Government of Western Australia
Department of Health
WA Country Health Service

WACHS Allied Health Assistant Training Mini-Module

Documentation

Contents

The Mini-Module includes:
- Information related to the actual training content
- Activities to take away complete and discuss with your local supervisor/s

Learning Objectives

At the end of the session AHA will:

- Understand AHA documentation responsibilities.
- Understand why documentation is important
- Understand how and where documentation is used in health care
- Have guidelines and principles for good documentation

Training Outline

- The Importance of Documentation
- Patient Related Documentation
- Documentation Principles and Guidelines
- Assessment

Note
The mini-module has been developed to complement ongoing training and supervision that occurs with the local AHPs. The information is designed to give some background information and does not replace face-to-face supervision, demonstration and monitoring by the supervision AHP. pathologist.

Section One: The Importance of Documentation

Aim

Allied health assistant will understand

- Their responsibilities for documentation
- What constitutes misconduct in relation to documentation
- Types of documentation (patient vs non-patient related documentation)
- What needs to be documented
- The Importance of documentation

Information

Documentation in client records forms an essential part of health professional and support worker daily activities. A high standard of patient record documentation is important to meet legislative (legal) and professional requirements and to facilitate communication between health staff.

Your Responsibilities

"All staff have a responsibility to maintain and keep adequate records of work processes and decision-making ensuring information is complete and provides a true representation of events"

Code of Conduct – Department of Health

Why is Client Related Documentation Important?

Communication: Assists in communication between health professionals seeing the same client. This makes sure that care is coordinated and that health professionals are aware of other aspects of the clients care. Clear, complete, accurate and factual documentation helps maintain a history of the client's care and progress he/she has made.

Accountability: Document records the activities that were undertaken by a health professional or support worker. It can be used to address questions or concerns regarding the care provided to a patient.

Legislative Requirements: Some health professions have legislative requirements regarding the need to maintain health records. The WA Code of Ethics requires all health staff to maintain and keep actuate records of work processes.

Quality: Documentation in patient records can be used in quality improvement activities such as audits. Documentation can help staff to reflect on their practice and make changes as necessary.

Research: Client records can be a valuable source of information for health research, and can help in determining the effectiveness of treatments.

Coding: Clinical coders use information documented in the clinical record to abstract information for coding.

Misconduct

Misconduct associated with documentation includes:

1. Failure to keep records as required
2. Inappropriate destruction of documentation
3. Falsification of clinical records:
    - Documenting care that never occurred
    - Signing a document that is known to contain false or misleading information
    - Signing for care that was carried out by another person

These offences are deemed a breach of the WA Health Code of Conduct.

Question:

Are there any issues or concerns you have encountered with regards to completing documentation as part of your role?

Section Two: Patient Related Documentation

Aims:

At the end of this section AHA will
- Understand what constitutes client documentation
- What needs to be documented in client records

Information

Types of Documentation

Client Related Documentation

Client related documents are 'all forms of documentation recorded by a service provider in a professional capacity in relation to the provision of client/patient care' (World Health Organisation). This may include written and electronic health records, audio and video tapes, emails, faxes, images, etc.

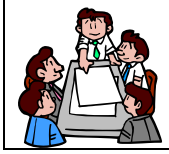
Client/patient records are legal records, and therefore must be done in a very careful legal way. They:
- Tell us and all the other members of the health care team about the patient, their care and treatments;
- Tell us facts about the patient/client;
- Help people, health professionals and health care workers, to make good decisions about the patient and their care; and
- Help us to find out how well the care that is being given is helping the person.

Other documentation not related to Client/Patient Care

In your role, you may also be required to assist with other forms of documentation not related to client/patient care. These include:

- Non client related letters, emails etc
- Policies, procedures and protocols
- Incident reports
- Statistical data (e.g. HCARE)
- Staffing rosters
- Personnel Files
- Performance Management documents

Activity



What types of documentation do you do in your role? Make a list of client related documentation and non-client related documentation.

What Needs to Be Documented

You need to document all aspects of patient care. This includes not only face-to-face sessions, but also:

- Telephone calls
- Meetings with other health professionals
- Meetings with carers or significant others (e.g. teacher)
- Missed or cancelled appointments
- Follow up on missed/cancelled appointments
- Information given/posted to the patient/client.

WHO

Documentation is
- First hand (direct)
- Knowledge understanding, observation, actions, decisions and outcomes
- Recorded by health care providers (doctor, nurse, allied health professional, assistant etc)

WHAT

- All aspects of patient care

WHEN

- In chronological order
- At the time (as soon as possible after)

WHERE

Documentation relating to patient care can be written/stored in:
- Electronic patient files (we don't have these in WA)
- Patient Medical Records (on the ward)
- Integrated Outpatient Records (shared between a number of health professionals)
- Profession Specific Records (usually stored in an individual department).

