GUIDELINE FOR CLINICAL DOCUMENTATION

RELEASE RECORD

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Contents

INTRODUCTION

Clinical documentation is an integral part of patient care. It is a tool for communicating patient care information among healthcare team. Good record keeping helps to protect patients by promoting:

- High standard of care
- Continuity of care
- Better communication among muti-disciplinary health care team
- An Accurate account of treatment and care planning
- The ability to detect problems, such as changes in patient's condition early.

The quality of documentation is a reflection of the standard of professional practice. Good documentation is a mark of the skilled and safe practitioner, while careless or incomplete record keeping will often highlight issues with individual practice. