MarshMcLennan Agency

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Professional Documentation Quick Reference

Clinical Documentation – Do's, Don'ts, and Terms to Avoid

DO	
Do document in the correct medical record	Do review your documentation before signing and submitting
Do document in chronological order	Do document in all required fields
Do authenticate every entry with your signature and designation along with the date and time of entry	Do follow regulations and policies/procedures related to documenting in the medical record
Do be specific; document factual information and quantify whenever possible	Do be objective; describe what you have seen, heard, smelled, and touched
Do use quotation marks when charting subjective information; include resident's own words, gestures, and non-verbal cues	Do document refusal of care/services and deviations from standards of care (including reason for it)
Do be complete (paint a picture); document all facts and pertinent information related to an event, course of treatment, resident's (patient's) condition, and response to care	Do document actions you take in response to complaints/symptoms/observations; do include resident's response to actions taken
Do record all communication to/from a physician or family member (representative); include message and response (also include attempts at notification and messages left)	Do minimize distractions and chart as soon as possible after care, treatment, or services; document on medications immediately after administration
Do maintain confidentiality of the medical record	Do read and act upon progress notes of the previous shift
Do follow correct procedure when correcting a documentation error; ensure the original information is still legible/viewable	Do use late entries and clarifications sparingly; clearly identify the date and time of original documentation

DON'T	
Don't destroy documentation; medical records are permanent	Don't alter a resident's (patient's) medical record
Don't allow others to use your computer login or password (lock your computer to prevent unauthorized access)	Don't chart what someone else said, heard, felt, or smelled unless you identify the person and use quotation marks
Don't chart for another person	Don't leave resident information on computer screen
Don't pre-date or back date entries; don't document medications/treatments before administered/completed	Don't take shortcuts in electronic records systems, including copying and pasting documentation
Don't use shorthand or improper/unapproved abbreviations	Don't be careless with words, spelling, or grammar
Don't document statements that blame, accuse, or compromise others	Don't document frustrations/voice complaints, e.g., staffing problems, issues with providers/colleagues

Professional Documentation Quick Reference (continued)

DON'T	
Don't label people or draw conclusions	Don't document assumptions or vague statements
Don't let emotions, personal opinions, or judgements show up in documentation	Don't reference incident/accident reports in the medical record
Don't chart a resident complaint/symptom without charting an intervention and resident response	Do not obliterate or otherwise alter the original entry (e.g., blacking out with marker, using white out)
Don't go back and complete and/or fill-in signature "holes" on medication/treatment records or other graphic/flow records	Don't delay documenting late entries (the more time that passes the less reliable the entry becomes)

TERMS TO AVOID	
Unnecessary, unintentionally, unfortunate, unsupervised, undesirable, unsatisfactory, unexplainably	Mishandled, misjudged, misinterpretation, miscalculate, mistakenly
Inadequate, incorrect, inappropriate, insufficient	Short-staffed, understaffed
Negligent, fault, blame, defective, substandard, mix-up	Accidently, careless, wrong, problem
Seems to, appears to, apparently, could be, might be	Severe, intense, mild, moderate pain (use pain scale)
Within normal range, within normal limits (be specific / state facts)	All needs met, normal, stable, as usual, status quo (be specific / state facts)
Will continue to monitor, close supervision continues, all needs attended, safety maintained (be specific / state facts)	Tolerated procedure well; shows signs of improvement (be specific / state facts)
Looks worse, did not complain of…(be specific / state facts)	A little, a lot, small, medium, large (quantify)
Good, fair, poor (quantify)	Found (use observed or noted)

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