health care outcomes for the patients highlighted in the case studies ranged from an allergic reaction brought on by a medication to death. As previously, mentioned, it can be argued that if effective documentation was completed by the health care professionals in each case, the negative health care outcomes experienced by the patients could have been avoided - thus, opening the door for potential legal action against the health care organizations and the health care professionals involved in each case study. If legal action were to be brought upon the health care professionals in each case, the first thing that may be examined is health care documentation. Unfortunately, for the health care professionals in each case, effective documentation was not completed, leaving them vulnerable to medical liability claims. Even though some of the health care professionals in the case studies took appropriate actions to either monitor, observe or administer health care to their patients, nothing was documented to shed light on what transpired or to provide evidence of the appropriate actions of the health care professionals. Therefore, because nothing was documented it may be concluded that nothing was done and the health care professionals were at fault in each case.

In the previously mentioned four cases studies, documentation could prove to be the health care professionals worst enemy because the lack of effective documentation may be used against them to solidify their negligence. To avoid scenarios like the ones presented in the above case studies, health care professionals should work to make documentation their biggest ally by completing effective documentation to outline their appropriate health care actions. Had the health care professionals in the four case studies documented their actions, they would have evidence to support their actions and thus may not be found liable in the cases of potential medical liability claims. In short, effective health care documentation can be used as a means to communicate vital patient information to fellow health care professionals, and it may also be used as a means for health care professionals to protect themselves against medical liability claims and/or malpractice claims. Effective health care documentation must be completed by health care professionals for their protection and, perhaps most importantly, the protection of their patients' overall health, well-being and quality of life.

Section 1: Summary

Health care documentation can refer to a digital or an analog record detailing the administration of health care to patients[1,2]. It has been said that documentation is the foundation on which safe and effective health care is built upon. If completed effectively, health care documentation can be used in daily practice by health care professionals to communicate vital patient information to other health care professionals in order to facilitate positive health care outcomes and to decrease the potential for negative health care outcomes, such as adverse events and patient mortalities. In essence, effective health care documentation can be used as a method to review patient cases and to ensure all aspects of an individual patient's health care are noted and evaluated to maximize therapeutic outcomes.

Effective health care documentation must be completed by health care professionals to ensure their messages and/or instructions are received, understood and acknowledged by intended parties. The goal of communication between two or more individuals exchanging important health care information should be to obtain meaning and a shared understanding of the exchanged information. Effective documentation can be a means to ensure the previously mentioned goal is achieved by reinforcing messages and strengthening the overall flow of communication between two or more health care professionals in order to provide clarity and a reference source for the optimal administration of health care to patients in need. Additionally, due to a host of different reasons including professional oaths and regulatory requirements, health care professionals must complete effective health care documentation because it is their professional responsibility to do so. When a patient is admitted into a health care facility, his or her health, overall well-being and quality of life, often rely on the safe and effective administration of health care - health care documentation can be a means to ensure patients receive the safe and effective health care they rely on.

Section 1: Key Concepts

• Health care documentation is essential to the safe and effective administration of health care.

• Health care professionals should document relevant patient information, observations, assessment results and special requirements to facilitate positive health care outcomes and decrease the potential for negative health care outcomes such as adverse events and patient mortalities.

• Health care documentation can be a method to prevent health care information from being lost and a means to ensure relevant patient information reaches the necessary individuals who have the ability to directly impact and improve a patient's care, treatment and health care outcomes.

• Effective health care documentation must be completed by health care professional to reinforce, strengthen and ensure their messages and/or instructions are received, understood and acknowledged by intended parties.

• Effective health care documentation must be completed by health care professionals because it is their professional responsibility to do so.

Section 1: Key Terms

Health care documentation *- a digital or an analog record detailing the administration of health care to patients*[1,2]

Miscommunication *- the inadequate transmission of information or messages between two or more individuals*[3,4]

Verbal communication *- the process of sharing information or messages between two or more individuals by the use of spoken word*[3,4]

Nonverbal communication *- the process of sharing information or messages between two or more individuals by the use of gestures, facial expressions, visual cues and body positions, otherwise known as body language*[3,4]

Older adult *- any individual 65 years old or older*[5]

Interpersonal communication *- the transmission of information, messages and/or ideas between two or more individuals*[3,4]

Beneficence *- the act of doing what is best for the patient*[6]

Nonmaleficence *- inflicting no harm to patients; do no harm to patients*[6]

Standards of practice *- the authoritative statements of duties that all health care professionals, regardless of role, population or specialty are expected to perform competently*[7]

Section 1: Personal Reflection Question

What roles can effective health care documentation play in the administration of health care?

