

GUIDELINES ON MEDICAL RECORD DOCUMENTATION OF ERROR

- ◆ The medical record should contain all information regarding care and treatment of the patient in the appropriate place in the record (progress notes, MAR, etc...)
- ◆ Make the narrative factual and as free of emotion as possible
- ◆ Avoid using the pronoun "I" - restate the narrative with the patient as the subject
- ◆ State only the known facts of what occurred and do not speculate as to the cause(s)
- ◆ Do not include editorial comments
- ◆ Avoid terms such as "error" or "inadvertent"
- ◆ Document what did happen, not what in your view should have happened
- ◆ Record, by name, who on the medical team was notified
- ◆ Describe the patient's condition, what was done in response to the error, and what effect the intervention had on the patient
- ◆ Record any involvement of supportive persons, such as the chaplain or social work
- ◆ Document what was told to the patient / family, by whom and when
- ◆ The medical record should not contain any references to Incident Reports or Risk Management

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