

Alaska Community Health Aide Program
Patient Encounter Form (PEF) Documentation Guidelines
for CHAP Basic Training and Village Clinic Practice

Introduction:

These guidelines are designed to improve the quality of CHA/CHP documentation. They outline the fundamentals of documentation of patient care in the CHAP Program and identify charting details that have been problematic. These guidelines augment Basic Training and are to be used as a tool for more thorough documentation in the village clinic. Training Center and Field Instructors will use these guidelines to teach, review and evaluate PEFs. Regional guidelines should be applied as appropriate. Each CHA/P should have a copy of these guidelines to use when writing up patient encounters.

A. GENERAL Items:

1. The CHAM must be used for every patient encounter, including home visits.
2. If any part of the CHAM History, Exam, or Plan is not done, an explanation should be given (e.g. "pt refused", "pt uncooperative", "pt unable to cooperate").
3. Use the PEF forms accepted in your region.
4. Use the CHAP Emergency PEF and/or CHAP Patient Encounter Flow Sheet or equivalent form when appropriate.
5. Record information in the correct sections on the PEF.
6. Use punctuation such as commas and periods to document History and Exam findings.
7. Use additional page/PEF as needed for long encounters or patients with more than one problem. Mark pages as "p. 1/2" and "p. 2/2" and when to turn to page 2.
8. Label every page with patient name, birth date, medical record number, date, time, and signature.
9. Write only in black or blue ink with ballpoint pen.
10. Write legibly. If your cursive handwriting is not legible, print or type.
11. Do not write in the margins or on the back of a page.
12. Do not scribble out, erase, or "white out" your entries. If you make a mistake, draw a single line through it and write your initials next to it.
13. Do not add to a previously written PEF unless you make a formal "late entry." A late entry should be at the bottom of a page, on a separate page, or otherwise separate from the original entry (do not squeeze it into a blank space within an earlier note). It should be clearly dated and labeled a "late entry."
14. Date all additional chart entries.
15. For emergency patients, record the time of each entry, patient evaluation, intervention, and communication with doctor.
16. Use only accepted abbreviations (see regional policy, CHAM R-269, and attached "Do Not Use" list, page 4).
17. All medical orders from a provider must be documented in the patient's chart.
18. All conversations with a patient involving medical advice must be documented in the patient's chart.
19. For minors, document who accompanies the patient.

B. HISTORY Section:

1. Identify the historian, if not the patient.
2. The History should begin with the patient's age and sex.
3. Write the Chief Complaint in the patient's words.
4. The History should be written as it is taken, not later.
5. Write separate Histories for complaints involving unrelated body systems (use additional PEFs as necessary).

History Section continues ►

B. HISTORY Section continues:

6. Write out every answer to every History question. Do not use a phrase like “All other History questions on p. 85 are negative.”
7. Positive and negative History findings may be noted as + and Ø.
8. For specific questions, e.g. Pain Scale, Allergies, Meds, Tobacco Use, negative findings must be documented rather than leaving the space blank.
9. When recording CHAM History positives and negatives, record them in the order that they are asked in the CHAM.
10. For the Past Health History in problem specific sections, write out the answer to every question, including “No” answers.
11. For High Risk Health Conditions (inside front cover), record only the positive answers. If there are none, write “No high risk health conditions” in Past Health History section.
12. For the Well Child Visit, age 2 weeks to 5 years, the answers to all the History questions must be documented.
13. For the Well Child Visit, age 2 weeks to 5 years, the 10 development steps may be documented by recording how many out of 10 were answered "yes" and listing only the ones that were missed, e.g. "9 of 10 developmental steps, not smiling yet."

C. EXAM Section:

1. For General Appearance, record your overall impression of the patient, including anything that is noticeable or stands out.
2. General Appearance should always include level of consciousness (e.g. “alert”).
3. NAD (No Acute or Apparent Distress) means that the patient is showing no signs of illness, pain, emotional distress or physical distress.
4. Record all parts of the CHAM Exam.
5. If not already listed on your PEF, organize your charting by listing each body part on a separate line, in head-to-toe order.
6. Describe actual Exam findings; avoid the use of such terms as “normal”, “okay”, and “good.”
7. Descriptions of symmetric body parts with identical Exam findings may be combined using terms such as “both” or “bilateral.”
8. For the Well Child Visit, age 2 weeks to 5 years, and for First OB visits, the Exam findings for the entire Screening Physical Exam must be recorded.
9. Record results of lab tests performed in the clinic in the “Exam” section. Lab specimens sent out belong in the “Plan” section.
10. For the urine dipstick, the abnormal results must be recorded. A summary statement may be used to chart the normal results (e.g. “All others negative”).