Section 2: Effective Health Care Documentation

It has been well established that effective health care documentation must be completed by health care professionals; however the following question remains - what makes health care documentation effective? Health care documentation may be considered effective when its two major objectives or functions are achieved. The first objective or function of health care documentation is communication. As previously highlighted, communication is essential to the administration of health care and health care documentation can be a means or a method of communication among health care professionals. The goal of communication is to convey information and an understanding of information in a manner which achieves a shared meaning

among two or more individuals[3,4]. If health care documentation achieves the previous goal of communication, then it may be considered effective.

The second major function of health care documentation is to establish a detailed record of health care administration, which can be easily accessed and/or understood by intended parties. In other words, health care documentation must provide an accessible account of health care administration, which can be used to track and/or obtain information regarding the administration of health care to patients. If health care documentation is clear, easily understood and can be used to establish continuity among necessary health care professionals over time, then it may be considered effective.

In short, in order for health care documentation to be considered effective it must be a viable form of communication as well as a means to establish a detailed record of health care administration. That being said, how can health care professionals ensure their health care documentation is effective? There are many different forms of health care documentation; however, if health care professionals include specific characteristics in their documentation, they can ensure that no matter what form of health care documentation they are completing, it may be used as a viable form of communication and as a means to establish a detailed record of health care administration, and thus be considered effective.

Objectivity and Accuracy

The first major characteristic of effective health care documentation is objectivity. Objectivity can refer to the process of obtaining meaning or information that is true outside of an individual's judgment, bias and/or opinion[9,10]. In other words, objectively is the process of determining fact and/or reproducible/measurable data; when something is objective, it is widely accepted as fact. For example in a health care setting, lab values such as a patient's white blood cell count or red blood cell count would be considered objective information. A white blood cell count or red blood cell count is information that is produced by scientific lab equipment. The data can be

reproduced and, moreover, the counts or lab values are not based on any one individual's judgment, bias or opinion. Blood is drawn from a patient. The patient's blood is taken to a lab. The patient's blood is then analyzed and the information is reported. There is very little or no human analysis of the information. It is simply reported as is. When information or data is obtained in such a manner, it is objective.

Objectivity can also be understood by reviewing subjectivity. Subjectivity can refer to the process of forming an opinion and/or judgment based on one's own point of view or perspective[9,10]. When something is subjective, it is an opinion or point of view. Subjectivity derives from one's own view point, meaning subjectivity is an interpretation based on individual perspective. For example, one individual may believe an object is beautiful while another individual may completely disagree and find the same object repulsive. The object remains the same independent of the individual's view point; however, the interpretation of the object differs depending on the individual's point of view/ perspective. Essentially, subjectivity is opinion based. Subjective information is not typically based on reproducible or measurable data - it is almost purely based on an individual's bias or judgment. For example, Nurse 3 may report to Nurse 4 that a patient is difficult. The information Nurse 3 reported to Nurse 4 is subjective. It is purely based on opinion. There is no scientific method to measure the information or determine whether or not it is fact. The information is simply a judgment, based on Nurse 3's point of view or perspective. When information is rooted in judgment, bias and/or opinion it is subjective. In other words, one can, typically, view subjectivity as the opposite of objectivity. Subjectivity is based in judgment while objectivity is based on reproducible and/or measurable fact. With that said, why should health care documentation include objective information?

As previously mentioned, the two main objectives or functions of health care documentation are to communicate and record information. In order for information to be communicated and/or recorded effectively, it must be clear, complete, concise, comprehensible, accessible and, perhaps most importantly, accurate, especially in health care settings. Accurate information is essential to health care documentation. After all, other health care professionals will be basing their health care and/or treatment strategies on the information included in a patient's health care documentation. Thus, accuracy is of the