WHY

- Communication between health professionals and workers
- Informs and is a record of client care
- Helps with quality improvement and reflection
- Demonstrates accountability
- Used for coding purposes (funding)
- Valuable data for research

HOW

- Concise, accurate and true record
- Clear, legible, permanent and identifiable
- Chronological, current and confidential
- Based on observation, evidence and assessment
- Avoids abbreviations, white spaces and ambiguity
- Consistent with organisational guidelines

Section Three: Principles of Documentation

Aim:

At the end of this section Allied Health Assistants will
- Understand the principles and guidelines for good documentation
- Review their current documentation
- Write actions for improving their documentation

Information:

Good documentation follows a number of key principles. Put simply, records must be FACTUAL

F = focused on the client
A = Accurate
C= Complete
T = Timely
U = Understandable
A = Always objective
L = Legible

When writing patient notes, your documentation must be:

1. Comprehensive and complete

Content

The content of documentation needs to be relevant, appropriate and accurate. In general the following information should be included in an entry.

- Date and time of the session
- Reason for the session (treatment, review, case conference)
- Who attended the session?
- Information about the type of entry (e.g. therapy session, discussion with supervisor, case conference, group).
- Any relevant information provided by the client or significant others (family, teachers, other health professionals etc).
- Therapy/session goal and activity and effect/result.
- Further observations/unusual events.
- Practice provided.
- Any pamphlets, information or resources given the patient/family.
- Actions required or future activities
- Recommendations for the next session.
- Name, signature and designation (title).

Your supervising therapist will provide you with guidelines regarding the type of documentation he/she requires you to complete.

Style

- All documentation should be in chronological order (i.e. in order of time).
- Entries should be concise, accurate, relevant and treated as confidential.
- Each record page should be clearly identified with the client/patient identification (always check to make sure the label is correct i.e. correct label for the correct patient).
- Each entry should be dated, timed, signed and the professional status of the writer designated.
- Entries must be legible and preferably in black or blue pen.
- Limit the use of non-standard abbreviations or terminology.
- Record only facts. Emotional statements or moral judgements should not be recorded.
- Read previous entries to avoid reduplication and repetition.
- Avoid general terms.
- When a word, line or extra note is written in error do not erase. Instead draw a simple line through each word and write 'error' above it and initial. Do not use corrector fluid.
- Avoid white spaced or gaps between entries. The same process (line through the unused space) is used for an unused space on the progress notes. It is not necessary to sign for unused space.

2. Timely

Always document information immediately or as soon as possible after the event. These will be more accurate than those recorded later, based on memory. Taking notes during the session will make documenting after the session easier, as you will have something to refer to.

If you finish your notes and then want to add something in, include this as a 'late entry'. Do not squeeze the information into the existing note (see example provided later).

3. First Hand

Documentation involves first hand observations by the person writing the notes. If information is provided by a third person (rather than what you have directly observed) you must state the source (e.g. 'xx's mother stated…'). It is recommended to be a specific as possible with regards to identifying the source. The exception to this is when the source is another patient (e.g. 'the patient in the next bed stated..')

4. Approved Abbreviations

Abbreviations can be a good way to document quickly, however it is important that anyone reading the notes will understand them. Ask you supervisor about abbreviations that are ok to you use. When reading notes, if you don't recognise an abbreviation, ask. It will take time to become familiar with all the abbreviations used in health.

5. Professional

Documentation should also be professional. Handwriting should be neat and easy to read. Spelling should be correct. Also, be professional and careful with what you write. These records are not the place to air your own feelings about the patient and their care. For example, you should never write that 'the nurse has not seen the patient all morning' or something like, 'As usual, the doctor has not come to see the patient after he was called'. Personal, offensive or humorous comments about clients should not be written in the medical record. These statements are not at all professional.

6. Objective and factual

Objective information is what is seen, heard, felt, or smelled.

- Seen - charting observations regarding bleeding, deformities, drainage, color of urine, patient posture and/or attitude;
- Heard - the patient's complaints/statements, moaning, breathing abnormalities, speech sound errors;
- Smelled - vomitus odor
- Felt - Hot, cold, dry or moist skin, range of movement

Subjective information is your own personal bias, judgement or speculation about the patient. It is sometime appropriate to write in subjective statements made by the patient, and should always be written with quotation marks around what they say (e.g. "when I breath I fill like an elephant is sitting on my chest")

Objective	Subjective
Half of breakfast eaten	Diet taken fairly
Limping on left side observed when walking	Has a sore leg
No complaints of pain	Had a good day
Left big toe red and hot touch	Toe looks infected
Thrashing in bed	Appears restless
Used the /k/ sound 100% of the time in conversation	Easier to understand

7. Confidential

Client/patient information is confidential and care should be taken to ensure that all documented information remains confidential.

