



## MEDICAL DOCUMENTATION IN EMERGENCY DEPARTMENT

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**Abstract:** Improving Emergency Department Documentation for Enhanced Patient Care

**Background:** Accurate and efficient documentation is crucial in the emergency department (ED) for optimal patient care, communication, and legal protection. However, capturing details promptly can be challenging, particularly during critical scenarios. This research investigates the importance, components, and potential improvements of ED medical documentation.

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**DOI:** 10.53555/ecb/2023.12.12.296

**Objectives:**

1. Define medical documentation in the ED context.
2. Identify the main components of an ED medical documentation report.
3. Explain the significance of proper documentation in the ED.
4. Explore methods to enhance documentation quality and efficiency.

**Methods:**

This descriptive analytical study utilizes questionnaires to gather data from healthcare professionals. Statistical analysis using SPSS will be employed to analyze questionnaire responses.

**Expected Findings:**

The research aims to demonstrate:

- The crucial role of comprehensive and timely ED documentation.
- The essential components of an effective ED medical record.
- The potential benefits of implementing strategies like templates, education, dictation, and electronic record optimization for improved documentation quality.

**Implications:**

This study aims to contribute to improved ED documentation practices, leading to:

- Enhanced patient care through accurate information availability and better decision-making.
- Efficient communication among healthcare professionals.
- Reduced risk of medical errors and malpractice.
- Improved healthcare system performance through data analysis and quality assurance.

**Keywords:** Emergency department, medical documentation, patient care, quality improvement, healthcare system

This abstract effectively summarizes the key points of your research:

- It outlines the research gap and objectives.
- It briefly describes the methodology and expected findings.
- It highlights the potential implications of the research.
- It includes relevant keywords.

**The introduction**

First of all, documentation in the ED is very challenging, as it may be hard to capture and note details in a timely manner. This happens particularly when dealing with critical case

scenarios. The medical record is so important on so many levels. It serves to reflect the general approaches, the main details of the patients' medical cases, the care provided to patients, as well as identifying gaps in the knowledge and training. Moreover, having a well-organized chart gives the reviewers and other medical staff an accurate picture of the doctor's thought process, the actions performed, providing a real-time snapshot of the patient's general condition at any given encounter. Like any other medical record, the emergency department document will be composed of the patient's history, physical examination findings, differential diagnoses, lab investigations, lab and imaging findings, assessment and plan (Carrol, 2016). Owing to the importance of documentation in the emergency department, the current research was conducted.

**The research problem**

Medical documentation is a tool which helps the health care staff to write and record all information about patients, health status and the procedures supported by the hospital staff. Medical documentation in the emergency department shows that the hospital staff are aware of what they are doing, and monitoring the care they give to the patient. This is carried out by taking down all important data from the patients' health status and his history, besides the detailed data including lab-results, X-rays, etc. (<https://is.muni.cz/el>). When writing the patient's history, one needs to be accurate, avoiding any complicated phrases.

Unnecessary details are better avoided. Recording the date and time when the patient was seen is so important, particularly in critical patients, as it helps create a timeline for when medications were administered or when time-sensitive interventions were done (Carrol, 2016). The research problem can be stated in clarifying the process of Medical documentation in emergency department.

**Research objectives**

*The current research aims at the following objectives:*

- 1- Identifying the definition of medical documentation
- 2- Clarifying the main components of medical documentation report in the emergency department
- 3- Clarifying the importance of documentation in emergency department
- 4- Identifying how to improve the documentation in emergency department

## Research questions

The current research will try to provide answers for the following questions:

- 1- What the definition of medical documentation?
- 2- What are the main components of medical documentation report in the emergency department?
- 3- What is the importance of documentation in emergency department?
- 4- How to improve the documentation in emergency department?

## Literature review

### Definition of medical documentation in the emergency department

Medical documentation is a tool which helps the health care staff to write and record all information about patients, health status and the procedures supported by the hospital staff. Medical documentation in the emergency department shows that the hospital staff are aware of what they are doing, and monitoring the care they give to the patient. This is carried out by taking down all important data from the patients' health status and his history, besides the detailed data including lab-results, X-rays, etc. (<https://is.muni.cz/el>)

### The importance of Medical Documentation in the emergency department

The importance of Medical Documentation in the emergency department can be stated as follows: -

- It provides the information regarding a specific patient that any physician checking the record would need to identify the main complaint of that patient.
- It is very important for standards of care to be met.
- Neglecting to document details of the patient can result in bad care results and malpractice conditions.
- Medical documentation is legal protection for both the patient and the physician in the event of dispute over care.
- The complete medical documentation assures patient confidentiality and assures that standards of care are met.
- Medical Documentation doesn't destroy evidence. In some states, destroying a record is regarded as an added offense.
- It includes significant positives and negatives from the patient's history and physical exam.

Moreover, in recent years, electronic medical record systems have been introduced into many Emergency departments to simplify the documentation of patient care episodes (Burke, et al., 2015). Despite this recent surge in electronic

medical record uptake, the quality of data in electronic medical record systems remains variable (Park, 2012). While some researchers have reported that electronic medical records improve guideline adherence, and decrease the medication errors (Burke, et al., 2015). The researches on the quality of electronic medical record tends to confirm that electronic medical records do not, by themselves, support enhanced physician documentation clarity, completeness, accuracy or other measures of quality (Nguyen, et al., 2014).

