Medical Record Documentation and Abbreviations Policy Guidelines

Local health departments (LHDs) should have a Medical Record (MR) Documentation and/or Electronic Health Record (EHR) Documentation policy outlining documentation requirements for all employees authorized to document in the medical record. They should also have an Abbreviation Policy or Approved Abbreviations List. The abbreviations policy or list can be included within the documentation policies, or separate. All policies should be reviewed (revised as needed) and signed at least annually. Agency staff should understand, have access, and adhere to these policies when documenting the medical record. Minimum expectations for inclusion in MR/EHR documentation and abbreviation policies and hyperlinks to supporting resources are listed below.

Minimum recommendations for Medical Record (MR) Documentation or Electronic Health Record (EHR) Policy

1. A definition of who may document in the record. Policy and Procedure Development-OCPHN webpage
2. Requirements for signatures in the medical record. Medicare Medical Records: Signature Requirements, Acceptable and Unacceptable Practices
   - The minimum should be first initial, last name & credentials. Your agency may choose more stringent requirements.
   - If initials are used (such as for flow sheets, etc.), there should be a corresponding full identification either on the same form or on a signature legend. Initials should not be used on narrative notes or assessments, or anywhere else a signature is required by law.
3. Timely signing off the medical record encounter
   - Every entry should include a complete date: month, day, year & time. Entries should be made as soon as possible after an event or observation is made. Your policy may define an acceptable time frame for signing or closing the record. Evaluation and Management Services-CMS
   - Documenting care during the encounter, or immediately thereafter, ensures the highest level of accuracy in medical records. 21 NCAC 36.0224, NC Board of Nursing Position Statement: History and Physical Examination
4. The policy should include how late entries are handled: how they are annotated (e.g., an addendum). Entries in Medical Records: Amendments, Corrections and Addenda-Palmetto GBA
5. Process for scanning paper documents, reports, letters, etc. into the medical record.
6. The documentation policy should outline how to document when multiple sections are completed by different healthcare providers, making it clear to the reader who completed each section (i.e., a nurse completes vital signs and interviews the patient before the patient is seen by the physician or advanced practice provider). NC Medical Board Position Statement 3.2.1: Medical Records-Documentation, Electronic Health Records, Access, and Retention

- The documentation policy should outline the process to determine who completed information in each section.
- Each provider must sign for the care, assessment, and data collection they completed.
- Authors must always document and sign their own entries in the medical record.

7. Agencies should perform periodic audits of electronic health records, using a standard tool. OCPHN provides a copy of its Clinical Record Review Tool on the Office of the Chief Public Health Nurse webpage. Agencies should determine how many records will be reviewed for a designated time frame. It is recommended that a multidisciplinary team who understand documentation, coding and billing principles conduct agency audits. Once findings are evaluated, a corrective action plan should be implemented to correct problem(s) and improve compliance. Staff should be educated and a follow-up audit should be done to ensure improved compliance. Documentation Matters Toolkit- CMS
8. Agencies may implement an organization-wide security and privacy policy governing protected health information (PHI). Furthermore, HIPAA requires covered entities to formally designate a trained, authorized privacy official responsible for developing, implementing, and maintaining these policies and ensuring ongoing compliance. All EHR users should be aware of and utilize the privacy and security features of their EHR system and follow agency policies on privacy and security. HIPAA for Professionals – US Department of HHS, What are the Duties of a HIPAA Compliance Officer?
9. For further guidance on developing policies and procedures, refer to the Office of the Chief Public Health Nurse webpage. The components for a well-written policy are outlined in the Policy and Procedure Development guide, and a Policy and Procedure Template is available. Using the template is NOT required. It is recommended, however, that all agency policies and procedures are in the same format. This decreases confusion and is easier to follow. Please refer to the resources at the end of this document or reach out to your OCPHN Nurse Consultant for further guidance.

Minimum recommendations for Abbreviation Policy or Approved Abbreviations List

1. Only abbreviations that are on the official policy and/or approved list should be used in MR/EHR documentation.
2. When there is more than one meaning for an abbreviation, the policy/ list should define which will be used.
3. Include “local” abbreviations specific to your agency or community if they are permitted. For example, the abbreviated name of your agency (e.g., BCHD = Bison County Health Department) or community partners often referenced (local hospitals, community resources, etc.). Standards FAQs- Joint Commission

References

Centers for Medicare and Medicaid Services. (2025, August 12). Documentation matters toolkit. https://www.cms.gov/medicare/medicaid-coordination/states/dcoumentation-matters-toolkit

Centers for Medicare and Medicaid Services. (2025, November). Evaluation and management services. https://www.cms.gov/files/document/mln006764-evaluation-management-services.pdf

Joint Commission. (2026). Standards FAQ: What are the key concepts organizations need to understand regarding the use of terminology, definitions, abbreviations, acronyms, symbols, and dose designations? https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/information-management-im/000001457/

North Carolina Board of Nursing. (2022, September). History and physical examination: Position statement for RN practice. https://www.ncbon.com/sites/default/files/documents/2024-03/ps-history-and-physical-examination.pdf

North Carolina Department of Health and Human Services. (2023, January). Policy and procedure development. www.dph.ncdhhs.gov/media/733/download?attachment

North Carolina Medical Board. (2026, January). 3.2.1: Medical records: Documentation, electronic health records, access, and retention. https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/medical-records-documentation-electronic-health-records-access-and-retentio#:~:text=All%20consultation%2C%20laboratory%2C%20and%20i.

North Carolina Office of Administrative Hearings. (2019, January 1). 21 NCAC 36 .0224 Components of nursing practice for the registered nurse. http://reports.oah.state.nc.us/ncac/title%2021%20-%20occupational%20licensing%20boards%20and%20commissions/chapter%2036%20-%20nursing/21%20ncac%2036%20.0224.pdf

Palmetto GBA. (2022, January 25). Entries in medical records: Amendments, corrections and addenda. https://palmettogba.com/jmb/did/94dlv84552?cat=jmb-evaluation-and-management-em

Palmetto GBA. (2023, February 13). Medicare medical records: Signature requirements, acceptable and unacceptable practice. https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/8EEM4Q2610~Comprehensive%20Error%20Rate%20Testing%20(CERT)~Documentation

The HIPAA Journal. (2026). What are the duties of a HIPAA compliance officer? https://www.hipaajournal.com/duties-of-a-hipaa-compliance-officer/#:~:text=The%20Health%20Insurance%20Portability%20and,Officer%20and%20a%20Security%20Officer

United States Department of Health and Human Services. (2024, July 19). HIPAA for professionals. https://www.hhs.gov/hipaa/for-professionals/index.html