upmost importance. To return to the previously posed question, why should health care documentation include objective information - the simple, straightforward answer is accuracy. The bottom line is, health care documentation must be accurate. Often, there is very little room for error when administering health care to patients. The individual patient's health, overall well-being and in many cases, life depends on the safe and effective administration of health care. Therefore, health care documentation must be accurate to ensure patient safety and the best way to keep health care documentation accurate is to include objective information. Incorrect or erroneous information included in a patient's medical record or related health care documentation could have dire consequences for the patient. The following example will highlight the aforementioned concepts. A 52-year-old male patient admitted to a psychiatric facility for alcohol addiction is administered a pass to leave the facility. Upon the patient's return, Nurse 5 observes the patient exhibiting some signs and symptoms of intoxication such as lethargy. Nurse 5 immediately documents the observations. Nurse 5 includes the following statement in the patient's related health care documentation: "patient returned from pass drunk." No tests are ordered to obtain the patient's blood alcohol level and the nurse does not even attempt to ascertain if the patient smells like alcohol or admits to being intoxicated. Nurse 5 documents the aforementioned note and continues to observe the patient. After some time, the patient simply enters his room and goes to sleep. Upon reading Nurse 5's note, the patient's physician cancels all future passes and outside privileges for the patient until further evaluation. The patient becomes aware of his physician's actions and becomes anxious. The patient was hoping to obtain another pass so he could attended his brother's upcoming birthday party. With no hope of future passes coming, the patient becomes increasingly agitated and enraged. Eventually, the patient begins to aggressively act out and has to be physically restrained, sedated and placed in a quiet room until further notice. The patient's physician learns of the events and investigates the situation. As it turns out, the patient was not intoxicated at all when he returned from his pass. He was simply exhibiting some side effects of a recently initiated mediation. However, due to Nurse 5's documentation, the patient was labeled as drunk, which led to a chain of events culminating in the patient's restraint, sedation and sequestering - all of which could have detrimental long-term effects on the patient's recovery, treatment, health,

overall well-being and quality of life. Due to inaccurate documentation, the patient suffered a trying ordeal which possesses the potential to negatively impact his therapy and, ultimately, his life.

The previous example highlighted the importance of accuracy when completing health care documentation. Essentially, Nurse 5's documentation regarding the patient was inaccurate, which led to negative consequences for the patient. Thus, health care documentation must be accurate to avoid scenarios like the one presented in the previous example from occurring. That being said, the best way to maintain accuracy when completing health care documentation is to include objective information. The information Nurse 5 included in the patient's documentation was subjective. It was based on the nurse's opinion and judgment as opposed to reproducible, measurable data. Initially, Nurse 5 acted appropriately by observing the patient; however, Nurse 5 inappropriately rushed to judgment and documented the patient was drunk before any tests were initiated to confirm or refute the validity of the suspicions. If Nurse 5 genuinely believed the patient was intoxicated based on the observations that were made and that information was essential or beneficial to the patient's treatment, health and overall well-being, then Nurse 5 could have documented the information but in a more objective manner by simply noting what was observed without including judgment, bias, opinions and/or labels, such as "drunk." If Nurse 5 observed the patient acting lethargically, then Nurse 5 should have documented that observation versus the judgment or opinion as to why the patient was acting lethargic. In the previous example, Nurse 5 fell into a classic pitfall of health care documentation. Nurse 5 documented a subjective opinion, which turned out to be inaccurate. As previously mentioned, inaccurate documentation can be detrimental to patient care. It can lead to negative health care outcomes and even patient mortalities. Inaccurate documentation must be avoided at all times in health care settings and the best way to avoid inaccurate documentation is to document objective information. With that said, how can health care professionals avoid the pitfalls of inaccurate information and ensure they are documenting objective information? To avoid the pitfalls of inaccurate documentation, health care professionals may follow the "See Rule."

The See Rule advises health care professionals to document what they can see. In other words, health care professionals should document what they can

physically see a patient doing or what they can see on a patient's body, patient monitor or lab report. The See Rule can help health care professionals avoid documenting subjective opinions and/or inaccurate information by focusing their attention and, subsequently, their documentation, on data which can be verified by another health care professional. When data or information can be verified by two or more individuals then it is less likely to be viewed upon as subjective information and more likely to be viewed as objective information. The more sources that can verify data or information, the greater the probability the data/information is objective and thus not a subjective opinion or, most importantly, inaccurate. By focusing their attention on data which can be seen, health care professionals can ensure they are documenting objective, accurate information. The following example will highlight the previous concepts. Nurse 6 observes a 47-year-old male patient's right knee. Nurse 6 notices the patient's right knee is inflamed and red. Nurse 6 also observes, on the patient's monitor, that the patient's blood pressure is 140/90 mmHg. Nurse 6 immediately documents the observations. Nurse 6 describes the patient's right knee as inflamed and red. Nurse 6 also notes the patient's elevated blood pressure and provides the exact reading as: 140/90 mmHg. Nurse 6 does not include any additional information. Nurse 6 only documents what was observed. Several minutes later the patient's physician reads Nurse 6's documentation regarding the patient's right knee and elevated blood pressure. Due to the clear, concise nature of the documentation, the patient's physician immediately understands the information included in the documentation. Upon examination, the patient's physician concludes the patient's right knee is indeed inflamed and has a reddish appearance. The patient's physician also observes the patient's blood pressure is elevated, verifying the information contained in Nurse 6's documentation. Based on the documentation and observations, the patient's physician adjusts the patient's therapy. Subsequent observations by the patient's physician reveal the patient's right knee is less inflamed and the pateint's blood pressure is within normal limits. In the previous example, Nurse 6 made some important observations regarding the patient's right knee and blood pressure. Nurse 6 then documented the data/ information in a clear and concise manner, documenting only what was seen. Nurse 6 did not include any subjective opinions nor was the documentation bias or judgmental in any way. Nurse 6 simply documented what was seen in a detailed manner. Nurse 6 did not include any other subjective information,

