

# Guidelines for Medical Record and Clinical Documentation



## Key Point Summary

- Documentation includes all forms of documentation by a doctor, nurse or allied health professional (physiotherapist, occupational therapist, dietician etc) recorded in a professional capacity in relation to the provision of patient care.
- Documentation and record keeping is a fundamental part of clinical practice. It demonstrates the clinician's accountability and records their professional practice.
- Documentation is the basis for communication between health professionals that informs of the care provided, the treatment and care planned and the outcome of that care as a continuous and contemporaneous record.
- Documentation is a record of the care and the clinical assessment, professional judgement and critical thinking used by a health professional in the provision of that care
- Documentation should be clear, concise, consecutive, correct, contemporaneous, complete, comprehensive, collaborative, patient-centred and confidential.
- Documentation must be patient focused and based on professional observation and assessment that does not have any basis in unfounded conclusions or personal judgements.
- Clinical staff must be able to competently communicate effectively with individuals and groups using formal and informal channels of communication and ensuring documentation is accurate and maintains confidentiality.
- Clinical staff are required to make and keep records of their professional practice in accordance with standards of practice of their profession and organisational policy and procedure.
- Documentation is often used to evaluate professional practice as a part of quality assurance mechanisms such as performance reviews, audits and accreditation processes, legislated inspections and critical incident reviews.
- Documentation systems should promote appropriate sharing of information amongst the multidisciplinary and teams.
- Accurate and comprehensive documentation is a valuable source of data for data coding, health research and a valuable source of evidence and rationale for funding and resource management.
- Documentation should record both the actions taken by clinical staff and the patient's needs and/or their response to illness and the care they receive.
- Clinical staff have legislative, professional and ethical obligations to protect patient confidentiality. This includes maintaining confidential documentation and patient records.
- Precautions must be taken to ensure that clinicians are fully informed of appropriate, safe and secure use of electronic information systems and the potential risks involved in using such systems in ensuring and maintain confidentiality.
- **It should be assumed that any and all clinical documentation will be scrutinised at some point.**

## **Purpose of Guidelines**

---

These guidelines support employers, policy makers, managers and clinical staff in documentation practices and policies that demonstrate the professional obligation, accountability and legal requirements to communicate patient health information and clinical interventions in the public interest. It should be assumed that any and all clinical documentation will be scrutinised at some point.

### **Professional documentation includes**

Any and all forms of documentation by a clinician recorded in a professional capacity in relation to the provision of patient care. This documentation may include written and electronic health records, audio and video tapes, emails, facsimiles, images (photographs and diagrams), observation charts, check lists, communication books, shift/management reports, incident reports and clinical anecdotal notes or personal reflections (held by the clinicians personally or any other type or form of documentation pertaining to the care provided).

### **Other documentation not directly related to the patient**

Other documentation may be relevant to evidence of clinical practice and of interest to the employer, a regulatory authority, the Ministry of Health, courts, a funding body or the general public. This may include;

- policies, procedures and protocols
- critical incident / occupational health and safety reports
- statistical and research data
- reports related to service and funding agreements
- staffing rosters
- personnel files
- performance appraisals
- clinical assessments
- published reports/papers.

## **Purpose of Professional Documentation**

---

### **Communication**

Documentation in medical records is the basis for communication between health professionals. It informs of the care provided, the treatment and care planned and the outcome of that care as a continuous and contemporaneous record. Documentation enables health professionals and other care providers to use current, consistent data, and care goals to facilitate continuity of care. Clear, complete, accurate and factual documentation provides a reliable, permanent record of patient care and is an accurate record of the history of the patient's health care.

### **Accountability**

Documentation demonstrates the clinician's accountability and records their professional practice. It may be used to determine responsibility of care providers and to resolve questions or concerns in relation to care required. The clinician's documentation may be used in relation to performance management, internal organisational inquiries and/or legal proceedings (such as civil lawsuits or coronial inquests).

### **Legislative requirements**

Nurses and midwives are required to make and keep records of their professional practice in accordance with standards of practice of their profession and organisational policy and procedure. Legislation in different countries may further identify and require specific information and content to be recorded and maintained.

Failure to keep and maintain certain documentation records as required, falsifying documentation, incomplete or inaccurate documentation, signing or issuing a document that the person knows or suspects to be false or misleading, may be found to constitute unprofessional conduct by a regulatory authority.

