Documentation - Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for clinical documentation throughout the WA Country Health Service (WACHS).

Health care records are inclusive of paper and electronic media (hybrid) and clinicians need to be aware of and utilise the suite of clinical systems that are available to collect and store health information while being aware of the integration requirements. This includes the My Health Record where a patient has one.

Health care records promote patient safety, continuity of care across time and care settings, and support the transfer of information when the care of a patient is transferred e.g. at clinical handover, during escalation of care for a deteriorating patient and transfer of a patient between settings. The absence of documentation infers care is not completed and may be interpreted by a court of law as evidencing neglect of the patient

This policy supports both the:

- Australian Commission on Safety and Quality in Health Care Communicating for Safety Standard. Specifically, the 'Documentation of information' criterion: Essential information is documented in the healthcare record to ensure patient safety.[2]

  > "The intent of this criterion is to ensure that relevant, accurate, complete and up-to-date information about a patient's care is documented, and clinicians have access to the right information to make safe clinical decisions and to deliver safe, high-quality care" [2]

- Aged Care Quality and Safety Commission's Aged Care Quality Standards, specifically Standard 2. Ongoing assessment and planning with consumers, requirement (3)(d). The intent of this requirement is that:

  > "A care and services plan is expected to be documented and reflect the outcomes of assessment and planning for each consumer. Accurate and up-to-date care and services plans are important for delivering safe and effective care and services, as well as positive outcomes for consumers".[4]

2. Scope

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

The healthcare record includes paper records and electronic records.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.

For guidance on the governance, management, creation, content, filing, accessibility, storage, and disposal of healthcare records refer to WACHS Health Record Management Policy and the WACHS Patient Administration Systems and Clinical Systems Business Rules Policy

3. Mandatory Requirements

Documentation in healthcare records must provide an accurate description of each episode of care or contact with healthcare providers and appropriate measures taken to ensure data quality and accurate identification of the patient. These measures should include but are not limited to:

- Verifying demographic information with the patient before and during a consultation
- The clinician discussing with the patient details about the event that is being documented
- Using the patient health summary (where available including reference to the patient's My Health Record where they have one) to allow the patient to verify accuracy and suggest amendments.

Mandatory requirements for documentation:

- accurate, integrated and readily accessible patient clinical records must be available to the clinical workforce at the point of care[1]
- use of iSoBAR format for handover of all patients and documented as such in alignment with WA Health MP 0095 Clinical Handover Policy and WACHS Allied Health Clinical Handover Policy
- use of the standardised suite of Mental Health Documentation for Mental Health Services (WA Health MP 0155/21 State-wide Standardised Clinical Documentation (SSCD) for Mental Health Services)
- information to ensure essential patient safety:[4]
    - Critical information, alerts and risks
    - Reassessment processes and outcomes
    - Changes to plan of care.

3.1 Privacy and Confidentiality

All information in the healthcare record is confidential and subject to prevailing privacy laws and policies. Healthcare records contain health information which is protected under legislation. Refer to WA Health MP 0010/16 Patient Confidentiality Policy and MP 0015/16 Information Access, Use and Disclosure Policy.

Healthcare staff are to only access a healthcare record and use or disclose information contained in the record when it is directly related to their duties and is essential for the fulfilment of those duties, or as provided for under relevant legislation.

A breach of health information is considered to be an incident whereby information has potentially been viewed, shared, stolen, removed, destroyed or used by an individual unauthorised to do so. Refer to the WA Health MP 0135/20 Information Breach Policy.

4. General Information

The healthcare record is where all health care providers contributing to the care of the patient document all relevant details of that care.

- All entries are to be timely, appropriate and legible; such that any health care provider will be able to determine the status of the patient through review of the record and continue to provide appropriate management
- It is in the best interest of every patient and care provider that the health record contains complete and accurate documentation of each episode of care.

Documentation is an essential component of effective communication. 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]

5. Documentation Processes

5.1 Entry Requirements

5.1.1 Identification on every page/screen/image

Identification using the three (3) core identifiers (full name, date of birth and unique medical record number) must appear **on every page of the health care record**, or on each screen of an electronic record (with the exception of pop up screens where the identifying details remain visible behind). A patient identification label is preferred for hardcopy records but must not cover any handwritten patient identification already on a form.

Care should be taken to ensure documentation is in the correct patient record, on a form with the correct patient label and/or a clinical image contains the necessary identifiers.

