PRINCIPLES FOR JOHNS HOPKINS CLINICAL DOCUMENTATION

"There is no more difficult art to acquire than the art of observation and for some men it is quite as difficult to record an observation in brief and plain language."

Sir William Osler

1. The medical record is created first and foremost to document the care provided to the patient. It is also used to support payment for hospital and physician services, clinical research, and quality reporting measures among other purposes.

2. Entries in the record should be contemporaneous, concise and complete to explain the patient's current status and reflect the actions and/or decisions as you cared for the patient.

3. The medical record should clearly describe the patient's clinical condition, the reason for the care and necessity of hospitalization, procedures and/or treatment decisions, as appropriate.

4. Copying information from another source into a note should be undertaken with great caution and the author is responsible to update dynamic information. The person who signs the clinical note takes responsibility for its content.

5. It is acceptable to refer to previously documented information such as history and review of systems without duplicating it in your note. Identify the source of the information by date, author, and type of note, followed by any changes to what was previously recorded, your findings, assessment and/or plans, as appropriate.

6. Each author is responsible for the accuracy of his/her medical record documentation and for the timely signing/finalizing of documents.

7. Late entries are to be clearly noted as such by the author.

8. An amendment is to be used to correct an entry after the original document has been signed/finalized.

9. Clinical professionalism extends to your documentation. It must be accurate, complete and timely.

10. The electronic medical record eliminates legibility problems. Therefore, stagnant or erroneous information is very apparent and care must be taken to update and refresh content.

REMINDERS:

- Entries in an electronic medical record are automatically date and time stamped and create a viewable audit trail.
- Hospital Bylaws and Policies, The Joint Commission, Medicare Conditions of Participation, and regulations for hospital and professional fee billing also address clinical documentation requirements in addition to the principles listed above.

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