### **Quality improvement**

Documentation may be used to evaluate professional practice as a part of quality assurance mechanisms such as performance reviews, audits and accreditation processes, legislated inspections and critical incident reviews. Clinical staff can also use this information to reflect on their practice and implement changes based on evidence. Documentation is evidence of the quality provision of care and services to the public.

### **Research**

Medical Record documentation is a valuable source of data for health researchers. It provides information in relation to clinical interventions, evaluates patient outcomes, patient care and is a concise record, essential for accurate research data and evidence based practice.

### **Funding and resource management**

Data accessed from medical record documentation and coded can be used as an appropriate tool for identifying the type of care that patients require, the services provided and the efficiency and effectiveness of care. Any of these factors may impact on funding and resource allocation. Accurate and comprehensive documentation of interventions provides a valuable source of evidence and rationale for funding and resource management.

# Maintaining Quality Documentation Practice

---

As partners in efforts to achieve a quality practice setting clinical staff, medical record staff and hospital managers have a shared responsibility and legal accountability to create and maintain environments that support competent clinicians in providing quality, evidence based outcomes for patients. In ensuring quality documentation practice, these documentation guidelines encourage employers, medical record and clinical staff to incorporate strategies, policies and procedures that strengthen effective documentation practices within the work setting.

## Strategies to maintain quality documentation practice include;

### Organisational Support

- Effective systems to support accurate and concise documentation of practice in medical records
- Appropriate policies and procedures in relation to effective documentation systems, practices and management of patient health information
- Risk management strategies that support effective documentation of practice (including incident reporting)
- The provision of adequate time allocation to document appropriately and review previous documentation as part of patient care.

### Leadership

- Encouragement of clinical staff to be involved in decision making in relation to selecting, implementing and evaluating documentation systems
- Implementing quality improvement processes related to effective documentation
- Promotion of documentation as an integral and core part of practice and professional responsibility.

### Resources

- Access to an appropriate physical environment that supports and increases efficiency and confidentiality of documentation
- Reliable, accessible and appropriately maintained equipment
- Documentation systems appropriate to/for the setting in which the care occurs.

### Professional Development

- Appropriate information, education and orientation for staff in relation to documentation systems and practices
- Performance management processes that provide opportunity to improve documentation practices.

### Communication Systems

- Documentation systems that promote appropriate sharing of information amongst the multidisciplinary team
- Effective exchange of information whilst ensuring and maintaining patient confidentiality
- Integrated progress notes for use by all disciplines and care providers
- Secure electronic data and transmission systems where appropriate
- Appropriate processes for patients to access information in relation to their care.

### Responsive to Change

- Documentations systems and practices that are responsive to change, (eg in relation to changing models of care, legislation)
- Systems that are responsive to, and accommodate changing patient population needs

# Documentation Policy

---

Medical Record Officers should ensure they have documented policy, procedure and quality assurance mechanisms in place which clarify:

- the legislative requirements for documentation
- the minimum requirements for documentation
- format and type of documentation (including acceptable documentation tools and forms)
- the roles and responsibilities of the clinical staff in relation to documentation
- accepted abbreviations in the organisation (including their agreed meaning)
- any requirements for witnessing or counter signing documentation (and the meaning and responsibility assigned to these practices)
- requirements for access, storing, archiving and retaining documentation
- requirements for documentation of verbal orders and provision of telephone advice/information
- requirements for confidentiality and privacy.

## Monitoring of documentation

An audit process is one component of appropriate risk management. An audit process will play an important role in monitoring quality and standard of care and the ability to produce accurate and complete coded data from available documentation and records. Audit tools developed at a local level to monitor the standards of documentation form the basis for review. The need to maintain confidentiality of patient information equally applies to documentation audit processes.

Organisations are encouraged to develop and implement an appropriate documentation policy and undertake regular auditing and monitoring of documentation and record keeping.

As maintaining the highest standard of patient care and the highest quality of coding rely significantly on the completeness, accuracy and currency of documentation, auditing and monitoring processes should focus on evaluating these areas.

### **A review of the standard and quality of the documentation may include compliance with;**

- relevant documentation policy and procedures
- professional/industry/sector standards
- relevant legislation
- consistency of understanding/documentation practices across organisation
- identified gaps of inconsistencies/discrepancies in documentation
- content/context of documentation
- requirements for coding.