Refer to:

- WACHS Patient Identification Policy
- WACHS Clinical Photography Policy

5.1.2 Standards for documentation

5.1.2.1 Paper and Electronic Records:

a. Entries required for each clinical attendance, whether inpatient or outpatient, face to face or via telehealth
b. Entries are to be accurate statements of clinical interactions between the patient and their significant others, and the health service relating to history, physical examination, assessment;

diagnosis; care planning, investigations, procedures and interventions, management / care / treatment / services provided and response / outcomes; professional advice sought and provided; observation/s taken and results

c. All entries will be contemporaneous, and include date and time
d. Entries must be signed and include the designation of the writer, and the initial and surname printed. For electronic records, the use of an electronic signature is required (often generated by the approved systems in use)
e. If an entry is made on behalf of others (e.g. a treatment team) the names of all present should be listed
f. The date will be recorded at the top of each page where clinical care necessitates multiple recordings over a short period of time
g. All entries will be on approved health record forms and clinical applications
h. Use clear language and minimise abbreviations and acronyms. with the exception of when referring to hospitals and departmental names e.g. Emergency Department is abbreviated to ED
i. Use of endorsed terminology where standards exist e.g. Australian Medicines Terminology
j. Entries made by clinicians in or for a patient's health record are not to be removed, left unfiled or deleted unless an appropriately authorised person determines it is to be removed in compliance with the requirements of relevant legislation.
k. Incorrect entries be ruled through with a line, and marked 'written in error' next to the incorrect entry by the author of the original entry
    - An original incorrect entry must remain readable i.e. do not overwrite incorrect entries, do not use correction fluid. An accepted method of correction 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
    - Electronic corrections should provide similar audit content and processes, as for paper records
l. Late entries are permissible but must:
    - be identified as such
    - be signed including designation, dated and timed
    - be entered as soon as possible after the event with an annotated reason
    - include additional information, or identify an omission or correction

5.1.2.2 Electronic records:

a. Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused
b. 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

c. It is appropriate to copy and include information needed to support clinical decision making and the care rendered during a specific episode of care
d. Information copied from a previous note by the same author should include only that information that is unchanged

5.1.2.3 Paper based records

a. All entries are to be made in black, water-fast ink. Black ink is preferred when scanning healthcare records, black reproduces much better quality
b. Pharmacists may use purple ink to differentiate their notation on the medication chart
c. Only original documents are to be documented on. Photocopies of original MR forms are permissible in the healthcare record in specific circumstances (e.g. transfers from other hospitals, faxed from another site or service).
d. Diagrams, tables, graphs and photos with appropriate notation are acceptable means of documentation.
e. Blank lines between entries are to be avoided. A line is to be drawn through, if a line left in error
f. Correction fluid, post it notes, highlighter pens and stamps other than self-inking stamps, must not be used.

5.2 Frequency of Entries

5.2.1 Acute Care Settings

- Nurses/midwives are to make an entry in the patient's health care record at a minimum of once each shift. Entries are to reflect in a timely way the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient's condition and/or treatment are to be documented as these occur where possible
- Midwives to document a minimum of two hourly in latent phase of labour and post cervical ripening, and half hourly once in active labour
- Medical officers are to make an entry in the health care record at the time of events including when reviewing the patient, or as soon as possible afterwards
- Allied health and other health professionals are to make entries to reflect their level of assessment and intervention consistent with the medical management plan, as soon as possible after reviewing the patient.

5.2.2 Residential Care or Long Stay Settings

Entries are to 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.

5.2.3 Non-admitted Patients (Outpatients, Community Services, Care Coordinators)

An entry must be made in the healthcare record for each patient attendance (including video conference and teleconference sessions) and for failures to attend.

Entries should reflect the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient's condition and/or treatment are to be documented.

To maintain continuity of care where clinicians use dictated letters to outline treatment plans, a notation in the healthcare record should indicate the timeframe of availability [of the letter] and reference to the correspondence section of the healthcare record for access [to the letter].

5.3 Entries by Specific Groups

In addition to requirements in sections 5.1 and 5.2, below are other profession specific requirements for documentation.

5.3.1 Medical Staff

- Name, title/position, date and time of attendance recorded
- Each entry signed
- Where an invasive procedure is performed, and/or an anaesthetic is administered, a record of the procedure including completion of all required consents and procedural checklists. Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required
- Where consultation with another medical practitioner has been made in regard to clinical decision making and patient care, the advice to be documented, including the medical officers name, position and site
- Where the patient's management should vary from an endorsed WACHS policy or guideline, this variation and clinical opinion as to reasons for variation must be documented
- A copy of certificates, such as Medical Certificates and Workers Compensation Certificates, provided to patients should be retained in the patient's health care record where possible
- Timely and accurate discharge summary. A principal diagnosis must be reported for every episode of admitted patient care; all conditions that were treated or required increased clinical care during the episode of care should also be recorded.

