Healthcare Documentation Creation Best Practices

A Note to Users from AHDI

The Association for Healthcare Documentation Integrity (AHDI) is actively engaged in offering our professional expertise to address the impact of problem healthcare documentation as it relates to documentation errors and critical flaws that can adversely impact patient safety, alter patient care of treatment, adversely impact the accuracy of coding and billing, result in a HIPAA violation, and adversely affect medicolegal outcomes.

With the many technical changes in healthcare documentation creation, the *Healthcare Documentation Creation Best Practices* toolkit has been updated to address these evolving practices. Included are tips for dictation best practices as well as best practices for EHR documentation creation using templates, front-end speech, drop-down menus, etc.

The *Healthcare Documentation Creation Best Practices* toolkit is designed to assist facilities with the adoption and implementation of policies and training practices that will promote and ensure the best documentation outcomes.

With multiple ways or approaches for creating healthcare documentation there is an increased risk for errors to be introduced, which may affect patient safety and documentation integrity. It is imperative for organizations to have well-defined documentation and clinician training programs to instruct clinicians not only on best practices related to the dictation and documentation of patients' health information but also on using the technology systems to input that information. This can to some degree ameliorate the likelihood of an adverse impact on patient safety as well as document integrity.

Health information technology (IT)–related issues have been a recurring theme on ECRI Institute's top 10 lists, appearing on the top 10 health technology hazards list for the last six years and on the top 10 list of patient safety concerns since its start in 2014. For the two most recent years, both lists have identified data integrity errors as a result of incorrect or missing data in electronic health records (EHRs) and other health IT systems.[1]

The *International Journal of Medical Informatics*[2] from May 2016 indicates "Speech recognition errors occur commonly with annunciation [*sic*] errors being the most frequent. Error rates were comparable if not lower than previous studies. 15% of notes contained at least one critical error, potentially leading to miscommunication that could affect patient care."

References

1. ECRI Institute. "Top 10 Patient Safety Concerns for Healthcare Organizations: 2015 (item No. 2)." ECRI Institute, 2015. www.ecri.org/PatientSafetyTop10

2. F. Goss, L. Zhou, S. Weiner. "Incidence of speech recognition errors in the emergency department." Elsevier, International Journal of Medical Informatics, 93 (2016) 70-73. www.ijmijournal.com