### **A review of the evidentiary compliance of the documentation may include;**

- that the document is contemporary
- that the documentation is a factual and true record (authentic)
- that the documentation is based on evidence and observation (accurate)
- the timeliness of entries
- inclusive of planned care provided and actions taken
- that the documentation is a complete record.

# Clinical Competence in Relation to Documentation

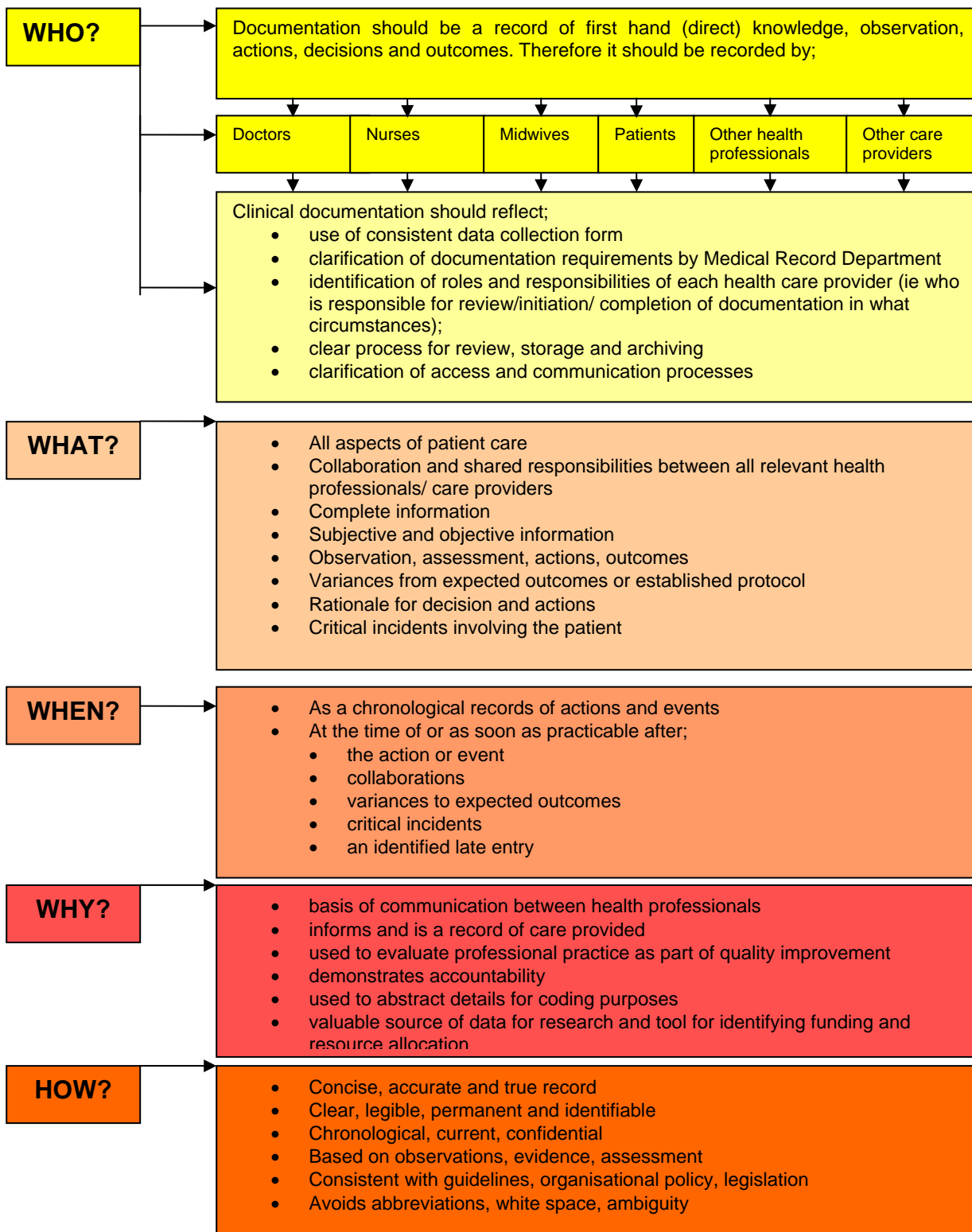
---

## **Appropriate documentation promotes;**

- a high standard of clinical care
- continuity of care
- improved communication and dissemination of information between and across service providers
- an accurate account of treatment, intervention and care planning
- improved goal setting and evaluation of care outcomes
- improved early detection of problems and changes in health status
- evidence of patient care.

