Clinical Documentation Policy

1. Purpose

The purpose of this policy is to outline the requirements for clinical documentation in healthcare records across WA Country Health Service (WACHS) sites and services.

Clinical documentation is an essential component of safe, effective integrated, multi-disciplinary, continuity of care. Given the complexity of health care and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians. Undocumented or poorly documented information relies on memory and is less likely to be communicated and retained. This can lead to a loss of information, which can result in misdiagnosis and harm.[1,2]

2. Policy

2.1 Scope

This policy applies to all WACHS staff, undergraduate or postgraduate health related students and authorised contracted health providers who document in the healthcare record.

Healthcare records are inclusive of paper and electronic records, this includes the My Health Record where applicable.

This policy does not cover documentation in the context of:

- Health records management
- Patient administration systems and clinical systems
- Clinical incident management
- Patient confidentiality
- Information management
- Information and communications technology
- Information received via third party communications.

2.2 Principles

The principles for documentation in the healthcare record include:

- Information is integrated for the multidisciplinary team (MDT) i.e., there are not separate sections for each professional group.
- Documentation represents accurate statements of:
  - interactions between the patient and their significant others, and the health service relating to assessment (including physical examination), diagnosis, care planning, management / care / treatment / services provided and response / outcomes
  - professional advice sought and provided
  - observations taken
  - results and follow up of investigations or tests.
- Information is sufficiently clear, structured, and detailed to enable other members of the MDT to assume care of the patient or to provide ongoing service at any time.

- Information is written in an objective tone and shows respect for patients, is non-judgemental and does not include remarks that may be interpreted as prejudiced, demeaning, derogatory, discriminatory, racist, or culturally unsafe.
- Documentation distinguishes between what was observed or performed, what was reported by others as happening, and/or professional opinion.
- Documentation is completed at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.
- Documentation is in the correct patient record, on a form with the correct patient label, and/or a clinical image containing the necessary identifiers – refer to the WACHS Health Record Management Policy, Patient Identification Policy and Clinical Image Photography and Videography Policy for further guidance.
- For documents where no clinician signing is required, ensure appropriate supervision and consideration of delegation responsibilities and requirements. For nurses and midwives refer to decision making framework and supervision resources from the Nursing and Midwifery Board of Australia.
- Chatbots, such as MS Co-Pilot and ChatGPT, must not be used to generate notes for the healthcare record.

2.3 Minimum documentation standards

Documentation in the healthcare record must comply with the following:

- Be on approved healthcare record forms and/or clinical applications.
- Be clear and accurate.
- Be legible and in English.
- Information is sequential – lines left between entries in paper-based records, must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.
- Be written in black water-fast ink (for paper-based records). The exception is for Pharmacists who are approved to use purple ink to differentiate their notations. Post-it notes, highlighters and stamps (other than self-inking stamps) must not be used.
- Have time of entry (using a 24-hour clock – hh:mm).
- Have date of entry (using dd/mm/yy or dd/mm/yyyy).
- Minimise the use of abbreviations and symbols.
- Each page of the healthcare record, or on each screen of an electronic record (with the exception of pop-up screens where the identifying details remain visible behind) must contain the three core identifiers:
  - Unit Medical Record Number (UMRN)
  - Patient family name and given name(s)
  - Date of birth (or gestational age / age if date of birth is estimated).
- A patient identification label is preferred for paper-based records but must not cover any handwritten patient identification already on a form.
- For progress notes and records indicating ‘sign off’ is needed, be signed by the author and to include their printed name and designation. In electronic systems this will require the use of an appropriate identification system e.g., electronic signature.
- Be relevant to that patient.
- Only include personal information about other people when relevant and necessary for the care and treatment of the patient.
- Consultation with another health practitioner is documented. Where clinical decision making and patient care is discussed, the advice is to be documented, including the consulted practitioner’s name, designation, and site.

- Include documentation of patient management where this varies from endorsed WACHS policy documents. This must include details of the clinical opinion and reasons for the variation.
- Include a copy of certificates, such as medical and workers compensation certificates, that have been provided to a patient.
- Include a notation in the healthcare record where clinicians use dictated letters to outline treatment plans. To maintain continuity of care the notation should indicate the timeframe of availability [of the letter] and reference to the correspondence section of the healthcare record for access [to the letter].

2.4 Co-signing of entries

Documentation in the healthcare record where co-signing / counter signing is required, entries must be signed by both parties (supervisor and supervisee). This includes signature, printing name and designation; or initialling (as indicated).

Local orientation should cover the practicalities of ensuring this process in paper-based records, electronic records and other clinical applications.

Electronic records
Entries are made by those authorised (i.e. have a login). Where entries are made by those being supervised and require co-signing, the supervisee can make the entry under supervision of the WACHS staff member. Co-sign statements by both parties must be made at the end of the entry.

2.5 Addendums to entries

Where an entry omits details, any additional details must be documented next to the heading ‘Addendum’, including the date and time of the omitted event and the date and time of the addendum. For paper-based records, addendums must be appropriately integrated within the record and not documented on additional papers and/or attached to existing forms.

2.6 Entries written in error

Entries that are written in error must be appropriately corrected:
- No alteration and correction of records is to render information in the records illegible.
- An original incorrect entry must remain readable i.e., do not overwrite incorrect entries, do not use correction fluid.
- An accepted method of correction for paper-based records is to draw a line through the incorrect entry or ‘strikethrough’ text in electronic records; document “written in error”, followed by the author’s printed name, signature, designation and date / time of correction.
- For electronic records the history of audited changes must be retained.

