

Risk Tips: Documentation Tips

Whether you are memorializing your patient's care, sharing records with the health care team or billing your encounter, documentation serves many purposes. Review your documentation policies and practices annually to help identify areas for improvement, ensuring you capture the key components of documentation listed below:

Documentation Policy:

- Requirements for content and format of a note
- Completion and signoff timeframes for the note
- Permissions for what team member can complete a given section of the note
- Instructions on how to amend and correct a record
- Instructions to avoid subjective or negative comments

Clinical notes:

- Medical/family history
- Medications, including OTC, herbal supplements and vitamins
- Medication instructions and education provided
- Pain scale when applicable
- Exam findings
- Follow-up on persistent and/or previous problem
- Differential diagnosis
- Final diagnosis
- Rationale for your treatment plan
- Recommended tests ordered
- Follow-up plan for return visits
- Patient education and understanding
- Informed consent discussions including RBA, expectations and limitations
- Specific details regarding patient non-compliance and the consequences of non-compliance

Additional documentation entries:

- Clinical call details-be specific
- Review of records from other providers
- Review of test results and your instructions
- Patient notification of test results
- Patient outreach efforts to support non-compliance
- Narcotics agreement when applicable

Concise and timely medical record documentation is critical to improving patient safety, reducing malpractice risks and maintaining the continuum of care.