which could have detracted from the information's relevance or distorted the data in any way. The data/information was presented in a straightforward manner as to communicate a message and record data/information. The documentation was not convoluted by unnecessary details or subjectivity. It was clear and to the point. Due to the clarity of the documentation, the patient's physician was able to immediately grasp the meaning of Nurse 6's notes and use the information to evaluate the patient. The physician verified the information contained within the documentation was accurate and then used the information, as well as observations, to adjust the patient's therapy to effectively manage the pateint's right knee inflammation and elevated blood pressure, ultimately improving the patient's health-related state. By following the See Rule and documenting what was seen or observed Nurse 6 was able to avoid the pitfalls of inaccurate documentation. Moreover, by following the See Rule, Nurse 6 was able to ensure the documentation regarding the patient was effective. The two main objectives of health care documentation are to communicate and record information. Due to the clear, concise, objective and accurate nature of the documentation, Nurse 6 was able to achieve those objectives. Data/information was recorded and communicated to the patient's physician, who was able to use the information to evaluate the patient, make adjustments to the patient's treatment and improve upon the patient's care, which furthers the following point of interest: health care professionals rely on health care documentation to obtain vital information about their patients; therefore, health care documentation must be accurate. By following the See Rule and by documenting objective data/information in a straightforward manner, devoid of subjective judgments, bias and opinions, health care professionals can ensure their documentation is accurate and effective.

Clarity and Completeness

The second characteristic of effective health care documentation lies within the two **C**s of effective health care documentation: **C**larity and **C**ompleteness. **C**larity, as it relates to health care documentation, can refer to a quality which enables multiple health care professionals to obtain meaning from recorded data and/or information relating to health care. **C**ompleteness, as it relates to

health care documentation, can refer to a state where all of the necessary components and/or parts are present. If health care professionals view health care documentation as a means of communication between two or more health care professionals and as a method to record data/information, then it should be no surprise that **C**larity and **C**ompleteness are essential to the health care documentation process.

To achieve **C**larity in health care documentation, health care professionals must always keep in mind that other health care professionals will be reading their documentation with the intent to obtain meaning. Thus, health care professionals must complete their documentation in a manner which facilitates or promotes meaning. If more than one health care professional cannot obtain meaning from health care documentation, then it may not be considered to be clear or effective. To ensure Clarity in health care documentation, health care professionals should be as concise as possible, only stating relevant information. For example, if a patient experiences a rash on his or her left arm, then the health care professional should document that information exactly as it is observed without adding any irrelevant details. In other words, the health care professional should be as brief and comprehensive as possible. Health care professionals may also obtain **C**larity in health care documentation by using universally accepted abbreviations. Organizations such as The Joint Commission have established acceptable abbreviations which may be used when completing health care documentation. The Joint Commission approved abbreviations are, typically, universally accepted throughout health care. Thus, by adhering to Joint Commission approved abbreviations, health care professionals can ensure other health care professionals will be able to obtain meaning from abbreviations. Lastly, to obtain **C**larity, health care professionals should follow the specific policies and procedures of their respective health care setting regarding documentation. A specific health care facility or organization may have unique guidelines relating to health care documentation **C**larity. Health care professionals should be aware of their organization's polices and procedure regarding health care documentation to maximize health care documentation **C**larity.

