HC-Client Documentation

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Purpose

This policy defines practices for documenting and managing client history and service records in line with legislative, ethical and current best practice requirements.

These records are permanent, legally accountable documents which must accurately record the total needs, care and management of clients while receiving care and services. They are an essential component of well-planned and managed client care and may need to be produced as physical evidence of care delivery.

Applicability

All Home Care Providers:

- all categories of employees
- governing body
- all volunteers
- contractors and consultants, whether or not they are employees all other service providers

client outcome

I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

Organisation statement

The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the client's needs, goals and preferences to optimise health and well-being.

Documents relevant to this policy

Consumer File Content Checklist

Managing business unit for this policy

Home Care Services

Policy Commitment

A comprehensive and accurate record must be kept for every client that describes all care provided to them. The record will be created on commencement of services in conjunction with the initial assessment and regularly reviewed, evaluated and updated to ensure it is always reflective of the current health and care status of the client.

All records are to be maintained in a manner that respects the dignity and confidentiality of the client and staff as well as meets regulatory requirements relating to the collection, use, storage, access and disposal of health and personal information.

Mandatory requirements

The client's family name and given name/s, date of birth and gender identity must appear on every page of a paper record or on each screen of an electronic record/or on each page of a hard copy.

Record keeping standards

To comply with the Australian Commission on Safety and Quality in Health Care standard on information documentation, all records must:

- be legible and written in English
- only use approved abbreviations and symbols
- be written in dark ink (for paper based records) that is difficult to erase and write over
- include the time (using a 24-hour clock - hhmm) and date (using ddmmyy or ddmmyyyy) of entry
- be signed by the author and include their printed name and designation. Entries by students involved in the care of a client must be co-signed by the student's supervisor
- be integrated i.e. there are not separate systems for different care types
- be accurate statements of interactions between the client and /or their representatives and the service
- be sufficiently clear, structured and detailed to enable other members of the team to resume care of the client or to provide ongoing service at any time
- be written in an objective way, not include demeaning or derogatory remarks and distinguish between what was observed or performed, what was reported by others as happening and/or professional opinion
- be made 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
- be sequential - for hard copies, lines are left between entries and must be ruled across to indicate they are not left for later entries and
- be relevant to that client and only include personal information about other people when relevant and necessary for the care and treatment of the client.

For hardcopy records, addendums must be appropriately integrated within the record and not documented on additional papers and/or attached to existing forms.

All errors are must be appropriately corrected in a manner that provides the viewer with both the erroneous and corrected record:

- For hard copy records, do not overwrite incorrect entries or use correction fluid. A line should be drawn through the incorrect entry and it noted as "written in error", followed by the author's printed name, signature, designation and date and time of correction.
- For electronic records, an additional note must be created to explain the previous incorrect entry. The history of audited changes must be retained.

Handover

The following process is used for effective written communication concerning care issues:

- Introduction to note entry.
- Situation that is or has happened to the client.
- Background to the issues that led to the documentation.
- Assessment of what the clinician believes the problem is.
- Recommendation regarding what should be done to correct the situation.

What to record

client records must be created and maintained by an appropriately qualified staff member and include:

- referral information, social and medical history
- the initial and all medical, risk and other assessments
- the care plan

- contacts including substitute decision makers and consents
- progress notes and clinical monitoring charts to record:
    - diagnoses, reports, assessments and recommendations from relevant health and medical practitioners
    - transfers and discharges
    - instructions from clients and/or their representative/s
    - changes in condition such as pain, wound care, behaviours and general condition and
    - consultation concerning treatment, goals, interventions with client, responsible person, medical officer, allied health, other consultants, Guardianship Board and Protective Officer.
- all incidents including relevant information, interactions related to open disclosure and cross reference/link to the incident management system
- all dignity of risk assessments - if a client seeks to make a choice that is possibly harmful to them, the organisation is expected to help the client understand the risk and how it could be managed and document
- any leave taken by the client along with the date and time they left and returned and any assessments prior to and/or on return and
- issues that require particular attention or pose a threat to the client, staff or others including:
    - allergies/sensitivities or adverse reactions and the known consequence
    - infection prevention and control risks
    - behaviour issues that may pose a risk to themselves or others and/or
    - where clients have similar names and other demographic details.

Any such issue should be 'flagged' or recorded conspicuously on appropriate forms, screens or locations within the care record. They must be apparent to and easily understood by health care personnel and regularly reviewed. Where alerts relate to behaviour issues the alert should be discreet to ensure the privacy and safety of the client, staff or others.

Complaint records are not to be kept with the client's health care record.

When to record it

Care coordinator: An entry on the client's record should be made at least monthly with additional entries made more often to reflect changes in the client's status, condition and/or care plan as these occur.

Registered nurses should make an entry at the time of events, or as soon as possible afterwards, including when clinically assessing the client.

Other health care personnel should make entries to reflect their level of assessment and intervention consistent with the care plan.

Care workers should enter information related to tasks or observations into the record.

Documenting Case Notes

When documenting case notes or changes in care or a condition staff should consider following the SAP documentation method:

Situation - what is reported by the worker or client i.e., a general summary of the situation or observation.

Actions - what actions need to be taken or were undertaken e.g. referrals to medical officer, dietician, other allied health professionals or instructions for staff to report certain changes.

Plan - what is the final plan? Once the above have been determined, a final summary of actions and plans should be recorded with who is responsible and when should it be followed up.

At all times the focus should be on the client's needs, goals and preferences.

Security and access

All information in a client's care record is confidential and subject to prevailing privacy laws and policies. Records must be securely stored when not in use e.g. in locked storage or password protected software. client records should only be accessed and the information used or disclosed when it is directly related to the staff member's duties and is essential for the fulfilment of those duties or as provided for under relevant legislation. All requests to access client records are to be managed in line with the Privacy Policy.

client records must be readily available at the point of care or service delivery. Records must not be removed from the business site unless prior arrangements have been made e.g. required for a home visit.

client records must be kept for the mandated retention period and disposed of in a manner that will preserve the privacy and confidentiality of any information they contain.

Staff education

All care staff inclusive of contractors such as allied health are to receive initial and ongoing education in the management of care documentation processes and procedures.

Monitor and review

The organisation will periodically assess the performance of the record management systems through client file audits and process review to evaluate the design and effectiveness of practices and identify areas for improvement.

Roles and Responsibilities

Senior management is responsible for:

- Establishing mechanisms to ensure compliance with the requirements of this policy.
- Ensuring implementation of a framework for auditing of health care records and reporting of results.

Care Coordinators and Nurses are responsible for:

- Ensuring the requirements of this policy are disseminated and implemented in their area of responsibility.
- Monitoring compliance with this policy, including health care record audit programs, and acting on the audit results.

Care workers are responsible for:

- Maintaining their knowledge, documentation and management of health care records consistent with the requirements of this policy.
- Ensuring they are aware of current information about the client under their care including where appropriate reviewing entries in the health record.

References

Name	Source
Documentation of Information Standard	Australian Commission on Quality and Safety in Health Care