Back To Basics: Documentation June 2018

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Learning Outcomes

• Describe the general principles of a well written patient record
• Discuss legal implications of documentation
• Identify some of the common problems with documentation
• Identify the correct procedure to correct the medical record and to make a late entry
• Discuss the elements required in daily clinical documentation
Health Care Records

A Clinical Record is a “collection of data and information gathered or generated to record the clinical care and health status of an individual or group”, this includes but is not limited to;

- Paper documents (incident reports & progress notes)
- Photographic & X-ray images
- Video & audio recordings
- Digital storage or digital equivalents (x-ray images)
- Patient management systems (Clinical Pathways)
- Databases/accounting systems
General Principles of Good Documentation - FACTUAL

**F**ocused on the client
**A**ccurate
**C**omplete
**T**imely
**U**nderstandable
**A**lways Objective
**L**egible
<table>
<thead>
<tr>
<th>Objective</th>
<th>Subjective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half of breakfast eaten</td>
<td>Pt didn’t like breakfast</td>
</tr>
<tr>
<td>Limping on left side observed when walking</td>
<td>Has a sore leg</td>
</tr>
<tr>
<td>No complaints of pain</td>
<td>Had a good day</td>
</tr>
<tr>
<td>Pt grimacing and reporting pain</td>
<td>Pt was in pain</td>
</tr>
</tbody>
</table>
Abbreviations / Symbols

What if you see the following charted?

The patient was LTBB – What do you think it means??

- Avoid abbreviations.
- Nominated references for abbreviation is the Australian Dictionary of Clinical Abbreviations, Acronyms & Symbols.
- If abbreviations are used they must be written out in full for the first entry of each episode of care to avoid misinterpretation.

LTBB – Lucky to be breathing.
A Client Record should facilitate

- A record of all transactions relating to the provision of clinical care
- Efficient and effective communication and client care across the continuum through tracking of client assessment, care delivery and evaluation of care
- Collection of information required for review and consultation
- Research, risk management, clinical governance, best practice and quality processes
- Support for medical-legal defence
Purpose: to provide a record

Medical Documentation: is to facilitate an optimal patient outcome through the;

➢ Accurate
➢ Objective
➢ Contemporaneous description of ongoing care.
Principles

- Evaluate care
- Demonstrate decision making
- Report by exception if using a Care Plan or Clinical Pathway
- Accurate
- Up to date
- Being used appropriately

- Quality/Quantity:
  - constructive
  - relevant
  - objective
  - verbatim
  - outcome focused
Practical Documentation

- Use black ink
- Date & time on each entry (use a 24 hour clock)
- Objective language – facts, not opinions
- Legible
- Do not obliterate (do not hide errors)
- Sign with name & designation
- Only use acceptable abbreviations, preferably avoid
When to Document

- Documentation should occur regularly at a minimum of once in a 24 hour period
- Significant event occurs
- Decisions or interventions
- Test or investigation ordered
- The patient’s condition improves or deteriorates
- Consultations
- Observations of the patient’s condition
- Decision makers/family members/others are consulted in relation to the care and treatment of the patient
Alerts

- Allergies
- ARP
- AHD
- Mental Health Act.
- Infections
- Falls and other risks

Where do you record it? Who records it?
Important points

- Forgotten information at time of entry should be included as an addendum
- Do not transcribe
- The person who carried out the procedure or administers the drug should write the report
- Never write or sign a report on behalf of another
- Avoid documenting information that has been passed on by others
- If you are required to countersign an entry, you must not do so unless you are satisfied that the drug/treatment was in fact administered.

If in doubt, do not countersign!
Identification

- ID labels should be on right hand side corner of each page of each form in the clinical record.
- If for any reason ID labels are limited or there is a limited space 3 identifiers i.e., patient’s name, date of birth and UR number should be written.

Why?
This could happen...

Knowing the identity of a patient is critical. Delivering important information to the wrong person is not only scary to the recipient, but it can result in a HIPAA violation. Not to mention, it can be quite embarrassing.

Use at least two ways to identify patients. For example, use the patient’s name and date of birth. This is done to make sure that each patient gets the correct medicine, information, and treatment.

It is also good practice to label any containers used for collecting blood or other specimens in the presence of the patient.

