**COPIC Tip:**

# Documentation Do's and Don'ts

The most important document in the defense of a medical liability claim is the patient's medical chart. If the documentation is accurate, objective, legible, timely, comprehensive, and free of alterations, it will reflect quality care rendered to the patient. Conversely, if these elements are not present, the plaintiff's attorney could suggest willingness on the part of the physician to carelessly endanger the patient. We offer the following "Do's" and "Don'ts" as a guideline to proper documentation.

**Do's**
- Confirm that items generated from lists, checkboxes, etc. are what was intended
- Be familiar with the content of any templates you use
- Double check results of drop-downs, templates, auto-complete, etc.
- Be judicious when using "copy" and/or "paste"
- Carefully edit and remove irrelevant/unintended content when using "copy" and/or "paste"
- Ensure history of present illness, review of systems, exam, and plan are individualized
- Have a way to incorporate relevant email and text messages into the EHR
- Ensure the "date-the-encounter-occurred" is evident for every entry
- Record patient ID on each page and ensure patient and provider identities are evident for every entry (onscreen and printed)
- Proofread for meaningful errors when using voice recognition or transcription; look particularly for words like "no," "not," "none," "does," "is," "he vs. she," etc.
- Record facts in an objective manner; avoid needless commentary
- Give overview and summary
- Document pertinent positive information
- Document pertinent negative information
- Record after-hours calls
- Review "inbox" messages before accepting them into the record
- Minimize use of abbreviations and have an approved list of abbreviations
- Correct errors in the record in a way that makes evident who made the change and when
- Correct errors in the record in a way that reduces the chance of users relying on inaccurate entries
- Establish mechanisms for reconciling/verifying record content with patients
- Record consent mechanism
- Fill in all blanks
- Read all providers' progress notes
- Providers should read all staff notes
- Document/dictate promptly
- Check all transcription dates
- Explain your thought processes
- Record non-compliance—consider use of informed refusal/AMA forms when there is a chance of significant harm
- Define activities and restrictions of patients
- Document current lists of allergies/adverse drug reactions

- List current medications
- Recheck decimal points
- Record all medically related communication
- Record family contacts/information
- Read and initial all your dictation
- Document discharge instructions
- Document prescriptions and follow-up visits

## Do's Specific to Paper Charts

- Write legibly
- Initial office lab and x-ray reports before filing in chart
- Sign corrections, addenda

## Don'ts

- Clone notes
- Share and/or borrow usernames and passwords
- Import content without reviewing it
- Let automatic "copy paste" become a regular component of your system
- Select "something close to the right choice" from a list, if the correct choice is not available
- Ignore critical information that shows up in your inbox
- Joke or be sarcastic
- Accept typing errors
- Chart non-medical information (e.g., call to COPIC, attorney, peer review activity, incidents)
- Criticize other medical personnel
- Be unnecessarily verbose
- Argue in the medical record
- Delay documentation and locking of notes
- Use inappropriate or pejorative language in the medical record
- Mix medical and legal information
- Mix medical and accounting information
- Use "Dictated but not read" or similar disclaimers
- Edit, delete, or modify documents if you receive a record request or subpoena

## Don'ts Specific to Paper Charts

- Use Liquid Paper® or erase
- File incomplete charts
- Cross out errors completely so that they are unreadable
- Write in margins and enter information in places in the record where it would not be expected to be found
- Use a Signature Stamp