5.3.2 Nurses and Midwives

- If a change in the patient's condition has been reported to the responsible medical officer or senior nurse, documentation of the interaction, including medical officer/senior nurse name and the date/time that the change was reported to him/her and the subsequent management plan are to be documented in the healthcare record
- Documentation of medical orders received verbally, by telephone / electronic communication are required to follow the WACHS Medication Prescribing and Administration Policy.

5.3.3 Documentation by Allied Health, Population and Community Health Professionals

Documentation is to include:

- treatment/management plan, including assessments and associated interventions undertaken
- comprehensive completion of all medical record forms, with reference to any specialised or additional forms completed as a part of the assessment / treatment
- where consent is required, a record of the treatment including documentation of consent
- documentation of any changes in the patient status or assessment findings
- information or education provided to the patient and/or care providers.

Where the Community Health Information System (CHIS) is used all resources and guidance for this system is on the CHIS resources intranet page.

5.3.4 Aboriginal Liaison Officers (ALOs)

Recommended documentation format:

- ALO at top (identifying role)
- Time of review/phone call
- Reason for review/phone call
- ALO actions (what you did)
- Plan from here
- Next review planned
- ALO name and contact details

5.3.5 Students

- Documentation within CHIS refer to the *How to guide* "Countersign Student Notes"
- All entries made by students are to be indicated as correct and countersigned by the supervising professional
- Medical students are not permitted to document medication administration orders on medication charts.

5.4 Working Folders/Files/Clipboards (hard copy at the bedside/cot)

- Sites can adopt the use of one working file while consultation/treatment is being provided to the patient. This documentation must be transitioned into the compiled health record for that site on completion of care or other frequency as determined by the site prior to that date
- They are required to be kept within the standards of the WACHS Environmental Cleaning Policy:
  - Be able to be regularly and easily cleaned as per all patient reusable equipment
  - They are to be considered part of the patient environment and require hand hygiene before and after handling

    - Standard precautions apply to the management of all patient charts/medical records
    - Working folders/files/clipboards to be disposed of when showing any signs of wear and tear
- Are required to meet the standards of Patient Confidentially Policy & Health Record Management Policy
    - Where clipboards are utilised – this must have an integral cover folded over the clip section to assist with maintaining confidentiality
    - Where Perspex wall mounted holders are used – consider using opaque rather than clear
    - Place charts to face the wall/bed to minimise viewable information
- Appropriate use and governance is the responsibility of the Operations and Site Managers to ensure compliance with systems and processes for documentation and health records management
- Sites require governance over standard format, content & control of working folders to reduce risk of errors/omissions
- The face of each form/content within working folders is to contain patient identification as per Health Record Management Policy.

5.5 Electronic Transmission

WACHS staff are to refer to the following WA Health Policies related to electronic transmission of patient health care records:

- MP 0067/17 Information Security Policy
  Of specific note in sharing information outside of the WA Health system network:
    - Section 3.2.4.3 Data Transfer - when information is transmitted outside of the WA health system network (e.g. . sent via email, SMS or social media over the internet, public switched telecommunications networks or unsecured wireless networks), it is considered unsecured information in transit. Confidential or health information must not be transmitted through unsecured channels without the use of appropriate cryptography. Transferring personal information may also require specific approvals (see Information Management Policy Framework)
    - Section 3.2.4.3.1 Data transfer via secure file transfer - outlines information related to My File eXchange (MyFX) and My File Transfer (MyFT).
- Guidelines for the Transmission of Personal Health Information by Fax Machine (2020).
    - Ensure that the cover sheet includes instructions for the recipient to **verify receipt of the document**

5.6 Documentation of patient related incidents

- In the event of a clinical incident:[6]
  - documentation of the clinically relevant aspects of the clinical incident should be made in the patient's medical record
  - notification of the incident in Datix CIMS should occur by the end of the notifier's workday

  Refer to MP 0122/19 Clinical Incident Management Policy 2019
- The investigations section of the healthcare record refers to the outcomes of clinical investigations (e.g. blood results, imaging reports etc.). This should not be confused with 'investigations' from a clinical incident perspective – these types of investigations are not filed in or included on the patient's healthcare record
- Other patient related incidents (e.g. safety risk reports or complaints) are maintained in separate corporate systems and should not be filed in or included on the patient's healthcare record.

6. Definitions

Contemporaneous Documentation	Recording of information in the health care record as soon as possible after the event that is being documented
Hybrid healthcare record	Records that contain both physical and electronic components
Patient	A person who has, will be or is receiving care in a health service organisation

7. Compliance Monitoring

Evaluation, audit and feedback processes are to be in place to monitor compliance.

