

Best Practices in Documentation

The following are considered to be best practices in Documentation:

- *Dictated note* (for Admission, Consultation, Weekly Medical Progress, Family Meetings, Palliative Care Summary, Transfer Note)
- Use a “*listing format*” in your dictated note
- Dictated Discharge Summary *dictated within 48 hours of Death*
- Discharge Summary should include:
 - Admission and Discharge Diagnosis
 - Pertinent physical exam and lab findings
 - Discharge medications
 - When Palliative Care was provided
 - Active Medical Problems at Discharge
- Follow up arrangements

Quality of documentation reflects on the care that we have provided our patients, and translates into the statistics that are the basis of so many decisions that are made by the MOH, LHIN, and others. Documentation needs to be timely, specific, accurate and legible!

- Time and Date all orders
- Highlight any and all co-morbidities (on Discharge Summary, Summary sheet, Final note, Admission Note)

The following are **co-morbidities** that we tend to miss:

- Decubitus Ulcers
- Diabetes (specify Type I or Type II, or even if pt has an elevated glucose > 14mmol!)

Document **all treated significant conditions**:

- Electrolyte abnormalities (hypernatremia, hypokalemia), anemia, uti
- Procedures carried out while in Hospital (feeding tubes, pacemaker insertions)

Different weights are given to different diagnoses, expected length of stay is based on the weight given to a case by diagnosis.

Be as specific as possible!

Rather than “MI” Document “Acute inferior STEMI” (higher case weight, more specific, and higher expected length of stay)

Rather than “Pneumonia” Document “*Pseudomonas* Pneumonia” or “*Bacterial* Pneumonia”

Rather than “Stroke” Document “*Hemmorhagic* Stroke” or “*Embollic* Stroke