Chapter 4

Documentation and Record Keeping

- **Lesson Purpose**

  To give the student an introduction to the necessity of documentation and detailed guidelines for proper documenting within the health care profession.

- **Lesson Objective**

  Upon completion the student will:

  - Learn the necessity for proper documentation
  - Learn common documentation methods and abbreviations
  - Learn the necessary components of the patient file
  - Understand special considerations for documentation

"You've got to be very careful if you don't know where you are going, because you might not get there."

—Yogi Berra

CHAPTER 4:

Documentation and Record Keeping

Review pages 53-68 of the textbook for this section of the workbook

DEFINE YOUR KNOWLEDGE

The patient record is a written or computerized record of a particular patient's health status at a given point in time and should include pertinent information that is clear, concise, comprehensively detailed, individualized, accurate and timely.

While recommendations for care can vary from state to state, documentation guidelines are consistent and universal. The information provided to you in the text book as well as here in the workbook is intended to provide a common framework for patient records. This will allow for more consistent reporting and improved communication between not only doctors and their staff, but between various clinics as well.

STUDY TIPS

Patient records serve as:

- *Narrative descriptions of experiences at any given point in time*
- *Historical records of case progression*
- *Legal documents*

Different formats exist within clinical record keeping. The **most common** is the SOAP format.

- **S**ubjective
- **O**bjective
- **A**ssessment
- **P**lan

Other forms that are less common include the following:

POMR

- **P**roblem
- **O**riented
- **M**edical
- **R**ecord

CHEDDAR
- **C**hief complaint
- **H**istory
- **E**xam
- **D**etails
- **D**rugs/dosages
- **A**ssessment
- **R**eturn/referral

SNOCAMP
- **S**ubjective
- **N**ature
- **O**bjective
- **C**ounseling/consultation
- **A**ssessment
- **M**edical decision making
- **P**lan

SORE
- **S**ubjective
- **O**bjective
- **R**x/treatment
- **E**xercise/ergonomics

Consistency is essential regardless of which format of record keeping is used. Abbreviations are often necessary and quite acceptable; however the utilization of commonly-accepted abbreviations is important. Non-standard abbreviations are acceptable when accompanied by a clear interpretational key or glossary.

STUDY TIPS

Documentation Tips and Guidelines:

- *Patient notes must be consistent, accurate, and contemporaneous.*
- *Chart entries must be legible and in ink. Don't use pencil.*
- *Notes must be chronologically arranged. The dates should not be out of order.*
- *Each entry must be signed by the person(s) who performs a given service.*
- *Corrections in a chart should be marked through with a single line. No white out, erasures, or mark-overs.*
- *Records must be easily and readily retrievable.*

Every patient file has necessary components. The **demographic** portion includes information such as their name, address and social security number. The **clinical** section is focused on more personal health information. This section contains health history, examination findings, any and all lab work, x-ray or

MRI findings and treatment plans. The last section is labeled **miscellaneous**. It is for insurance information, work/school slips, letters to other physicians or to the patients themselves. Proper organization of this information is critical to the care of your patients. When categorized according to this system, it allows anyone in the office to access critical information quickly when needed.