D. ASSESSMENT Section:

1. Use only CHAM Assessments, including the “Other (body system) problem” Assessment (or Dr’s Assessment in the rare case when there is no CHAM Assessment).
2. Record the complete Assessment as detailed in specific CHAM Assessment sections.
Examples:
 - Laceration, right hand [see CHAM p. 459]
 - Chemical in the eye: Right eye, bleach, fluorescein dye exam is not normal [see CHAM p. 204]
 - Diabetes, Chronic Care. Doing well [see CHAM p. 660]
3. Number multiple Assessments, listing the most significant first.
4. If you report, ask for the Dr’s Assessment and record it also. If it is the same as yours, record “Agrees/Same/As above.”
5. Do not use “possible” or “rule out” in the Assessment section.

Assessment Section continues ►

6. For visits that are “labs only”, “meds only”, or “procedure only” the Assessment should be the medical condition. For example, “Hypertension” is the Assessment.

E. PLAN Section:

1. Record all parts of the CHAM Plan (including other/special care, pt ed, medicine pt ed, and recheck).
2. Record and number separate Plans for each assessment (see attached PEF example).
3. Record the source of the Plan (CHAM page number or Doctor’s name).
4. Record the first page number of the CHAM Plan for each assessment.
5. Record if you used your Standing Order rather than reporting this encounter.
6. If reported, record the Dr’s name and date and time of the contact.
7. Record clearly all the Dr’s instructions. If verbal instructions, record that they were read back and confirmed.
8. For serial monitoring of a patient, record repeat exams, treatments, and reports on the CHAP Patient Encounter Flow Sheet or equivalent form.
9. If the patient is transferred, record time/date and to whom patient is transferred.
10. Document urgent travel arrangements (time/date medevac departed with patient; first flight tomorrow).
11. For patient education, record the CHAM page number and either the title of the pt ed chart (“Acute Otitis Media, p. 241”) or the number (“Ear 3, p. 241”).
12. Document the source for regionally approved pt ed not from the CHAM.
13. Record all medicines, including name of medicine, strength (in mg per pill or concentration), dose, route, frequency, and duration.
14. For medicines administered in clinic, also record the time.
15. Do not use the word “dispense” when recording medicines.
16. For injections administered in clinic, record name of medicine, dose/volume, route, location, time, and CHA/P’s initials.
17. For immunizations administered in clinic, record name of immunization, dose/volume, route, location, time, manufacturer, lot number, expiration date, and Vaccine Information Statement (VIS) date and CHA/P’s initials.
18. Document offers and refusals of vaccines and any other treatments.
19. Document Medicine Handbook pt ed for every CHAM medicine given. Record the CHAM page number and title of the pt ed chart (“Albuterol M-284”).
20. Document procedures and treatments completely following the CHAM (e.g. wound care).
21. For O₂ treatment, record start and stop times as well as flow rates and delivery device.
22. For IV treatment, record solution, volume, flow rate, start and stop times, gauge of catheter, and site.
23. List all lab test/specimens sent out.
24. For Recheck, use the CHAM wording. Do not use the phrases “Recheck as needed” or “Recheck prn.”
25. Document “Telemed consult requested/sent to Dr. via AFHCAN”. Also “Polycom/video teleconference visit requested”.

F. OTHER Items:

1. Record provider code and initials, following regional guidelines.
2. Document if the accident/encounter is ETOH related.
3. The CHA/P should sign the PEF with first name or initial, last name, and title/level of training: “J. Doe CHA III”. Level of training is the last Session that was fully completed, including the field training requirements (or CHP, if credential is current).
4. The CHA/P’s title should include “C” if certified by CHAPCB, e.g. “CHA III-C.”
5. Document the type of visit (normal, after hours, home).

“Do Not Use” List*

DO NOT USE	POTENTIAL PROBLEM	USE INSTEAD
U, 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) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other Period after the Q mistaken for “I” and the “O” mistaken for “l”	Write “daily” Write “every other day”
Trailing zero (X.0 mg)	Decimal point is missed	Write “X mg”
Lack of leading zero (.X mg)	Decimal point missed	Write “0.X mg”
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write “morphine sulfate” Write “magnesium sulfate”

* National Patient Safety Goals/Joint Commission 11/29/07