Patient Chart Documentation

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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.

- ☐ The 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