

Documentation Essentials

Documentation in patient health records and other clinical systems fulfills many purposes. It memorializes patient care, facilitates communication among caregivers, forms the basis for coding and billing, provides data pertinent to quality improvement, and may provide information that is critical to the defense of a legal action.

Healthcare organizations should have written policies and procedures to ensure thorough and consistent documentation and mitigate liability exposure. This checklist can help healthcare organizations review important risk management strategies for documentation and identify potential areas for improvement.

	Yes	No
<i>Documentation Policies</i>		
Does your organization have written policies that delineate documentation expectations for healthcare providers and staff members?	<input type="checkbox"/>	<input type="checkbox"/>
Do documentation policies:		
<ul style="list-style-type: none"> Specify requirements related to documentation format, content, review, and signoff? 	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Include information about accountability and responsibility for various types of documentation? 	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Contain detailed guidance about alteration of patient health records, including how to appropriately amend a record and guidance for when alteration is prohibited? 	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> Strictly prohibit negative, judgmental, or subjective comments about patients, their families, and other healthcare providers in health records and other forms of documentation? 	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Documentation Policies (continued)		
<ul style="list-style-type: none"> • Establish proper notation methods to prevent misunderstandings about the level of care or the timing of care? • Include guidance and requirements related to using scribes to document clinical care? • Stipulate that appropriate and qualified healthcare personnel must review and approve dictated and transcribed documentation? • Define and encourage appropriate use of checklists and forms? • Establish appropriate terminology and medical abbreviations to help prevent confusion and errors? • Establish appropriate timeframes for completion of documentation-related tasks, such as health record entries, development of operative reports, review of transcribed information, and signoff of consultative reports? • Account for unique risks related to electronic documentation? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Clinical Encounters		
<p>Is thorough information documented for patients during initial clinical encounters and at each follow-up visit, including:</p> <ul style="list-style-type: none"> • Health history and family history? • Medications, including prescription and over-the-counter medications, vitamins, supplements, and herbal remedies? • Drug, material, and food allergies (including the name of the allergen, the date the allergy was identified, and the patient’s reaction)? • Physical exam findings? • Recommended screenings and tests as well as results? • Referrals and consultations? • Differential diagnosis and final diagnosis? • Treatment recommendations (including the clinical rationale) and the provision of care? • Administration of medications or vaccines during the clinical encounter? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	Yes	No
Clinical Encounters (continued)		
<ul style="list-style-type: none"> • Patient education, including techniques used to improve comprehension or address health literacy barriers (e.g., the teach-back method)? • Follow-up for persistent problems? 	<input type="checkbox"/>	<input type="checkbox"/>
Are informed consent and informed refusal discussions documented, including risks and benefits, treatment alternatives, self-care regimens, and patient education?	<input type="checkbox"/>	<input type="checkbox"/>
Are issues related to patient nonadherence documented, including methods used to address the problem (e.g., additional education, patient agreements, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>
Does documentation about patient encounters use language that is specific and objective? Are direct patient quotes included to clarify context?	<input type="checkbox"/>	<input type="checkbox"/>
Administrative/Systems		
<p>Is a reliable system in place to document:</p> <ul style="list-style-type: none"> • All tests and consults ordered? • All test results and consultative reports received? • Review of all test results and consultative reports by an appropriate and qualified healthcare provider? • Any clinical decisions (and corresponding rationale) based on test results or consults? • Patient notification of test results and consultative reports? 	<input type="checkbox"/>	<input type="checkbox"/>
Are hospital records and information from other healthcare providers incorporated into patient records?	<input type="checkbox"/>	<input type="checkbox"/>
Are telephone calls to pharmacies documented, including the name of the pharmacy, phone number, medication prescribed, dose, schedule, volume dispensed, and number of refills authorized?	<input type="checkbox"/>	<input type="checkbox"/>
Are any limitations or requirements related to automatic medication refills documented in patient records (e.g., the patient must be seen prior to a refill)?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Auditing		
Are documentation policies periodically audited to identify gaps and information that requires updating?	<input type="checkbox"/>	<input type="checkbox"/>
Are hardcopy records periodically reviewed to ensure text is legible, information is chronological, and all entries are dated and signed?	<input type="checkbox"/>	<input type="checkbox"/>
Is the tracking documentation for test results and consultative reports periodically reviewed to ensure entries have appropriate dates, times, and reviewer signatures?	<input type="checkbox"/>	<input type="checkbox"/>
Is disclosure of patient health records and protected health information (PHI) periodically reviewed for compliance with organizational policies on release of health records ?	<input type="checkbox"/>	<input type="checkbox"/>
Staff Education		
Are healthcare providers and personnel educated about organizational documentation policies during orientation and as part of in-service training?	<input type="checkbox"/>	<input type="checkbox"/>
Are healthcare providers and personnel educated about the risks of: <ul style="list-style-type: none"> • Including incident reports or lawsuit-related correspondence in health records? • Using legal terms such as “negligence,” “duty,” or “liability,” in health records? • Speculating about, or criticizing, the actions of other healthcare workers or professionals in health records? • Editorializing or including subjective information in health records? • Altering or revising health records? 	<input type="checkbox"/>	<input type="checkbox"/>
Are healthcare providers and personnel educated about the organization’s policy guiding the release of health records and the confidentiality of PHI?	<input type="checkbox"/>	<input type="checkbox"/>
Are healthcare providers and personnel educated about the organization’s record retention policy?	<input type="checkbox"/>	<input type="checkbox"/>

Resources

For more information about various aspects of documentation, see the following MedPro resources:

- [Checklist: Using and Electronic Health Record System to Support Quality Improvement](#)
- [Electronic Health Records: Patient Safety and Liability Concerns](#)
- [Risk Q&A: Documenting Care for Transgender Patients](#)
- [Risk Resources: Electronic Health Records](#)
- [The Role of Documentation in Diagnosis-Related Malpractice Cases](#)
- [Why Documentation Is a Crucial Aspect of Disclosing an Unanticipated Outcome](#)

This document does not constitute legal or medical advice and should not be construed as rules or establishing a standard of care. Because the facts applicable to your situation may vary, or the laws applicable in your jurisdiction may differ, please contact your attorney or other professional advisors if you have any questions related to your legal or medical obligations or rights, state or federal laws, contract interpretation, or other legal questions.

MedPro Group is the marketing name used to refer to the insurance operations of The Medical Protective Company, Princeton Insurance Company, PLICO, Inc. and MedPro RRG Risk Retention Group. All insurance products are underwritten and administered by these and other Berkshire Hathaway affiliates, including National Fire & Marine Insurance Company. Product availability is based upon business and/or regulatory approval and may differ among companies.

© 2022 MedPro Group Inc. All rights reserved.