To achieve **C**ompleteness in health care documentation, health care professionals must always remember that health care documentation is a means to create a record of health care administration to patients. Records of

health care administration can be very valuable to health care organizations such as hospitals. Hospitals and other health care facilities often use health care documentation, such as patients' medical records, to observe trends in health care, identify patterns of infection or disease, obtain information which can be used to increase patient safety and to secure financial reimbursement, payment and/or funding. Without complete health care documentation, a health care organization may lose out on important information which may be used to increase patient care and/or obtain funding. Additionally, health care professionals must also understand that Completeness also impacts the **C**larity of health care documentation. Clarity and Completeness go hand and hand, and often without Completeness there can be no Clarity. For example, if it is documented that a patient is scheduled to receive a dressing change at specific time and there is no additional documentation completed to confirm or indicate the dressing change was completed, then it is not clear if it indeed occurred.

Without complete documentation to record health care administration, there can be no clear indication or record that any health care was administered, leading to potential gaps in patient care and confusion among health care professionals using patient medical records or related health care documentation to determine patient care. Thus, health care documentation must be complete. To ensure **C**ompleteness is achieved in health care documentation, health care professionals must document any and all forms of health care administered to a patient and any health care outcomes which are relevant to the patient's treatment and overall health. For example, if a patient is scheduled to receive a medication, then a health care professional must document that the patient received the medication. Furthermore, if the patient experienced a reaction to the medication, that too must be documented. In addition, changes to a patient's condition or status should also be documented by health care professionals. In certain health care settings, such as a hospital, a patient's condition may change dramatically or rapidly. Any change to a patient's condition or status must be documented to accurately reflect and record the patient's status throughout his or her admission. Finally, to ensure **C**ompleteness health care professionals must not leave sections of health care documentation blank or empty. Only when all of the necessary components and/or parts of a health care document are present, including a

signature, may it be considered complete. When sections of a health care document are left blank or empty, it may not be considered complete and thus it may not be viewed as effective.

The two Cs of effective health care documentation, Clarity and Completeness, must be achieved in health care documentation in order for it to be effective. Health care professionals must be able to obtain meaning from health care documentation and they must be able to use health care documentation as a means to link patients' symptoms, diagnosis, treatments and outcomes by following an intact record of health care administration. By confirming their health care documentation achieves both Clarity and Completeness, health care professionals can ensure their health care documentation is effective.

Time/Date

Finally, effective health care documentation must include accurate times and dates of health care administration. Health care data and information should be documented in a timely fashion and health care professionals should include accurate times and dates of health care administration. Accurate times and dates of health care administration are typically required to establish an orderly, chronological sequence of data/information. As previously mentioned, the two main objectives or functions of health care documentation are to communicate and record information, which means the data/information included in health care documentation must be accessible. In other words, individuals must be able to locate and identify the data/information they require from a patient's health care documentation with relative speed and ease. For example, if a health care professional needs to know what medications were administered to a patient at 9:00 AM on a specific date, he or she should be able to obtain that information from the pateint's health care documentation effortlessly. The health care professional should not have to sift through data/information for hours on end to acquire the necessary information. The health care professionals should be able to simply follow an orderly, chronological flow of information to obtain what he or she requires. Also, in emergency situations, health care professionals should be able to

quickly access data/information contained in a patient's health care documentation to respond rapidly and administer the required health care.

The data/information fond in health care documentation is there for others to access in order to obtain relevant information and maximize patient health care. Therefore, health care documentation must be kept in an orderly, chronological sequence to ensure accessibility. Thus, health care professionals must include accurate times and dates of health care administration when completing health care documentation to facilitate the availability of health care information and to ensure their health care documentation is effective.

Section 2: Summary

Health care professionals must complete effective health care documentation. In order for health care documentation to be considered effective, it must function as a viable form of communication as well as a means to establish a detailed record of health care administration. There are many different forms of health care documentation; however, if health care professionals include specific characteristics in their documentation they can ensure it is effective.

The first characteristics of effective documentation are objectivity and accuracy. Health care documentation should include objective information free of subjective judgment, bias or opinion. Health care documentation should also be accurate - meaning it should include information which can be measured or verified by another individual. To ensure the information included in health care documentation is both objective and accurate, health care professionals may follow the See Rule. The See Rule encourages health care professionals to document what they can physically see on a pateint's body, monitor and/or lab report.

Additional characteristics of effective health care documentation lie within the two **C**s of effective health care documentation: **C**larity and **C**ompleteness. **C**larity, as it relates to health care documentation, can refer to a quality which enables multiple health care professionals to obtain meaning from recorded data and/or information relating to health care. **C**ompleteness, as it relates to

health care documentation, can refer to a state where all of the necessary components and/or parts are present. Only when **C**larity and **C**ompleteness are achieved can health care documentation be considered effective.

