UC San Diego Health

Department of Neurosciences

ALCOAC Principles

"If it was not documented, it was not done."

A	Attributable	Is it obvious who wrote/did it and when? If changes were created, is it obvious who, when, and why changes were made?
L	Legible	Can it be read easily?
C	Contemporaneous	Are the study information/results recorded as they are observed current and in the correct time frame?
O	Original	Is it a copy? Has it been altered?
A	Accurate	Are conflicting data recorded elsewhere?
C	Complete	Has the information been recorded in its entirety?

At a minimum, the following general standards must be followed:

- Keep handwritten notes and signatures legible. If necessary, the individual's name may be printed underneath the signature.
- Sign and date all entries in real time.
- Make error corrections by 1) drawing a single line through the incorrect information, 2) initialing, dating, and stating a reason for the change (if necessary), and 3) inserting the correction. If the change is obvious, i.e., a transcription error that can be verified with the original source, then a rationale for the change is not required. If the change is not obvious, i.e., a diagnosis or symptom that was deleted after initial entry, then there should be a rationale for the change.
- Never obliterate entries that require correction.
- Never destroy original documents, even if they require error correction.
- Keep subject records secure yet accessible.
- Do not alter past-dated notes, chart notes/progress notes, e.g., by writing alongside or adding to prior entries.
- Only use dark ink.
- Never use whiteout.
- Never use pencil.