

MODULE 06

Documentation Standards

The FACT Principles, Visit Notes & Error Correction

WHAT YOU'LL LEARN

Learning Objectives

- 01 Complete a visit note with all required elements within the required timeframe
- 02 Apply correct documentation principles — objective, accurate, complete, timely
- 03 Identify and avoid the most common documentation errors
- 04 Explain how to correct a documentation error
- 05 Describe the importance of documentation for compliance and patient safety

THE RULE

*"If it wasn't documented,
it didn't happen."*

This is not a cliché. It is the legal, clinical, and financial reality of home health care.

FOUR REASONS

Why Documentation Matters

Your visit note is not busywork. It serves four critical purposes.

1

LEGAL RECORD

Your visit note is the official legal record of the care you provided. In a lawsuit, it speaks for you.

2

CARE PLAN COMPLIANCE

It proves the agency is meeting care plan requirements. No documentation = no proof of care.

3

CLINICAL COMMUNICATION

Your supervisor and the clinical team rely on your notes to monitor the patient's status and make care decisions.

4

BILLING

No note, no payment. Incomplete or late documentation can trigger payment denials that hurt the entire agency.

THE DEADLINE

The 24-Hour Rule

All visit notes must be completed within 24 hours of the visit. No exceptions.

- Do not wait until the end of the week
- Delayed documentation is **inaccurate** documentation — memory fades and details are lost
- Best practice: complete your note **during or immediately after** the visit
- Late notes are a compliance issue **and** a billing issue

The best time to document is right now. The worst time is "later tonight."

THE STANDARD

The **FACT** Principles

F

FACTUAL

Document what you observed and did. Not what you think. Not what usually happens. Only facts.

A

ACCURATE

Use correct spelling, approved abbreviations, specific times and measurements. Precision matters.

C

COMPLETE

Cover all assigned tasks and any significant observations. "All care provided" is never adequate.

T

TIMELY

Within 24 hours. Ideally during or immediately after the visit while details are fresh in your mind.

REQUIRED ELEMENTS

What a Complete Visit Note **Includes**

- 01 **Date and time** of visit — both arrival and departure
- 02 **Patient name** and identifying information
- 03 **All tasks performed** — checked off or described individually
- 04 **Patient's condition and response** to care ("patient tolerated bath without distress")
- 05 **Significant observations** or changes in condition
- 06 **Patient or family communications** — requests, concerns, information shared
- 07 **Any refused care** with reason if known
- 08 **Signature and credentials**

THE DIFFERENCE

Objective vs. Subjective

Your notes must describe **observable facts** — not your interpretations or feelings.

OBJECTIVE — WRITE THIS

- "Patient was unable to recall the day of the week"
- "Required repeated redirection during morning care"
- "Patient stated 'I'm very tired'"
- "Supervisor notified at 10:15 AM"

SUBJECTIVE — NEVER WRITE THIS

- "Patient seemed kind of confused"
- "Maybe more tired than normal"
- "Patient was difficult this morning"
- "I think she might have dementia"

SPECIFICITY

Detail Matters

Compare these two notes from the same visit. Which one protects you?

VAGUE — UNACCEPTABLE

- "Gave patient shower, did laundry, made breakfast."

No detail. No patient response. No specifics. This note is clinically useless.

SPECIFIC — PROFESSIONAL

- "Provided assisted shower — patient tolerated well, no skin breakdown observed"
- "Completed one load of laundry (washed, dried, folded)"
- "Prepared scrambled eggs and toast per patient preference; patient consumed approx. 75% of meal"

Specific documentation has clinical value and legal value. Vague notes protect no one.

ERROR CORRECTION

How to Correct a Mistake

Everyone makes documentation errors. What matters is how you correct them.

PAPER RECORDS

- 01 Draw a **single horizontal line** through the error
- 02 Write the correct information above or beside it
- 03 Add your **initials, date, and time** of correction

ELECTRONIC RECORDS

- 01 Follow your EHR's **amendment procedure**
- 02 The original entry **must remain visible**
- 03 Add the correction with your name and timestamp

NEVER use white-out. **NEVER** obliterate an entry. **NEVER** discard and replace a page.

PROHIBITED CONTENT

What **Not** to Document

Some things should **never** appear in a patient's visit note.

- **Opinions** — "Patient is difficult" or "Family doesn't seem to care"
- **Speculation** — "I think the family may be neglecting her"
- **Information about other patients** — never reference another patient
- **Personal opinions about the family**
- **Hearsay** — "The neighbor said..." is not an observation

If you have concerns that require interpretation — suspected neglect, unusual behavior — document the objective facts and notify your supervisor verbally.

SPECIAL SITUATIONS

Documenting Refusals

When a patient refuses a scheduled task, your documentation must be thorough.

