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

Introduction:
Community Health Aides and Community Health Practitioners (CHA/Ps) should use these guidelines when documenting a patient encounter on paper, and many of these guidelines apply to Electronic Health Records (EHR) as well. Each CHA/P should have their own copy. Training Center and Field Instructors will teach from these guidelines and they will also be used to review and evaluate patient encounter documentation.

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 or comparable electronic health record (EHR) 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 or EHR.
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 if using paper PEF.
8. Label every page with patient name, birth date, medical record number, date, time, and signature.
9. Document 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. Proofread your documentation.
13. If you make a mistake, draw a single line through it and write your initials next to it. Do not scribble out, erase, or "white out" your errors.
14. Do not change or tamper with a previously written PEF.
15. Do not add to a previously written PEF unless you make a formal "late entry" or addendum. 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”.
16. Date all additional chart entries.
17. For emergency patients, record the time of each entry, patient evaluation, intervention, and communication with referral provider.
18. Use only accepted abbreviations (CHAM Reference/Procedure>Medical Words and Abbreviations> Common Abbreviations and regional policy and attached “Do Not Use” list, page 4).
19. All medical orders from a provider must be documented in the patient’s medical record.
20. All conversations with a patient involving medical advice must be documented in the patient’s medical record.
21. Document if any chaperones are present. For minors, document who accompanies the patient.

B. HISTORY Section:

1. Identify the historian, if not the patient.
2. The History should include the patient’s age and sex.
3. Document the Chief Complaint in the patient’s words.

4. The History or detailed notes should be written as the History is taken.
5. Write separate Histories for complaints involving unrelated body systems (use additional PEFs as necessary).
6. For most patient encounters, document every answer to every History question. Do not use a phrase like “All other History questions are negative.”
7. Positive and negative History findings may be noted as ⊕ (positive) or ⊖ (negative).
    a. On PEF forms with spaces for specific questions, negative findings must be documented rather than leaving the space blank, e.g. Pain Scale, Allergies, Meds, Tobacco Use.
    b. When recording CHAM History positives and negatives, record them in the order that they are asked in the CHAM.
    c. For the Past Health History in problem specific sections, write out the answer to every question, including “No” answers.
8. For High Risk Health Conditions record only the positive answers. If there are none, write “No high risk health conditions” in Past Health History section.
9. For the Well Child Visit, age 2 weeks to 5 years, the answers to all the History questions must be documented.
10. For the Well Child Visit, age 2 weeks to 5 years, the 10 developmental 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, or emotional distress.
4. Record all parts of the CHAM Exam.
5. If not already listed on your PEF, organize your documentation by listing each body part on a separate line.
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. Record results of lab tests performed in the clinic in the “Exam” section. Lab specimens sent out belong in the “Plan” section.
9. 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 referral provider’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:
    a. Laceration, right hand.
    b. Chemical in the Eye. Right eye, bleach, fluorescein dye exam is not normal.
    c. Diabetes, Chronic Care. Doing well.
3. Number multiple Assessments, listing the most significant first.
4. If you report, ask for the referral provider’s Assessment and record it also. If it is the same as yours, record “Agrees/Same/As above.”
5. You must give the Assessment for encounters that are “labs only”, “meds only”, or “procedure only”. For example, “Seizures, chronic care” is the Assessment; “labs only” is the Plan.

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.
3. Record the source of the Plan (CHAM Plan number and ordering provider).
4. Record if you used Standing Orders.
5. If reported, record the provider's name and date and time of the contact.
6. Record clearly all the provider's instructions. If verbal instructions, record that they were read back and confirmed.
7. For serial monitoring of a patient, record repeat exams, treatments, and reports on the CHAP Patient Encounter Flowsheet or equivalent form.
8. If the patient is transferred, record time/date and to whom patient is transferred.
9. Document urgent travel arrangements.
10. For patient education, record the CHAM Patient Education box number and name (Ear 3, Acute Otitis Media).
11. Document the source for regionally approved pt ed if not from the CHAM.
12. Record all medicines, including name, strength (in mg per pill or concentration), dose, route, frequency, and duration.
13. For medicines given in clinic, also record the time given.
14. For injections and immunizations given, record the name, dose/volume, route, location, time, and CHA/P's initials.
15. For immunizations, also document manufacturer, lot number, expiration date, Vaccine Information Statement (VIS) date, and National Drug Code (NDC) number.
16. Document offers and refusals of vaccines and any other treatments.
17. Document CHAM Medicine Patient Education for every CHAM medicine given. For example, for Albuterol, "CHAM Patient Education for Albuterol given".
18. Document procedures and treatments completely following the CHAM (For example, wound care).
19. For O_2 treatment, record the start and stop times as well as flow rates and delivery device.
20. For IV treatment, record solution, volume, flow rate, start and stop times, gauge of catheter, and site.
21. For Recheck, use the CHAM wording. Do not use the phrases "Recheck as needed" or "Recheck prn."
22. Document Telehealth consults and visits per regional guidelines.

F. OTHER Items:

1. Record provider code and initials.
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.
4. The CHA/P's title may include "C" if certified by CHAPCB, (For example, CHA III-C) if approved by regional documentation guidelines.
5. Document the type of visit (normal, after hours, home).

Unacceptable Abbreviations: Do Not Use

The following information in the table below is taken form the Joint Commission's website (https://www.jointcommission.org/facts_about_do_not_use_list/ current as of 6/9/17, verified 12/8/17).
Your referral hospital may have a list of other approved and unapproved abbreviations. It is a good idea to check every year with the referral hospital to see if other abbreviations or symbols have been added to these lists.

Official "Do Not Use" List[1]
The Joint Commission's "Do Not Use" List is part of the Information Management standards. This requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

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)	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.0 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"
MSO_4 and $MgSO_4$	Confused for one another	Write "magnesium sulfate"

[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.