For more information on the Joint Commission Patient Safety Goals, go to www.jointcommission.org
Maintaining Accurate & Detailed Notes

Ask yourself:

- Does this note tell the whole story?
- Will I be able to understand this note in 7 years time?
Clinical Record Forms

- Use approved clinical forms.
- Forms must be authorised by MNHHS clinical forms committee.
- Refer to CISS form register for accessing a list of approved clinical record forms and filing structure.
- Individual form filing is a responsibility of the staff member initiating the documentation.
Contextualise your documentation process for the clinical area in which you work according to patients needs e.g. Rehabilitation or Intensive Care.
Implications

Documentation failings can be a symptom of other workplace issues, such as scope of practice awareness, clinical handover and discharge planning.

Incidents occur where the failure to effectively **document, escalate and hand over care**, can affect patient outcomes.
Common problems

- Action => documentation
- Subjective vs objective
- Print name after signature
- Legibility
- ID stickers on each page, both sides
- Review and change NCP document
- Don’t put info into the medical record on post it notes….why?
- Don’t forget to use “alert” stickers
Clinical Handover

Formalises the transfer of professional accountability and responsibility from some or all aspects of care of the patient, or group of patients, to another person or professional group on a temporary or permanent basis (Australian Commission on Safety and Quality in Health Care, 2011)

Within CISS – clinical handover should provide “appropriate and adequate clinical information which supports a seamless and safe continuum of care for the client/resident/patient” (CISS Clinical Handover procedure).
Communicating Clinical Concerns

Communication Tool

**IDENTIFY**
- Identify self, name, position, location
- Identify patient name, age, sex, location

**SITUATION**
- State Purpose: "The reason I am calling is ..."
- If urgent, say so

**BACKGROUND**
- Provide relevant information
  - Relevant history
  - Relevant examination including vital signs & MEWS
  - Relevant test results
  - Current medication

**ASSESSMENT**
- State what you think is going on
  - I think the problem is ... or I don't know what the problem is but I am concerned"

**REQUEST**
- State request
  - I would like you to ...
  - (give timeframe for actions)
  - Review the patient
  - Perform / review tests

**RECOMMENDATION**
- I would like you to ...
  - e.g. Review regarding need for transfer to CCU
  - Come to see patient
  - Tests ...
  - Change in treatment
Benefits of Utilising a Standardised Communication Framework

• Assists in effective communication (concise and focused) between healthcare colleagues

• Improved flow of communication

• Improves accuracy

• Standardises messages

• Develops teamwork

• Improves client safety
ISBAR

ISBAR – what does it stand for?

I - Identify
S - Situation
B - Background
A - Assessment
R - Request
Confidentiality and Access to Records

Patients have a right to confidentiality.

Access given:

- Health Care Providers
- Therapeutic Benefit
- Research
- Police/Third Parties (through appropriate process)
- Patients/Family Members
- Freedom of Information Act 1992
- Administrative access to Health Records
- Don’t leave charts lying around
Negligence

Negligence can be defined as:

... an act or omission which, in the opinion of the court, is below the standard reasonably required in the circumstances

4 ‘D’ Elements of a successful action in the tort of negligence:

1. **Duty** of Care
2. Breach of the Duty of Care *(Dereliction)*
3. **Damage** as a result of the breach
4. **Direct** damage caused as a result of the breach
Ways to minimise liability:

- Code of Ethics for Nurses and Midwives
- Develop therapeutic relationships with patients & families
  - effective & regular communication
  - know clients expectations & meet appropriate needs
- Maintain clinical competence
- Know your legal responsibilities – scope of practice
- Accountable for practice
- Document, document, document - ESCALATE
- Decrease risk of system error
Anything else?

- Observations – full, any variations. QADDS score
- Weight - variations
- Complaints of nausea, pain or discomfort – action and evaluation
- Current infections – actions and follow-up
- Any changes in the patient’s physical and cognitive abilities
- Any incidents and their outcomes
- Referrals that need following up
- Any requests or feedback from patient, family member or carer
- Changes to medication regime
- Frequency of prn/ staff initiated meds over the past month – does action need to be taken?

Please refer to CISS Procedure 0017
Questions?