- 01 Document that the patient **verbally refused** the specific task
- 02 Include the patient's **reason** if given ("patient stated she did not want a bath today")
- 03 Document **your response** — how you addressed the refusal
- 04 Note **supervisor notification** — who you called and when
- 05 Never **omit** the refused task — leaving it off the note is falsifying records

All refusals are clinically and legally significant. Document every one.

AVOID THESE

Most Common Errors

- **"All care provided per care plan"** — This is never an acceptable note. List each task.
- **Wrong times** — guessing arrival/departure times instead of recording actual times
- **Copy-paste notes** — identical notes day after day suggest fabrication, not care
- **Missing signatures** — an unsigned note is an incomplete note
- **Documenting for someone else** — you may only sign your own notes
- **Pre-charting** — never document care before you have actually provided it
- **Late completion** — notes completed days later are unreliable and a compliance flag

LEGAL REALITY

Documentation & the Law

Your notes can be subpoenaed in legal proceedings. They speak for you when you cannot speak for yourself.

- If a patient is injured after your visit, your note is the **first document reviewed**
- A detailed, objective note **protects you** from false accusations
- A vague or missing note makes you look **negligent** — even if your care was excellent
- Falsifying documentation is a **terminable offense** and can result in criminal charges
- ODH surveyors **review documentation** during every agency inspection

YOUR PROTECTION

Good Notes **Protect** You

Think of documentation as your professional shield.

A GOOD NOTE PROVES

- You were there when you said you were
- You provided the care that was assigned
- The patient's condition at the time of your visit
- You communicated concerns properly
- You followed the care plan

A MISSING/VAGUE NOTE MEANS

- No proof you were there
- No proof care was provided
- No baseline if something goes wrong
- You look careless or dishonest
- The agency cannot defend you

QUICK REFERENCE

Documentation Checklist

Use this mental checklist before submitting every visit note.

- Did I record my **actual arrival and departure times**?
- Did I describe **each task** I performed — not just "all care provided"?
- Did I note the patient's **condition and response** to care?
- Did I document any **refusals, concerns, or changes**?
- Did I include **supervisor notifications** with times?
- Is my language **objective and factual** — no opinions?
- Did I **sign and date** the note?
- Am I completing this **within 24 hours**?

WHAT WOULD YOU DO?

Scenario

SITUATION

Sandra finishes her shift and, running late for a personal appointment, decides she'll fill out the visit note **"tonight when I get home."** By evening, she can't remember her exact arrival time, whether she completed all tasks, or what the patient said about not feeling well.

A) Fill in approximate times and write "all care provided" — close enough

B) Skip the note entirely and hope no one notices

C) Complete the note as accurately as possible, then commit to documenting during or right after visits going forward

D) Copy yesterday's note since the visits are usually the same

CORRECT ANSWER: C

Document Now — Change the Habit

WHAT SANDRA'S DELAY CAUSED

- **Inaccurate times** — wrong arrival/departure is falsification
- **Missing details** — "not feeling well" was never captured
- **Billing risk** — incomplete notes trigger payment denial
- **Legal liability** — if something happened to the patient, her vague note provides nothing useful

THE LESSON

- Complete documentation **during or immediately after** the visit
- Memory fades **within hours** — not days
- Your documentation is your **professional record**
- No personal appointment is worth a **compliance violation**

WHAT WOULD YOU DO?

Scenario

SITUATION

While writing your visit note, you realize you accidentally wrote **the wrong date** on the paper form. The note is otherwise complete and accurate.

- A) Use white-out to cover the wrong date and write the correct one
- B) Throw away the form and start a new one with the correct date
- C) Draw a single line through the error, write the correct date, and add your initials and the date/time of correction**
- D) Leave it — one wrong date won't matter

CORRECT ANSWER: C

Single Line, Correct, Initial, Date

WHY THE OTHERS ARE WRONG

- **A – White-out** is never acceptable. The original must remain legible.
- **B – Discarding** creates a gap in the record and may appear as falsification
- **D – Leaving errors** creates inaccurate records that could cause harm

CORRECT METHOD

- 01 Single line through the error (still legible)
- 02 Write the correct information nearby
- 03 Add your initials
- 04 Add the date and time of the correction

REVIEW

Knowledge Check

1. How do you correct an error on a paper visit note?

Single line through the error, write correction, add initials and date/time.

2. Which entry follows documentation standards: "Patient seems confused" or "Patient unable to recall date when asked, required two redirections"?

The second — it is objective, specific, and factual.

3. When must visit notes be completed?

Within 24 hours of the visit. Ideally during or immediately after.

4. A patient refuses a scheduled task. How do you document it?

Document the refusal, patient's reason, your response, and supervisor notification.

5. What does FACT stand for in documentation?

Factual, Accurate, Complete, Timely.

Documentation Standards

KEY TAKEAWAYS

- If it wasn't documented, it didn't happen
- FACT: Factual, Accurate, Complete, Timely
- 24-hour rule — no exceptions
- Objective language only — no opinions or speculation
- Single-line corrections — never white-out or discard
- Your notes are your professional and legal shield

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