

Patient Chart Documentation

Documentation of the patients' chart is the most fundamental element of risk management. It memorializes patient treatment and information, provides, and communicates this information to other staff and health care providers, and may support the practitioner and the standard of care rendered which is critical to the defense of a claim or litigation.

It behooves all healthcare providers to create an office policy manual with policy, protocols, and procedures that mandate consistent and comprehensive patient chart documentation. The checklist below suggests important elements for comprehensive chart notation.

	I he office manual must ensure all providers enter consistent, accurate and comprehensive
	chart documentation.
	All documentation must follow consistent format, terms, content, and responsibility.
	Proper protocol followed to amend or add an addendum to patient chart
	documentation. Restrict chart documentation to objective clinical information and
	mandate prohibition of negative, unprofessional, and disparaging remarks.
	Unless there is uniform routine usage of abbreviations, they should not be allowed.
	Further, there can also be no use of cryptic terms.
	All patient chart entries entered by staff or transcribed must be reviewed and verified by the provider.
	All patient chart entries must be entered in a timely manner without delay.
	All recommendations, referrals, and compliance matters must be documented in the
	patient chart.
CLINICAL DETAILS	
	Current and past medical history
	All current medications, supplements, vitamins, OTC
	medications All allergies to medications, materials, or foods
	Complete examination including all imaging
	Recommendation of specialist referral and additional
	tests Results of tests and consults that have been
	ordered Patient notification of test results
	Diagnosis
	Treatment plan and options
	Education and communication of patient with consent to treat obtained
	After informed consent discussion, education of risks, benefits, alternatives, and patient
	education, all of which are documented in patient chart
	Documentation of all patient encounters which are complete, specific, and objective

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