Healthcare Documentation Creation Best Practices

Tip Sheet for Documentation by Type

The creation of healthcare documentation is a collaborative effort, requiring all involved to properly carry out their role to ensure documentation that is accurate and complete. Any disruption in this process can result in incomplete and inaccurate information being disseminated throughout the healthcare record, with potentially negative impacts (e.g., patient care, billing) and even unanticipated consequences (e.g., future patient ineligibility for insurance). It is essential that each person who documents healthcare information be conscientious in performing their role and recognizing the roles of others. It is strongly encouraged that the following best practices be reviewed, implemented, and practiced for elimination of errors in documentation.

Clinician/Author—Documentation Tips

- Understand the connecting points of the documentation process, including:
  - Patient, patient's family, healthcare provider, healthcare documentation specialist/editors, coders, billers, insurance reviewers, referring providers, etc.
  - Equipment and technology used (hardware and software) and its limitations.
  - Purpose or outcome, which is a clinically accurate health record.
- Know the equipment and technology used.
  - Different systems use different methods to access the dictation portion. It is important to know how to access the system and make initial entries to capture accurate patient documentation.
- Adopt good dictation habits.

Clinician/Author—Dictation Tips

- Organize notes prior to recording.
- Avoid using speakerphones and refrain from using mobile phones on traditional telephone call-in dictation systems, both of which may contribute to suboptimal audio quality.
- Choose a HIPAA-compliant dictation location that is quiet and secure, away from background noises, such as ringing phones, music, shuffling papers, and other conversations.
- Become familiar with how to adjust the volume and all equipment features, such as pause, review, insert, and new report modes.
- Enter the clinician author's own user ID only.
- Speak at a normal conversational rate and tone.
- Dictate one patient report per dictation.
- State dictating clinician's first and last name and work type, for verification.
- State and spell the patient's first and last names and identifiers.
  - Be aware of clearly stating letters that sound the same, e.g., "B" and "D" or using the phonetic alphabet to clarify, e.g., B as in boy.
- Dictate date of service and other essential dates as required.
- Hold handheld devices 4 to 6 inches from the mouth.

- Speak at conversational rates.
- Clearly pronounce sound-alikes, e.g. peroneal/perineal/peritoneal; 15 mg versus 50 mg.
- Clearly enunciate and spell new terminology, drugs, equipment, proper names, and geographic locations.
- If a report is to be sent to another provider, dictate first and last names and location, if available.
- Clearly speak numeric values including ages, drug doses, and laboratory values.
- Comply with the organization's approved abbreviation policy.
- Report technical issues promptly.

Clinician/Author—Direct Entry

- Verify information is being entered in the correct patient's record.
- Use only organization-approved abbreviations.
- Work with facility EHR and HIM team members when creating macros/templates/normals to assist in direct entry to ensure correct grammar, spelling, etc., is used.

Clinician/Author—Partial Dictation

- Verify Partial Dictation is being created in the correct patient's record as this provides metadata information that links the document to hyperlink placement.
- Verify cursor placement is where transcribed text should appear prior to creating Partial. After dictation, a hyperlink appears as a placeholder for transcribed text to appear when accepted.
- Hyperlink contains the voice file and can be played prior to the text replacing the hyperlink, if necessary.
- Verify this process with the facility based on the system being used. For example, it is known that in the Epic EHR the transcribed Partial Dictation draft is viewable within the EHR and files are sent to the clinician author's InBasket for review, editing, and authentication/signature. Once authenticated, transcribed text replaces the hyperlink.

Clinician/Author—Front-End Speech Recognition

- Dictate in a quiet, HIPAA-compliant environment.
- Speak at normal conversational tones.
- Edit the speech-recognized draft produced prior to signing. NOTE: Upon final signature, the clinician is responsible for the content and errors contained in the legal medical documentation. Statements referring to the use of FESR technology do not change the legality of the content in the legal medical record.