## **A clinician's documentation should be able to demonstrate;**

- a full account of the clinician's assessment of the patient and the care planned and provided
- relevant information in relation to the patient's condition at any given time and the interventions and actions taken to achieve identified health outcomes and/or respond to actual or potential adverse events
- evidence that the clinician met their duty of care and taken all reasonable decisions and actions to provide the highest standard of care
- evidence that the clinician met their duty of care and that any actions or omissions did not compromise the patients safety or identified health outcomes
- a record of all communications with other relevant others in relation to the patient



# GUIDING PRINCIPLES FOR DOCUMENTATION

---

## **Guiding Principle 1: Comprehensive and complete record**

**Clinical staff have a professional obligation to maintain documentation that is clear, concise and comprehensive, as an accurate and true record of care.**

Professional documentation by clinical staff is an integral part of practice to ensure safe and effective care. Documentation is a record of the care provided, and the judgement and critical thinking used by a health professional in the provision of that care.

Documentation acts as evidence of the unique and important contribution of each staff member to health care. It forms the basis for evidence of care that can be used for research, legal analysis and determination, allocation of resources and as a primary communication between health professionals.

## **Comprehensive and complete documentation and record keeping**

- clear, concise, complete record of clinical care (including, assessment, plan of action outcomes and evaluation of care)
- factual, accurate, true and honest record
- avoids duplication of information
- legible and non-erasable, permanent, retrievable, confidential, patient-focussed and non- judgmental
- representative and reflective of professional observations and assessment
- timely and completed as close as possible after episode of care or event
- a complete record including completed forms, charts, methods and systems
- chronological record of care (late entries recorded as soon as possible as to rectify the absence)
- prefaced with date and time of care or event (including recording of late entries, changes or additions)
- identifying details of person who provided / documented care
- identifying of source of information (including information provided by another health care professional or provider)
- inclusive of signatures (or initials) and professional designation of person recording information
- contains meaningful and relevant information (avoids meaningless phrases such as '*slept well*' or '*usual day*')
- minimise transcription of data
- easily interpreted over time and after significant time has elapsed
- avoid use of abbreviations (other than those approved and documented in organisational policy by the Medical Record Department)
- detailed documentation in relation to critical incidents such as patient falls, harm to patients, or medication errors.

## **Guiding Principle 2: Patient centred and Collaborative** **Documentation is patient centred, patient focussed, collaborative and appropriate to the setting in which the care is provided and the purpose for which the information recorded.**

Documentation must be patient-focussed. Clinical documentation may record diverse information within and across services and settings. Given the diversity of care provided, clinicians must consider the purpose of documentation and how, by whom and for what purpose that information is to be used.

Effective documentation systems require regular review and revision.

### **Patient centred documentation and record keeping**

- documentation systems and practices appropriate to the specific needs of the patient/patient population and context of the care
- appropriate documentation systems to support shared documentation processes
- a record of independent and collaborative actions with other health professionals or care providers (eg those ordered by another appropriate health professional)
- contemporary, secure, resource efficient documentation systems
- documentation systems relevant to the setting in which the care occurs (including patient held records, electronic records and mobile record systems)
- identification of objective and subjective data in documenting assessment of the patient needs/health status
- individualised, comprehensive and current plan of care
- based on professional observation and assessment that does not have any basis in unfounded conclusions of personal judgements
- identifies problems that have arisen and actions taken to rectify/address
- frequency of documentation consistent with professional judgement in relation to complexity/stability of patient, organisational policy, standards and legislation
- documented valid consent of any clinician proposed intervention or operation
- accessible relevant previous/other documentation (including patient history, long and short term intervention, diagnostic investigations most recent previous documentation by other clinical staff)
- appropriate supporting documentation systems and forms
- documentation of intervention via telephone ( including information obtained and advice given)

### **Guiding Principle 3: Ensure and maintain confidentiality**

#### **Documentation systems (including electronic systems) will ensure and maintain patient confidentiality, in all care settings.**

Clinicians have legislative, professional and ethical obligations to protect patient confidentiality. It is essential that the confidentiality of that information be safeguarded and shared only as necessary to protect the interests of the person and to ensure the best outcomes of care. This includes maintaining confidential documentation and patient records.