Finally, the information found within health care documentation should be readily accessible and available to all those who require it. Thus, health care professionals must include accurate times and dates of health care administration when completing their health care documentation to further its effectiveness.

Section 2: Key Concepts

• Health care documentation has two major objectives or functions. The first objective or function of health care documentation is communication. The second major function of health care documentation is to establish a detailed record of health care administration, which can be easily accessed and/or understood by intended parties.

• Health care documentation may be considered effective when its two major objectives or functions are achieved.

*• Characteristics of effective health care documentation include objectivity, accuracy, **C**larity, **C**ompleteness and the inclusion of accurate times and dates of health care administration.*

Section 2: Key Terms

***Objectivity** - the process of obtaining meaning or information that is true outside of an individual's judgment, bias and/or opinion; the process of determining fact and/or reproducible/measurable data*[9,10]

Subjectivity *- the process of forming an opinion and/or judgment based on one's own point of view or perspective; when something is subjective, it is an opinion or point of view*[9,10]

The See Rule *- advises health care professionals to document what they can physically see a patient doing or what they can see on a patient's body, patient monitor or lab report; encourages health care professionals to document data/ information which can be verified or reproduced by two or more individuals*

Clarity *(as it relates to health care documentation) - a quality which enables multiple health care professionals to obtain meaning from recorded data and/ or information relating to health care*

Completeness *(as it relates to health care documentation) - a state where all of the necessary components and/or parts are present*

Section 2: Personal Reflection Question

How can health care professionals ensure their health care documentation is effective?

Course Review

The following questions are presented to further review the concepts found in this course. By reviewing these questions health care professionals can obtain knowledge which may be used to complete effective health care documentation.

What is the primary goal of communication in health care settings?

There are many goals of communication; however, it has been said that the primary goal of communication in health care settings is to obtain meaning and

a shared understanding of information and/or messages exchanged between two or more individuals.

What is the difference between objective information and subjective information?

Objective information is true or valid outside of an individual's judgment, bias and/or opinion. Objective information can typically be verified, reproduced and/or measured by two or more individuals. Subjective information is often an opinion and/or judgment based on one individual's point of view or perspective.

Why is it important for health care professionals to avoid "labels" when completing health care documentation?

Labels such as "difficult," "needy" or "unpleasant" should be avoided when completing health care documentation because they may represent subjective information based on judgment, bias and/or opinion, and thus may prove to be inaccurate. Health care professionals must do what is in their power to avoid documenting inaccurate information. Inaccurate information included in health care documentation may lead to miscommunication among health care professionals and, ultimately, patient adverse events, and perhaps even patient mortalities. Health care professionals should focus on documenting accurate information when completing health care documentation to ensure patient safety.

Why should health care professionals complete health care documentation in a timely fashion?

Health care professionals should complete health care documentation as close to the administration of health care as possible to foster accurate, up-to-date information. Accurate, up-to-date information is essential to the administration of health care. Waiting hours after health care administration to complete documentation may lead to inaccuracies due to an inability to recall events as they actually occurred. Moreover, waiting to document health care data can deprive fellow health care professionals of vital information which they may

require to make important decisions regarding a patient's treatment and overall health. Health care professionals must have accurate, up-to-date health care data/information to maximize patient care. Thus, health care documentation must be completed in a timely fashion.

Conclusion

Health care documentation can refer to a digital and/or analog record detailing the administration of health care to patients[1,2]. It has been said that documentation is the foundation on which safe and effective health care is built upon. If completed effectively, health care documentation can be used in daily practice by health care professionals to communicate vital patient information to other health care professionals in order to facilitate positive health care outcomes and to decrease the potential for negative health care outcomes, such as adverse events and patient mortalities. Health care professionals must complete effective health care documentation to strengthen and reinforce communication among health care professionals and because it is their professional responsibility to do so.

In order for health care documentation to be considered effective it must function as a viable form of communication as well as a means to establish a detailed record of health care administration. There are many different forms of health care documentation; however, if health care professionals include specific characteristics in their documentation they can ensure it is effective. Characteristics of effective health care documentation include: objectivity, accuracy, clarity, completeness and the inclusion of accurate times and dates of health care administration.

Finally, health care documentation is essential to health care. When a patient is admitted into a health care facility, his or her health, overall well-being and quality of life often rely on the safe and effective administration of health care - effective health care documentation can be a means to provide patients with the safe and effective health care they rely on.

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