# Medical record documentation: What to do, and what to avoid

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Medical record documentation serves as a reminder of previous discussions with patients and what happened during their visits, a reimbursement justification for services, a communication tool to coordinate care with current and future clinicians, and a basis for defense in legal or regulatory matters.[1,2] Documentation should be thorough, accurate, timely, and objective, with the ultimate goal of communicating our thoughts in an easily understood manner to other clinicians or attorneys.[2] If we fail to achieve this goal, we may inadvertently give the impression that our care was hurried, incomplete, or thoughtless.[2]

Although not an exhaustive list, this article outlines strategies to employ and practices to avoid in our documentation efforts so we may enhance our defense in case of litigation and ensure the smooth transition of care for our patients.

## Strategies to employ

Proper and accurate documentation details the course of patient care, and we should describe our thoughts in a clear and logical manner. Doing so minimizes the risk of misinterpretation by other clinicians or attorneys. Make sure the documentation of each appointment details the reason(s) for the patient's visit, the effectiveness of treatment, possible treatment nonadherence, our clinical assessment, treatment consent, changes to the patient's treatment plan, follow-up plans, reasons for not pursuing certain actions (eg, hospitalization), and a suicide risk assessment (and/or a violence risk assessment, if clinically indicated).[2] Document missed or rescheduled appointments, and telephone and electronic contact with patients. Also be sure to use only commonly approved abbreviations.[2] Document these items sooner rather than later because doing so improves the credibility of your charting.[1] If you are handwriting notes, add the date and time to each encounter and make sure your handwriting is legible. Describe the behaviors of patients in objective and nonjudgmental terms.[3] Documenting quotes from patients can convey crucial information about what was considered when making clinical decisions.[1]

## Practices to avoid

If there is a need to make changes to previous entries, ensure these corrections are not mistaken for alterations. Each health care institution has its own policy for making corrections and addenda to medical records. Corrections to a patient's medical record are acceptable, provided they are done appropriately, as I outlined in a previous Pearls article.[4] Minimize or eliminate the copying and pasting of information; doing so can improve the efficiency of our documentation, but the practice can undermine the quality of the medical record,



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increase the risk of outdated and repetitive information being included, lead to clinical errors, and lead to overbilling of services.[5] Finally, be sure to avoid speculation, personal commentary about patients and their family members, and language with negative connotations (unless such language is a direct quote from the patient).[2,3]

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