Electronic information, mail and communication systems are increasingly used as effective means of maintaining and transferring documentation and information in the health care environment. Precautions must be taken to ensure that clinical staff are fully informed of appropriate, safe and secure use of electronic information systems.

It should be assumed that any and all clinical documentation will be scrutinised at some point.

#### **Confidential documentation and record keeping**

- ensure and maintain the confidentiality of the patient
- develop and implement practices that protect confidentiality of information and data when documenting in a record (including charts)
- records stored and archived confidentially
- confidentiality of electronic documentation and information
- systems and practices are in place that maximise the confidentiality of documentation and records in diverse settings
- systems for sharing information with others ensures only relevant information with relevant others (also required to maintain confidentiality)
- ensuring copies are used, managed stored and/or destroyed appropriately
- ensure copies are readable (including photocopies/faxes)
- patient records are secure from unauthorised access, loss or theft during transfer, transmission (ie electronic transfer) or transportation
- disposing of documentation (where appropriate to destroy) in a manner which maintains confidentiality (eg confidential bins /shredding)
- those accessing (or seeking to access) documentation have the authority to access it.
- meets requirements for storage and disposal scheduling.

## Additional details for Principle 1

- Information documented during or immediately after care is provided or an event has occurred is considered to be more reliable and a more accurate record of care or an event than information recorded later, based on memory.
- Chronological entries present a clear picture and sequence of care provided and events over time and facilitate better communication amongst and between care providers. Late entries should be appropriately recorded as soon as possible as to rectify the absence.
- For documentation to be reliable it must clearly state when care was provided or an event occurred. Ensuring entries are made as close to the time of the care or the event is essential but where this has not occurred clinical staff may make late entries. The time should be an accurate record of the correct time of the event. Late entries must only be made when the clinician can accurately recall the care provided or the event. For this reason, making a late entry into the patient records must be voluntary and should be clearly identified as a late entry. Changes or additions should be minimised as they can lead to confusing records and perceptions of poor care and decision making practices. Changes or additions should be clearly marked as such and should not obscure or delete any previously recorded entry or data. Changes must only be made to the clinician's own documentation (never to another person's documentation).
- Clinicians may obtain information from a third person that is relative to the patient's care (eg a family member). In these circumstances the information is documented and should include the source of the information. The exception to this is if the person is another patient, if so they should not be identified by name *eg patient in next bed stated...*.
- The clinician who provided the care or witnessed the event should be the person who documents the information. An exception may be where a specific scenario has a designated recorder (such as in a cardiac arrest), or where one clinician assists another to provide care (such as another clinician to support a patient to ambulate). Where a clinician is documenting information (as a designated recorder) the recorder must identify the other person/s (and their role or professional designation) to accurately identify them as part of the care provided or the event.
- Transcription of data potentially increases the risk of error of documentation due to for example inaccurate, misinterpreted misspelt information. It is not appropriate for a clinician to transcribe Medication Orders unless they are an authorised prescriber.

## Additional details for Principle 1 (cont)

- Legal or regulatory proceedings may eventuate after a significant period of time has elapsed after the event. As a general rule legal proceedings tend to find that written records are considered more accurate and credible when recorded in a timely manner. Further written records are more credible than verbal accounts after the event (more influenced by memory). Health care documentation is admissible in legal proceedings without the person who documented giving additional evidence. Therefore it is pertinent that documentation be able to be clearly interpreted and understood over extended period of time as stand alone evidence and without further clarification or explanation from the person who wrote the. Timeliness should be seen to mean at the time the clinician undertook/provided the care or as soon as practicable after the care was provided.
- Abbreviations and symbols can be an effective and efficient form of documentation if their meaning is well understood by the health provider who is using them and/or reading them. Abbreviations that are obscure, poorly defined and open to broad interpretation or have multiple meanings can lead to confusion and error in relation to patient care. Abbreviations should only be used where they are approved and defined by organisational policy
- Organisational policy normally requires documentation of critical incidents involving patients to be documented on a purpose specific form. Regardless of whether a separate report is required, clinical staff have a professional obligation to document such incidents in the patient health care record as a true and honest record of the event and the actions taken in response to it.
- Legislation and standards of practice of the professions require nurses and midwives to document the care that they provide as a record of their accountability for their actions and decisions. Clinical staff sign their entries in patient records to indicate their accountability for their actions and decisions.

