Methods of Charting and Documentation

Rules for Documentation

One of the most important things that takes place in a healthcare facility is the documentation of the signs, symptoms, diagnoses, and treatment of a patient. It is important for the medical assistant to document everything in a professional manner. The patient’s chart, whether it is paper or electronic, is a legal document and can be subpoenaed to be taken to court. It is important that documentation be clear and concise. Anyone reading the document must be able to understand what was written. Documentation must be objective and in chronological order.

A medical assistant must follow these rules when documenting in a patient’s chart.

- When documenting in paper charts, medical assistants must use blue or black ink.
- Date and time every entry into the patient’s chart.
- Leave no space between entries in the chart.
- Do not erase or obliterate any entry in a paper chart. If a mistake is made, draw one line through the mistake, write the corrected entry, and initial it.
- If a mistake is found in an electronic record, a new entry must be made to correct the mistake.
- Sign both paper and electronic entries with first initial and full last name, with credentials after each entry.
- Use universal accepted abbreviations and medical terms.
- It is important to never leave a chart or the electronic record open for others to read or add to the chart.

Any errors made in a paper or electronic record must be handled carefully, either by correcting and initializing it (paper chart) or by making a new entry to correct the mistake (electronic record).