- Clinical audits of the healthcare record documentation will occur through clinical units and will be reported to the relevant health service's clinical ward meetings, committees or to clinicians. Frequency and other governance information should be included in regional action plans.
- Some audit criterion will relate to statutory requirements and will be performed via the WACHS Health Information Management division.
- Audit results are reviewed, evaluated and strategies for improvement implemented according to regional/local Quality Improvement processes

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

8. Relevant Legislation

Carers Recognition Act 2004 (WA)
Disability Services Act 1993 (WA)
Freedom of Information Act 1992 (WA)
Guardianship and Administration Act 1990 (WA)
Health Practitioner Regulation National Law (WA) Act 2010
Health Services Act 2016 (WA)
Medicines and Poisons Act 2014 (WA)
Medicines and Poisons Regulations 2016 (WA)
Mental Health Act 2014 (WA)
State Records Act 2000 (WA)

9. Relevant Standards

National Safety and Quality Health Services Standards
- Clinical Governance Standard: 1.15, 1.16, 1.17 and 1.18
- Communicating for Safety Standard: 6.1, 6.4, 6.5 and 6.11

Australian Standards:
- AS2828.1 Health records – Paper-based health records
- AS2828.2 Health records – Digitized health records

10. Related Policies

WACHS Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard
WACHS Allied Health Clinical Handover Policy
WACHS Clinical Image Photography and Videography Policy
WACHS Health Record Auditing Procedure
WACHS Health Record Management Policy
WACHS Health Record Form Management Policy
WACHS Medication Prescribing and Administration Policy
WACHS My Health Record Manual
WACHS Patient Administration Systems and Clinical Systems Business Rules Policy
WACHS Patient Identification Policy

11. Related WA Health Policies

MP 0066/17 Acceptable Use of Information and Communications Technology Policy
MP 0095 Clinical Handover Policy

MP 0122/19 Clinical Incident Management Policy 2019
MP 0124/19 Code of Conduct Policy
MP 0015/16 Information Access, Use and Disclosure Policy
MP 0135/20 Information Breach Policy
MP 0067/17 Information Security Policy
MP 0094/18 My Health Record (MHR) Policy
MP 0010/16 Patient Confidentiality Policy
MP 0096/18 Recognising and Responding to Acute Deterioration Policy
MP 0053/17 WA Clinical Alert (Med Alert) Policy
MP 0155/21 State-wide Standardised Clinical Documentation (SSCD) for Mental Health Services
OD 0657/16 WA Health Consent to Treatment Policy
Guidelines for the Transmission of Personal Health Information by Facsimile Machine (2020) – supporting information to MP 0067/17

12. WA Health Policy Framework

Clinical Governance, Safety and Quality Policy Framework

13. References

1. Australian Commission for Safety and Quality in Health Care. National Safety and Quality Health Service Standards Second edition. Sydney, NSW: Australian Commission for Safety and Quality in Health Care; 2017: https://www.safetyandquality.gov.au/wp-content/uploads/2017/11/National-Safety-and-Quality-Health-Service-Standards-second-edition.pdf [Accessed: 22/03/2021]
2. Australian Commission on Safety and Quality in Health Care [Internet] Communicating for Safety Standard ACSQHC: Sydney 2019 [Accessed: 22/03/2021]
3. Western Australia. Department of Health. Patient confidentiality Policy. Mandatory Policy MP 0010/16. Perth, WA: Department of Health; 2016[Accessed: 22/03/2021] https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Legal/Mandatory-requirements/Patient-Confidentiality-Policy
4. Australian Government. Aged Care Quality and Safety Commission [Internet] Aged Care Quality Standards - Standard 2. Ongoing assessment and planning with consumers, requirement (3)(d) [updated 2020 Jan; cited 2020 Nov 06; Accessed 22/03/2021]. Available from: https://www.agedcarequality.gov.au/providers/standards/standard-2
5. Australian Commission on Safety and Quality in Health Care [Internet] Recommendations for terminology, abbreviations and symbols used in medicines documentation. Sydney, NSW 2016: Australian Commission for Safety and Quality in Health Care; [Accessed 22/03/2021] https://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-medicines/recommendations-terminology-abbreviations-and-symbols-used-medicines-documentation

6. Western Australia. Department of Health. Clinical Incident Management Policy 2019 MP 0122/19. Perth, WA: Department of Health; 2019 [Accessed: 25/05/2021] https://ww2.health.wa.gov.au/About-us/Policy-frameworks/Clinical-Governance-Safety-and-Quality/Mandatory-requirements/Clinical-Incident-Management-Policy

This document can be made available in alternative formats on request for a person with a disability

Contact:	Project Officer - Clinical Practice Standards, S&Q		
Directorate:	Medical Services	**TRIM Record #**	ED-CO-15-91228
Version:	4.00	**Date Published:**	26 May 2021