Perry et al. (2014) noted that some physicians spent significantly more time entering data into electronic medical record applications as compared with paper charts further, and so several emergency departments continue to depend on paper or hybrid charts. There is a broader need to adopt prominent approaches to documentation improvement that are not exclusively electronic medical record-dependent. such approaches may include: templates, physician education, dictation, and scanning of free-text paper notes into electronic medical records (hayrinen, et al.,2008). The extent to which these interventions can enhance documentation quality, particularly in the context of emergency departments, is clear. accurate physician documentation is essential to ensuring that patients receive appropriate care (Kuhn, et al.,2015). in the future, it may be possible to embed artificial intelligence technologies, including machine learning, into electronic medical record systems to alert physicians to patient information or physician orders that are potentially inaccurate, imprecise, incomplete, or inappropriate (Forsyth, et al.,2018).

### The medical documentation in the emergency department

The main components for medical documentation in the emergency department include the following:

- Chief Complaint  
This usually contains the presenting complaint, according to the patient's words, with the complaint duration.
- History of Present Illness  
There are two formats when writing a history of present illness, the narrative format and the bullet points format. Both formats are acceptable as long as the history is written in a complete, and coherent manner. This will lead the person reading the chart towards what differential diagnoses to consider, depending on what the patient is presenting with.
- Review of Systems  
The other organ systems that were not

mentioned in the medical documentation report are to be reviewed to make sure the patient does not have other complaints. If the review or system cannot be attained because of the patient's underlying condition, this should be noted in the chart.

- **Past Medical History**  
The medical documentation shall have any known active illnesses the patient might have. In the documentation report, this includes any surgical procedures he had.
- **Family and Social History**  
It is so important to document a brief family history that may be relevant to the chief complaint. Social history mainly includes asking about smoking habits, sexual history and illicit drug use. It might be important to ask about the patient's financial and health status, particularly in certain healthcare settings, to avoid ordering unnecessary tests and paying extra costs.
- **Physical Examination**  
When recording physical examination findings, it is much better to start with the patient's general appearance and vital signs, clarifying the abnormal ones. It is important not to fabricate any findings that were not examined; committing to such findings may have medical and medico-legal implications that should be avoided. It is so important to document all findings from examined systems including findings from palpation, inspection, auscultation, etc. There is no need to document findings that are not pertinent to the chief complaint. It is much advisable to include important positive and negative findings for any given case (Carrol, 2016).
- **Assessment**  
It is so essential to capture the essence of the case and defend the rationale for potential further examinations. It usually contains an objective summary of the case with differential diagnoses based on physical examination findings.
- **The Medical Plan**  
The medical plan should include what investigations, procedures, and consultations are to be performed. Time of consultation is very significant, and the doctor's name and his recommendations are to be documented in an appropriate manner.
- **Disposition**  
This usually is the last part of the note. It mentions whether the patient is going to be admitted, discharged, or transferred to another facility. If discharged, follow-up instructions and return instructions should be documented

clearly (Carrol, 2016).

### **Few helpful hints during documentation**

Write a date and time for notes in the medical record

Write notes clearly

Document a focused but thorough history and physical Examination

Avoid using unclear abbreviations that are not used commonly

Report vital signs and address abnormalities

report the results of all diagnostic tests that ordered when appropriate

Report the patient's response to therapy

Avoid writing derogatory comments in the record

Avoid changing or adding comments to the record after completion.

Write all procedures performed If a patient leaves against medical advice, document that specific risks of leaving AMA have been explained to the patient and relatives

If using an electronic medical record instead of a handwritten one, all of the above sections, components and hints apply (Dunbar, 2014)

### **Research hypotheses**

- Medical documentation in the emergency department improve health care system
- The medical documentation assures that standards of care are met.

### **Experimentation and data collection**

In order to achieve the objectives of the research, the researcher will use the descriptive analytical approach, which is a method of the research that examines the phenomenon, explaining its properties, studying its size, variations and degrees of association with other phenomena.

Depending on the nature of the data to be collected, and on the methodology used in the research, the researcher will use the questionnaire.

The questionnaire is used to collect facts and information on a specific topic and directly, through which we can access views easily and simply.

### **Data analysis**

All questionnaires will be entered by a researcher into the SPSS (version 23.0) database and analyzed. Data will be examined using descriptive statistics, frequencies for categorical data and means and standard deviations (SD) for continuous data. All survey questionnaires will be sorted out and cleaned.

### **Conclusion**

The emergency department documentation note

includes chief complaint, History of present illness with pertinent positives and negatives, the brief review of systems, focused past medical and surgical history, focused pertinent medications and allergies, focused family and social history if required, vital signs, highlighting any abnormal readings, focused and pertinent physical exam, assessment, plan and disposition

Issues, available at,  
<https://www.samerkanaanmd.com/pdf/importance-documentation.pdf>, accessed in 10/12/2022, at 10:00, p.m

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