FUNCTION: Clinical

TITLE: Documentation Policy

VERSION DATE: December 2013

POLICY STATEMENT:

Clinical records are the major source of personal health information for patients/clients/residents attending Benalla Health (BH). Health care facilities are obliged by law to ensure clinical records are kept in an accurate, concise and timely manner by all staff contributing to patient/client/resident care. All clinical staff have a responsibility for ensuring the information contributed is of a standard that provides for effective ongoing care of the patient/client/resident and for optimal legal defense.

PRINCIPLES:

1. The Clinical record is the official paper based or electronic chronology of a person's illnesses and the treatment or management of those illnesses. The primary purpose of the clinical record is that it is used as a tool for documenting the treatment / care of patient/client/residents – this purpose is the same regardless of the format (paper based or electronic).

2. Currently clinical records are used to provide:
   - 2.1. A means of communication between clinical staff providing care to the patient/client/resident
   - 2.2. A basis for evaluating the adequacy and appropriateness of care
   - 2.3. Data to substantiate funding and insurance claims
   - 2.4. Protection of the legal interests of the patient/client/resident, the clinical staff and BH
   - 2.5. Clinical data for research, education and quality activities.

OBJECTIVES:

1. The clinical record shall contain sufficient information to justify treatment including admission, continued hospitalization, support diagnoses and describe the patient/client/resident's progress and response to medication and services.
2. All staff documenting information within the clinical records do so in a consistent manner and understand their responsibilities in relation to documentation, and
3. BH clinical records meet the standards required by legislation, professional bodies, accrediting organizations and the governing body of BH.

These objectives shall be achieved by ensuring that the standards outlined in the documentation procedures are adhered to.

DEFINITIONS:

Patient/Client/Resident:

Refers to an individual who is seeking treatment from BH. This may be an inpatient / emergency patient / resident / outpatient / community care client / consumer at BH.

Clinical Record:

Also medical record, patient record, health record, client record. A clinical record is a systematic documentation of a patient/client/resident's medical history and care.

Clinical Staff:

Refers to care providers employed by BH.

REFERENCES

National Safety and Quality Health Service (NSQHS) Standards

1. NSQHS Standard 1 - Criterion 1.9 - Using an integrated patient clinical record that identifies all aspects of the patient's care
2. NSQHS Standard 1 – Action 1.9.1- Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care
3. NSQHS Standard 1 - Action 1.9.2 - The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards.

Author:	Chief Health Information Manager (Veronica Young)
Validated by:	Director of Clinical Services (Janine Holland)
Approval:	Guiding Documents Committee
Approval date:	11th Dec 2013
Review Date:	11th Dec 2016
Responsibility for Review:	Health Information Manager
Authorised by:	Director of Clinical Services (Janine Holland)
Authorised date:	11th Dec 2013

Janine Holland