Major Health Care Documentation Errors and Their Prevention

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Errors in clinical documentation and incomplete medical records have been among the top reasons for restricting the number of hours for which resident physicians are permitted to work. To be able to provide the most optimal care and achieve patient safety, physicians and medical practices require full and up-to-date medical histories and other patient information. Clinical documentation plays a crucial role in the health care management of individuals. What Makes Clinical Documentation Vital? Erroneous medical records are one of the major reasons for patients' death the world over. Incomplete or unclear medical records may lead physicians and other medical professionals to arrive at wrong decisions about treatment plans and procedures. Patients' safety relies on their health information documentation to a large extent. Errors in documentation may prove disastrous. In addition to being one of the driving factors that assist medical practices and physicians in efficiently managing patients' health, clinical documentation plays a significant role in a medical facility's financial setting as well. Payers, external auditors, and Medicare audit contractors who are expected to scrutinize insurance claims need to verify medical record documentation as it proves to be proof of quality indicators and medical necessity. ***Frequent Medical Documentation Errors*** The best route to prevent documentation disaster is through identification of the common errors and having procedures in place for stopping them. As derived by health information management experts, the following are the frequent documentation mistakes that crop up in the health care industry: ? Missing or incomplete documentation ? Misplaced medical documentation ? Misuse of copy and paste functions in health information systems such as EMR ? Errors cropping up because of illegible handwriting or misunderstood dictation ? Failure to document omitted treatments or medications ? New medical conditions or symptoms not being documented ? Information being entered into the wrong charts ? Duplication of data ? Blank spaces in forms inside the records ***Remedies for Common Errors in Documentation*** ? Avoid shortcuts such as copy and paste in electronic records system ? Make sure that you are charting on the right record ? Avoid documentation delay – record details as soon as an action is taken ? Use of vague terms such as 'normal' and 'fair' must be avoided – being specific and concise is suggested ? Try to use the patient's own words and gestures as far as possible – this helps describe things factually ? Documenting treatments and medications before they are completed or administered must be avoided ? When you come across mistakes, take sincere efforts to correct them promptly ***Numinatrans has been offering reliable and meticulous medical transcription solutions to global medical practices. We have a satisfied client base distributed across the world. Physicians and health care facilities may approach us for accurate clinical documentation solutions. For more details, you are welcome to visit our website www.numinatrans.com***

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