## Additional details for Principle 2

- Generally, organisations who employ health professionals to document or record information in relation to patient health care needs and interventions of care are the legal owners of that documentation. Increasingly however, documentation and records may be held by the patient and/or may be shared (including shared responsibility and ownership) across a number of organisations or service providers. Patients may also own their own health records. When keeping shared records, consideration must be given to each organisation's and individual's responsibility in relation to recording data/events, access (to read/document in), retaining/archiving records, review of documentation (eg care plans) and informing others of change. Such consideration may identify the need to retain copies of shared records within negotiated protocols.
- Clinical staff often collaborate with other health professionals and care providers. This may involve speaking with a medical practitioner or allied health professional and may occur in person or using such means as telephone, case conferences, teleconferencing and other electronic or communication technologies.

This may also involve shared documentation (including pro forma, patient progress notes, history taking etc). This collaboration is documented in the patient record and should include information in relation to the nature or the collaboration, the persons involved and the plan of actions and/or outcomes agreed upon and any determination in terms of continued collaboration.

- Documentation should record both the clinical actions and any information given, and the patient's response to illness and the care they receive, including refusal of treatment. Subjective data is an important component of assessing the patient's health status and care needs. It must also however be supported by objective assessment that is non-judgmental and based on observation and evidence. Clinical documentation reflects dignity and respect for the patient, their significant support network and other members of the health care team.
- Clinical staff document conclusions and decisions that can be supported by data. Documentation does not reflect value judgements about a patient, their behaviour or their circumstances. Value judgements or any other unfounded conclusions may be taken by others to reflect fact and have the potential to influence (even unconsciously) other health professionals or providers in their assessment of the patient and/or their relationship with the patient.

*Example:*

*Nurses and midwives should avoid statements such as 'patient uncooperative' or 'patient depressed'. Documentation reflects observed behaviour such as 'patient refuses bath, shouts*

## Additional details for Principle 3

- In relation to electronic documentation systems, the following are important
  - maintaining the confidentiality of passwords or any other access information
  - changing a password as per the organisation's policy or more frequently if security risk has been identified
  - using passwords that are not easily deciphered (eg date of birth that can be accessed in personnel record)
  - being aware and up to date on policies and procedures related to access to confidential information
  - fully logging off when not using the system or when leaving a terminal
  - maintaining confidentiality of any hard copy information reproduced from the electronic system
  - protecting the confidentiality of information as it is displayed on monitors (including consideration of the location and direction of monitors)
  - never deleting information
  - only accessing information for which the clinician has a professional need to access
  - using only secure electronic information and communication systems approved by the organisation
  - use of confidentiality statements and warnings on email transmissions (ie only to be read by intended recipient)
  - verifying that the information is legible and complete when receiving electronic documentation (eg medical orders being confirmed by fax)
  - ensuring the recipient has been informed so as to retrieve faxed documentation as soon as possible.

## References

- College of Nurses of Ontario *Practice Standards Documentation* (2004)
- American Health Information Management Association *Long Term Care health Information Practice and Documentation Standards* (Sept 2001)
- College of Registered Nurses of Nova Scotia *Documenting Care A Guide for Registered Nurses* (first printed 1997, revised 2002)
- Nursing & Midwifery Council *Guidelines for records and record keeping* (April 2002)
- Navuluri, Ramesh B., (2001) *Documentation: What, Why, When, Where, Who and How? Research for Nursing Practice* Spring 2001
- Richmond J (Edit) *Nursing Documentation writing what we do* Ausmed Pub2001
- South Australian Department of Human Services *Medical Record Documentation and Data Capture Standards* August (2000)
- South Australian Nursing Board Draft Guidelines for Documentation  
[http://www.nursesboard.sa.gov.au/word/Draft\\_Guidelines\\_for\\_Documentation.doc](http://www.nursesboard.sa.gov.au/word/Draft_Guidelines_for_Documentation.doc), accessed 22.8.2007
- Staunton & Chiarella *Nursing and the Law* 5<sup>th</sup> Edit Churchill Livingstone 2003