2.7 Cloning or copying entries

In electronic records:
- Cloning of documentation is prohibited. If documentation is pulled forward or copied, it must be reviewed and updated or edited for accuracy prior to author authentication.
- It is appropriate to copy and include information needed to support clinical decision making and the care rendered during a specific episode of care.

- Information copied from a previous note by the same author should include only that information that is unchanged.

2.8 Frequency of entries

Entries in acute care settings must be made when changes in clinical status or care planning occur or at least once each shift.

For residential care or long stay settings entries must be made at least once per day. Additional entries are to be made to reflect changes in the patient/resident status, condition and / or treatment or care plan as these occur.

For non-admitted patients (outpatients, community services) entries must be made for each patient attendance / episodes of care / clinical contact (including video conference and teleconference sessions), for failures to attend and entries that do not involve patient attendance (e.g. consulting with another health professional, or meeting with a teacher / daycare etc.) and include phone communication with family, carers and/or other professionals relevant to patient care as soon as possible after the event.

2.9 Labels

Non-permanent adhesive labels must be avoided. Where considered essential the label must be relevant to the patient and placed so that they do not occlude any other entry to the healthcare record.

3. Roles and Responsibilities

To support safe, comprehensive, multidisciplinary, integrated and continuous healthcare, all clinicians are to follow the principles of documentation and the requirements for entries in the patient healthcare record outlined in this policy. Those documenting in the healthcare record are to work within their scope of practice, level of training / education and job role.

All staff are required to comply with the directions in WACHS policies and procedures as per their roles and responsibilities. Guidelines are the recommended course of action for WACHS, and staff are expected to use this information to guide practice. If staff are unsure which policies procedures and guidelines apply to their role or scope of practice, and/or are unsure of the application of directions they should consult their manager in the first instance.

4. Monitoring and Evaluation

Monitoring of compliance with this policy directive will be via audit of healthcare record documentation as specified in the WACHS Audit and Reporting Framework.

Audit findings and any recommendations will at a minimum be reported to regional Clinical Governance Committees for review and identification of any opportunities for improvement and escalated to the WACHS Safety and Quality Executive Committee as relevant.

This policy will be reviewed and evaluated as required to ensure relevance and currency by the Director Safety and Quality. At a minimum it will be reviewed within one (1) year after first issue and evaluated at a minimum every three (3) years thereafter.

5. References

1. Bhabra G, Mackeith S, Monteiro P, Pothier DD. An experimental comparison of handover methods. Ann RCSE 2007;89(3):298–300
2. Pothier D, Monteiro P, Mooktiar M, Shaw A. Pilot study to show the loss of important data in nursing handover. Br J Nurs 2005;14(20):1090–102
3. Australian Commission for Safety and Quality in Health Care. National Safety and Quality Health Service Standards Second edition [Internet]. Sydney, NSW: Australian Commission for Safety and Quality in Health Care; 2017 [Accessed: 09 November 2023]
4. Australian Government Aged Care Quality and Safety Commission. Aged Care Quality Standards - Standard 2. Ongoing assessment and planning with consumers, requirement (3)(d) [Internet] [updated 2020 Jan; cited 2020 Nov 06; Accessed 09 November 2023]
5. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia [Internet] AHPRA October 2020 [Accessed 23 April 2024]
6. Nursing and Midwifery Board of Australia. Decision-making framework [Internet] AHPRA. March 2020 [Accessed 23 August 2024]
7. Nursing and Midwfiery Board of Australia. Supervised Practice [Internet] AHPRA June 2023 [Accessed 23 August 2024]

6. Document Summary

Coverage	WACHS wide
Audience	All WACHS staff, undergraduate or postgraduate health related students and authorised contracted health providers who document in the healthcare record.
Records Management	Health Record Management Policy
Related Legislation	Nil
Related Mandatory Policies / Frameworks	• Assistant in Nursing Duties (Nursing Setting) • Assistant in Nursing Duties (Maternity Setting) • Clinical Incident Management Policy 2019 MP 0122/19 • Clinical Governance, Safety and Quality Policy Framework • Information Management Framework • Information and Communications Technology Framework
Related WACHS Policy Documents	• Clinical Image Photography and Videography Policy • Health Record Form Management Policy • Health Record Management Policy • Medication Prescribing and Administration Policy • Patient Administration Systems and Clinical Systems Business Rules Policy • Patient Identification Policy
Other Related Documents	ACSQHC Recommendations for terminology, abbreviations and symbols used in medicines documentation
Related Forms	Nil
Related Training Packages	Nil
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 3525
National Safety and Quality Health Service (NSQHS) Standards	1.15, 1.16, 1.17, 1.18, 6.1, 6.4, 6.5, 6.11
Aged Care Quality Standards	Standard 2(3)(d)
Chief Psychiatrist's Standards for Clinical Care	Standard: Assessment (2.3)
Australian Standards	AS2828.1 and AS2828.2

7. Document Control

Version	Published date	Current from	Summary of changes
5.00	18 November 2024	18 November 2024	• reformatted as a policy with an update to the title • removal of duplicate information and information covered in other policies; inclusion of principles for all documentation to reduce duplication across disciplines • monitoring information updated to include the new WACHS Audit and Reporting Framework; references updated.

8. Approval

Policy Owner	Executive Director Clinical Excellence
Co-approvers	Executive Director Nursing and Midwifery Services
Contact	Director Safety and Quality
Business Unit	WACHS Safety Quality and Performance
EDRMS #	ED-CO-15-91228

This document can be made available in alternative formats on request.