

Training requirements for student placements

Documentation learning module – Transcript

December 2015

Slide 1

Welcome to this learning module on Documentation.

Clinical records must contain all aspects of a health consumer's care. They must also meet legal requirements and industry standards in order to manage patient safety and quality risks.

Slide 2 – Learning Objective

Clinical documentation can apply to every component of a patient's record including a progress note, consent form, a clinical finding or investigation. The objective of this training module is to orientate allied health staff and students to the clinical and legal guidelines for documentation within Queensland health. It will cover; what to document, how to document it, confidentiality and documentation by non-Queensland health personnel.

Slide 3 – Good clinical documentation

Good clinical documentation will achieve many things.

For example it will:

- Ensure that a complete record of health care is created
- Substantiate decisions and management plans
- Support continuity of care
- Facilitate proactive and reactive risk management
- Help prevent and defend legal claims
- Provide useful information for quality improvement and research purposes

Remember: The test of a good clinical record is - will this clinical record tell the whole story in a year?

Slide 4 – Management of records

There are certain rules pertaining to medical records. Firstly, access to a patient's chart is essential at all times. This means that you should not remove a clinical record from a ward while a patient is admitted. For records of patients that are not currently admitted, there will be administration processes to follow to ensure that the chart can be located at any time in case of an emergency admission.

You may be required to keep parallel records, for example in a rehabilitation or outpatient unit. Your supervisor will be able to provide guidance on how to identify a parallel record in the main medical chart. Record keeping expectations can differ across clinical areas while remaining in line with professional practice and medico legal considerations.

Many Queensland Health facilities will be transitioning to electronic medical records. You will be advised by your supervisor if training is required.

Slide 5 – Privacy

Queensland Health places very high importance on maintaining patient confidentiality and protecting privacy and is committed to ensuring that the privacy and confidentiality of personal information collected is maintained. That commitment is supported by nine National Privacy Principles in the *Information Privacy Act 2009 and strict confidentiality obligations of the Hospital and Health Boards Act 2011*.

Slide 6 – Confidentiality

Confidentiality applies to documentation in many different ways.

The Hospital and Health Boards Act covers the patient's chart but also other written information from which health consumers could be identified, such as appointments handwritten in diaries, notes written in notebooks, case studies and presentations. This means that any written information from which a person could be identified MUST NOT be removed from the health facility without first being de-identified.

Queensland Health information must not be stored on USB devices and if stored temporarily (e.g. for a presentation) must be stored and secured on and approved USB with the approval from your supervisor. It is a good idea to check with your supervisor what information can be temporarily stored on a USB for short-term use. USB devices housing Queensland Health information cannot be removed from the health service premises.

You should not show clinical records to a consumer. If the patient requests access to their records, advise your supervisor.

Sometimes working in a health care setting can be stressful, or exciting. Take care not to identify patients if debriefing with people who are not staff. This includes social media avenues.

Lastly, you should gain and document consent from a patient to share information with others. For example, seeking consent to call a family member to discuss a patient's preadmission level of function.

Slide 7 – What to document

The first step to documentation is to confirm that the record you are adding to belongs to the correct patient.

Information that might be documented in a clinical record will vary depending on the setting, profession and local guidelines.

Allied health will often include details of consent, the patient's history, assessments, interventions and care planning. Guidance should be available from your supervisor regarding what is required in your area.

Slide 8 – You should record

As a general rule, you should record

- Contemporaneous notes. Always record the date the entry was made. If you are late in recording your entry, demonstrate this with, “Written in retrospect” and when the service occurred
- Enter the time in the left hand margin using the 24-hour clock
- Your signature and name hand written with designation underneath, including if you are a student. Electronic notes will record this information automatically.
- Write in black pen
- Use approved abbreviations only. Please refer to your supervisor for a list of approved abbreviations.

Slide 9 – Additional Points

If you do make any mistakes when writing an entry, correct the error with a single line through the text, include your initials and write “written in error”. It is important that what was initially written remains legible. Blank areas surrounding written entries should be minimised by crossing through gaps and lines between entries.

It is important to always be objective and accurate. Be sure that your writing is legible and that you have included sufficient detail. For example, noting that the patient was “pale, sweating and shaking” is more objective than to simply state the patient was “in shock”.

Slide 10 – How to present your information

There are many tools available to structure the order of information included in a clinical record. One example is **SOAP** which stands for subjective, objective, assessment and plan. Different departments may have other tool for their area. The benefit of using a tool such as SOAP is that it guides where to begin, how to progress and important points to include.

Slide 11 – Hand written example

Here is a handwritten entry from an occupational therapist. We can see that:

- The patients identification is clearly marked
- She used a black pen
- She entered the date, (circle) and time using the 24-hour clock (circle) in the left hand margin.
- She has crossed through gaps.
- She signed the entry (circle) and wrote her name clearly in full underneath (circle) with her title (circle).

Slide 12 – Electronic example

This is an example of an electronic Physiotherapy chart entry in an Intensive Care Unit.

The format is slightly different and will be dictated by the program that is used. Regardless of which program is used, it is still important to include crucial information such as date and time and the name of the treating therapist. The SOAP format has been used in both the written and electronic examples.

Slide 13 – Non Queensland Health personnel

Non Queensland Health personnel include students both undergraduate and post graduate. Any individual who is not employed by Queensland Health must have their chart entries co-signed by a health professional who is employed by Queensland Health. Often students will draft their clinical record for an educator to review prior to entering it in the official record. This remains the decision of the clinical educator.

Slide 14 – Take home message

Important points about documentation are:

- To use **SOAP** notes or other tools to guide your content and layout.
- As a student always have your supervisor or clinical educator co-sign or annotate your notes.
- Always keep written information about health consumers confidential.