Documentation

The recording of care (documentation) is a tool that:

1. Communicates information about the patient to other healthcare professionals.
2. Aids in continuity of care of the patient.
3. Aids in audit and peer review activities.
4. Verifies for financial records.
5. Satisfies requirements of various regulatory agencies.
6. Acts as the #1 witness in litigation.

"Rules" of Documentation

1. Must be: accurate, concise, and legible, in chronological order, signed, initialed, or identified in some way.
2. Use abbreviations carefully-use only approved abbreviations & make them uniform.
3. Regulations and policies must be followed.
4. Use forms as they were intended-revise to fit documentation needs.
5. Never destroy or alter any part of a record.
6. State fact, not opinion!
7. Facts should be pertinent to the patient and his/her care.

Documentation should include:

1. What was actually done for a patient and his/her reaction to that treatment.
2. Patient's response or lack of response to a medication.
3. Special measures taken to protect a patient and/or belongings.
4. Reasons for deliberate omissions or commissions.
5. Communications with others including physicians, healthcare team, family.

Common Deficiencies:

1. Omissions
2. Contradictions & inconsistencies
3. Time delays or unexplained time gaps.
4. Alterations or appearance of alterations
5. Illegibility
6. Extraneous remarks that reflect unprofessionalism, confusion, frivolity, or inattention.
7. Blanks spaces on forms