- Do not allow anyone to touch or look at a patient record unless they are a healthcare provider taking care of that patient or resident;
- Keep all patient records in a safe and secure place;
- Do not tell anyone about what is in a patient record unless they are taking care of the person.

8. Consistent Format

Formats used by other health professionals

When looking at client files, you may notice that health professionals use specific formats to document the note. The give the health professional a consistent way to write notes, and make it easier for other people to read. Two common format styles include SOAP/SOAPIER and APIE

SOAP/SOAPIER

- Subjective data:
- Objective data: factual data
- Assessment: the diagnosis
- Plan: what is planned in terms of care

Expansions include

- Intervention: what treatment/care was provided
- Evaluation: the results/impact of the treatment/care
- Recommendations/Revisions: what is recommended to happen next time, or what has changed in the client care

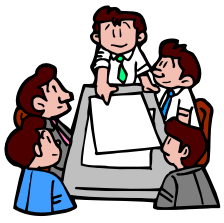
APIE:

- Assessment
- Plan
- Implementation
- Evaluation

Formats used by Allied Health Assistants

Quite often your supervising therapist will give you a specific format to write in the client file. This may involve modification of the above formats to reflect the scope of practice of an assistant, or may be another format with different headings. Your supervisor may even give you a specific form to complete progress notes in.

Activity: Documentation Checklist



- Select 2-3 client/patient records/files that you record in or keep.
- Photocopy the attached (appendix two) Client Documentation Checklist form (one for each record you are going to audit.
- For each record, complete the checklist.
- After completing the checklist, write down areas for improvement.
- Discuss this with your supervising AHP.

Appendix One: Example of Documentation in a Client Record

CLIENT IDENTIFYER

PROGRESS NOTES

JOHNNY SMITH
DOB: 1/1/02

DATE **TIME**

12/01/05 Therapy Session # 4 4.00pm – 4.30pm

Session attended by Johnny and his mother.
Johnny's mother reported that he had progressed well with practice over the week. Difficulty reported still with /k/ at the end of works.

Goal: /k/ at the end of single words
Result: 6/10 correct on first attempt. ~~10/10~~ (error MJ) 9/10 with help. Prompt – reminder of tongue placement.

ERROR

Goal: /k/ at the beginning of words in a sentence
Result: 5/10 correct on first attempt. 10/10 with help.

Home practice: /k/ at the end of words – single words. Picture given to Mum
/k/ at the beginning of words in sentences.
Ideas given to mum on how to use picture to make sentences.

Next session: /k/ all positions in sentences.

SIGNED
STATUS

Mary Jones
Therapy Assistant

LATE ENTRY 21/01/05 5.00pm

Johnny's mum called – school teacher would like a copy of pictures.
Action: TA to contact therapist and relay request.

Mary Jones
Therapy Assistant.

Appendix Two: Patient Documentation Audit Tool: Allied Health Assistants

Criteria	Complete	Incomplete	Absence	Comments/Action
Are the patient records				
In reverse chronological order (most recent entry at the front)?	○	○	○	
Written in black or blue pen?	○	○	○	
Written neatly?	○	○	○	
Stored confidentially?	○	○	○	
Written in a consistent and organized format?	○	○	○	
Does the patient records have				
Patient/client identification on each page	○	○	◉	
No spare lines/gaps between entries	○	○	○	
Does each individual entry include:				
Date and time of session?	○	○	○	
Who attended the session?	○	○	○	
Any relevant information provided by the client or significant others (family, teachers, other health professionals etc).	○	○	○	
Therapy/session goal and activity undertaken?	○	○	○	
The effects/results of the therapy?	○	○	○	
Further observations?	○	○	○	
Practice provided?	○	○	○	
Information on any handouts, brochures etc provided?	○	○	○	
Recommendations for the next session?	○	○	○	
Signed with a name, title and signature?	○	○	○	
No inappropriate alterations or omissions (e.g. all corrections made correctly)?	○	○	○	
No inappropriate information (e.g. personal remarks about patient, family, or other caregivers)?	○	○	○	

ACTIONS (What do I need to do to improve my documentation)?

1. _____
2. _____
3. _____

Assessment

1. Why is documentation important?

2. When should you write patient notes?

3. How can you make sure your patient notes are kept confidential?

4. If you make a mistake when writing in patient notes, how do you correct this?

5. What types of things should be included in patient notes?

6. What type of abbreviations should be used in medical notes?

7. How should you record information provided to you by someone else (rather that what you have observed yourself)?