Medical Record Documentation Policy Guidelines

Local health departments should have a policy on medical records documentation. The policy should be reviewed, updated as needed, and signed at least annually within your agency. **Agency staff should have access to this policy and should follow it when documenting in the medical record.** At a minimum, the following considerations should be included in your agency Medical Record Documentation policy:

1. A definition of who may document in the record.
2. Requirements for signatures in the medical record.
    a. The minimum is 1st initial, last name & credentials. Your agency may choose more stringent requirements.
    b. If initials are used (such as for flow sheets, etc.), there needs to be a corresponding full identification either on the same form or on a signature legend. Initials should not be used on narrative notes or assessments, or anywhere else a signature is required by law.
3. Timely signing of the medical record.
    a. Every entry should include a complete date: month, day, year & time. Entries should be made as soon as possible after an event or observation is made. Your policy may define an acceptable time frame for signing/ "completing" the record.
    b. The policy should include how late entries are handled: how they are annotated (i.e., an addendum).
4. Process for scanning paper documents, reports, letters, etc. into the medical record.
5. If documents are completed in multiple sections by different healthcare providers (for example, if a nurse completes vitals and interviews the patient before the patient is seen by the physician or advanced practice provider), the documentation policy should outline how to document, making it clear to the reader who completed each section. Each provider must sign for the care, assessment, data collection they completed. The documentation policy should outline the process to determine who completed information in each section. Authors must always make and sign their own entries in the medical record.
6. Requirements for abbreviations.
    a. If your medical records documentation policy does not include abbreviations, your agency should have a separate approved abbreviations policy or list.
    b. Only abbreviations that are on the official policy/ approved list should be used.
    c. When there is more than one meaning for an abbreviation, the policy/ list should define which will be used.
    d. Include abbreviations specific to your agency/ community. For example, the abbreviated name of your agency or any community partners you often use (local hospitals, community resources, etc.)

More information on documentation standards can be found:
https://bok.ahima.org/Pages/Long%20Term%20Care%20Guidelines%20TOC/Legal%20Documentation%20Standards/Documentation%20Standards