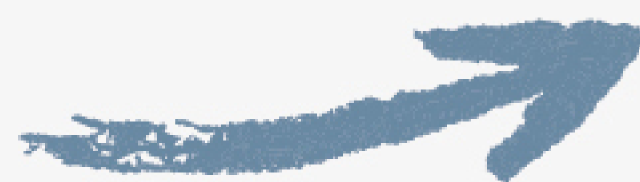
BEST DOCUMENTATION PRACTICES

Creating accurate, complete medical health records is imperative to continuity of care, improved patient outcomes and quality assurance throughout your health care organization. Medical records are also legal documents that can be used in a court of law.

Follow these tips for best documentation practices...



CHECK THE CHART. Ensure you have accessed the correct patient's chart before recording any data.

AVOID ABBREVIATIONS. Abbreviations can be misinterpreted and result in confusion and errors. Always write out words.

LEAVE OUT OPINIONS. Record clear, concise and objective data that doesn't draw conclusions or include opinions and subjective descriptions.

BE COMPLETE. A patient's chart must be a comprehensive, accurate record to not only treat the patient but to also communicate with other health care professionals.

DATE, TIME AND SIGN ENTRIES. Create a sequential timeline, recording the date and time with every entry. Remember to record details as they happen so no information or details get lost.

CORRECT ERRORS. If you notice an error, follow your organization's policies

SOURCES

http://rnspeak.com/fundamentals-of-nursing/charting-for-nurses/
http://www.nursesbooks.org/ebooks/download/ANA_Principles_Nursing.pdf
https://www.medcomrn.com/index.php/articles/prevent-documentation-errors-nursing/
http://www.rn.org/courses/coursematerial-66.pdf

Protect yourself now.
*Visit **www.proliability.com** to apply.*
It's easy, fast and very affordable
— and that's a fact!

proliability®
powered by AMBA