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IV ВСЕУКРАЇНСЬКА НАУКОВО-ПРАКТИЧНА ІНТЕРНЕТ-КОНФЕРЕНЦІЯ

з питань методики викладання іноземної мови

«Дослідження та впровадження в навчальний процес сучасних моделей викладання іноземної мови за фахом»

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of Ukraine concerning the celebration of the Defender of Ukraine Day on 14-th October, at the same day with other historically related holidays inherited the military courage of the past generations of Ukrainian warriors.

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FORMAL STLYLE IN FULFILLMENT OF MEDICAL DOCUMENTATION

Nowadays medical documentation is an important component in diagnosis and treatment which provides cooperation of medical workers. Clinical documentation is the creation of a digital or analog record detailing a medical treatment, medical trial or clinical test.

It must be accurate, timely and reflect specific services provided to a patient the information contained in the medical record allows health care providers to determine the patient's medical history and provide informed care.

Good medical documentation promotes patients' and physicians' best interests for different reasons. Recording all relevant information of a patient's care helps practitioners monitor what's been done, and minimizes the risk of errors creeping into the treatment process. Careful attention to detail also reduces the likelihood of patients returning for additional treatment. The process also demands a high degree of self-evaluation that's essential to promoting good

clinical practices, as well as a practitioner's professional development.

The main types of medical documentation for the hospital:

- Medical card of an outpatient;
- Medical card of an inpatient;
- The history of childbirth;
- The history of the development of the newborn;
- Individual card of the pregnant woman and the woman in labor;
- Medical card of the child;
- Medical certificate of death [3, p. 333].

Medical documentation or documentation of a medical condition is usually filled by the licensed physician or other appropriate practitioner. The medical record serves as the central repository for planning patient care and documenting communication among patient and health care provider and professionals contributing to the patient's care. An increasing purpose of the medical record is to ensure documentation of compliance with institutional, professional or governmental regulation. The traditional medical record for inpatient care can include admission notes, on-service notes, progress notes (SOAP notes), preoperative notes, operative notes, postoperative notes, procedure notes, delivery notes, postpartum notes, and discharge notes.[2, p.1647]

Personal health records combine many of the above features with portability, thus allowing a patient to share medical records across providers and health care systems. Adequate medical documentation assures patient confidentiality and ensures that standards of care are being met. Doctors and other medical personnel have an obligation to treat illnesses to the best of their ability in regard to information documented in a patient’s medical record.

Filling out medical records is very responsible process and requires certain rules:

- Member identifiers appear on every piece of documentation;
- Entries are legible to others and are recorded in black or blue ink if on paper;
- Entries are dated and authenticated by the author;
- Documentation is made at the time service is provided;

- Documentation must support all codes submitted;
- Only standard medical abbreviations should be used in documentation;
- All patient encounters, including telephone, fax, and electronic message exchanges are documented;
- Documentation of any advance directives is in a prominent part of a member's medical record and includes whether or not a member has executed an advance directive, as well as documentation of any information about advance directives that was made available to the member [1, p.456]

The patient's history is a vital piece of information that enables physicians to determine the best diagnosis and treatment plan for that individual, based on information found in the medical record. It must contain Subjective/History, Past Medical History (PMH), Medications Allergies, Allergies Medications, Illnesses Pertinent past history, Doctor Last oral intake, Surgery Events leading to illness or injury. Documentation must include the following content:

- Problem list, including significant illnesses and medical conditions;
- Medications;
- Adverse drug reactions;
- Allergies;
- Smoking status;
- Any history of alcohol use or substance abuse;
- Biographical or personal data;
- Pertinent history;
- Physical exams;
- Documentation of clinical findings and evaluation for each visit;
- Laboratory and other studies that signify review by the ordering provider;
- Working diagnoses consistent with findings and test results;
- Treatment plans consistent with diagnoses;
- A date for return visits or a follow-up plan for each encounter;
- Previous problems addressed in follow-up visits;

- A current immunization record;
- Preventive services and risk screening [4, p.125];

To draw the conclusion, one can say that competent and full management of medical documentation greatly facilities to arrange medical diagnosis and treatment which can speed up the process of patient's recovery. Medical records reflect the scope and nature of the work of health facilities and are necessary for planning actions to improve the state of health and provide medical assistance to the population, assess the quality and effectiveness of medical institutions, provide medical and statistical information to health authorities at various levels.

The formal style in the medical documentation is necessary for correct and clear record keeping of medical documentation because it affects the organization and quality of medical care.Excellence in medical documentation reflects and creates excellence in medical care. At its best, the medical record forms a clear and complete plan that legibly communicates pertinent information, credits competent care and forms a tight defense against allegations of malpractice by aligning patient and providers of medical care.

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