Healthcare Documentation Creation Best Practices

Dictation Quick Reference

1. Dictate in appropriate areas away from distractions and noise; avoid speakerphones and cell phones. Organize data before beginning.
2. Enter appropriate identification codes:
   - ✓ Physician ID
   - ✓ Patient ID
   - ✓ Work Type
3. Perform short review/rewind to verify that voice is recording appropriately.
4. Speak in normal conversational voice, clearly enunciating new or unfamiliar terms.
5. Dictate appropriate identifying information:
   - ✓ Physician Name
   - ✓ Patient Name (Spell all uncommon names or spellings)
   - ✓ Record identifiers (Account #, medical record #, DOB, SSN)
   - ✓ Type of Report
   - ✓ Important dates (admission, date of procedure, discharge)
6. Avoid over-use of abbreviations, especially those considered dangerous by ISMP and the Joint Commission. Follow organization's policy for accepted abbreviations.
7. Follow standard document formats for use of headings:

HISTORY & PHYSICAL
- Chief Complaint
- History of Present Illness
- Past Medical History
- Past Surgical History
- Family History
- Social History
- Allergies
- Medications
- Review of Systems
- Physical Examination
- Diagnostic Studies
- Impression/Assessment
- Plan

DISCHARGE SUMMARY
- Admit/Discharge Dates
- Admission Diagnosis
- Pertinent History
- Diagnostic Studies
- Hospital Course
- Discharge Condition
- Discharge Disposition
- Discharge Medications
- Discharge Instructions
- Discharge Diagnosis
- Final Diagnosis

OP/PROCEDURE NOTE
- Date of Procedure or Surgery
- Preoperative Diagnosis
- Postoperative Diagnosis
- Operation Performed
- Surgeon
- Assistant
- Anesthesia
- Estimated Blood Loss
- Operative Findings
- Pathology
- Description of Procedure
- Complications
- Disposition

8. Indicate end of record.