MedPro Group
a Berkshire Hathaway company

Checklist

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 billing and coding, 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 comprehensive 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
Documentation Policies		
Does your organization have written policies that delineate documentation expectations for healthcare providers and staff members?	☐	☐
Do documentation policies:		
• Specify requirements related to documentation format, content, review, and signoff?	☐	☐
• Include information about accountability and responsibility for various types of documentation?	☐	☐
• Contain detailed guidance about alteration of patient health records, including how to appropriately amend a record and guidance for when alteration is prohibited?	☐	☐
• Strictly prohibit negative, judgmental, or subjective comments about patients, their families, and other healthcare providers in health records and other forms of documentation?	☐	☐
• Establish proper notation methods to prevent misunderstandings about the level of care or the timing of care?	☐	☐

	Yes	No
Documentation Policies (continued)		
• Include guidance and requirements related to using human scribes or artificial intelligence 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?	☐	☐
Clinical Encounters		
Is thorough information documented for patients during initial clinical encounters and at each follow-up visit, including:		
• 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?	☐	☐

	Yes	No
Clinical Encounters (continued)		
• Patient education, including techniques used to improve comprehension or address health literacy barriers (e.g., the teach-back method)?	☐	☐
• Follow-up for persistent problems?	☐	☐
Are informed consent and informed refusal discussions documented, including risks and benefits, treatment alternatives, self-care regimens, and patient education?	☐	☐
Are issues related to patient nonadherence documented, including methods used to address the problem (e.g., additional education, patient agreements, etc.)?	☐	☐
Does documentation about patient encounters use language that is specific and objective? Are direct patient quotes included to clarify context?	☐	☐
Administrative/Systems		
Is a reliable system in place to document:		
• 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?	☐	☐
Are hospital records and information from other healthcare providers incorporated into patient records?	☐	☐
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?	☐	☐
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)?	☐	☐

	Yes	No
Auditing		
Are documentation policies periodically audited to identify gaps and information that requires updating?	☐	☐
Are hardcopy records periodically reviewed to ensure text is legible, information is chronological, and all entries are dated and signed?	☐	☐
Is the tracking documentation for test results and consultative reports periodically reviewed to ensure entries have appropriate dates, times, and reviewer signatures?	☐	☐
Is disclosure of patient health records and protected health information (PHI) periodically reviewed for compliance with organizational policies on release of health records?	☐	☐
Staff Education		
Are healthcare providers and personnel educated about organizational documentation policies during orientation and as part of in-service training?	☐	☐
Are healthcare providers and personnel educated about the risks of:		
• Including incident reports, debriefing documentation, 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?	☐	☐
• Inappropriately altering or revising health records?	☐	☐
Are healthcare providers and personnel educated about the organization’s policy guiding the release of health records and the confidentiality of PHI?	☐	☐
Are healthcare providers and personnel educated about the organization’s record retention policy?	☐	☐

Resources

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

- Checklist: Improving Nursing Documentation
- Checklist: Improving Patient Identification and Matching in Electronic Health Records
- Checklist: Using an Electronic Health Record System to Support Quality Improvement
- Continuing Education On-Demand Program: Mitigating Risk Through Effective Documentation: Protecting Your Practice
- Electronic Health Records: Patient Safety and Liability Concerns
- Risk Q&A: Documenting Care for Transgender Patients
- Risk Resources: Electronic Health Records
- The Power of Words: Using Language to Support Collaborative Provider–Patient Relationships
- 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.

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