service to which the addended information is linked. If necessary, a notation referencing the addendum may be made near the location of the original entry (for example, "see addendum {current date}", followed by the clinician signature).
Paper Chart Use of Pages	• All pages will be secured using record prongs. • Except for preprinted double-side forms, entries will be completed on one side of paper only. • Notes that are continued to a new page should be noted with "cont" at the bottom of the completed page and "cont" at the top of the new page. • Written notes will be written horizontally, and with sufficient margins to prevent loss of information when notes are filed or photocopied. • Where lined paper is used, all lines must be used in sequence. If a line is left blank, a line or X should be place through it.
Forms	Only approved ODCHC chart forms will be used in the chronological record of care. Additional forms or tools may be used, at provider discretion, but they must supplement, not replace, the chronological note. Such additional forms or tools will be filed in other areas of the chart. In using forms, the following requirements apply: • All multiple choice boxes must be addressed. • All blanks must be completed. If information is not obtained or item is not addressed, "unknown" or "n/a" should be written.
Legibility	All written records must be clear and legible.

Approved:

Cheyenne Spetzler

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