CLINICAL DOCUMENTATION STANDARDS

1. Documentation Principles

Clinical documentation must be accurate, complete, timely, and legible. All entries must be dated, timed, and signed by the healthcare provider. Documentation should reflect the patients condition, treatment provided, and response to treatment. Abbreviations should be limited to approved lists only.

2. Medical History Documentation

A complete medical history must include chief complaint, history of present illness, past medical history, family history, social history, and review of systems. Allergies must be prominently documented including the type of reaction. Current medications must be listed with dosages and frequencies.

3. Progress Notes Requirements

Progress notes must be written for each patient encounter. The SOAP format is recommended: Subjective, Objective, Assessment, and Plan. Notes should document changes in patient condition, response to treatment, and any complications. All verbal orders must be documented and signed within 24 hours.

4. Medication Documentation

All medications administered must be documented including drug name, dose, route, time, and administering provider. Adverse drug reactions must be immediately documented and reported. Medication reconciliation must occur at admission, transfer, and discharge. High-alert medications require independent double-checks.

5. Informed Consent Documentation

Informed consent must be obtained and documented before any procedure or treatment. Documentation must include explanation of procedure, risks, benefits, alternatives, and patient questions. The consent form must be signed by the patient or legal representative. Emergency exceptions must be clearly documented.

6. Discharge Documentation

Discharge summaries must be completed within 48 hours of discharge. Required elements include admission diagnosis, procedures performed, discharge diagnosis, discharge medications, follow-up instructions, and warning signs requiring immediate attention. Patient education must be documented.

7. Error Correction Procedures

Errors in documentation must never be erased or obscured. Draw a single line through the error, write error above, initial and date. Electronic systems must maintain audit trails of all changes. Late entries must be clearly marked as such with current date and time.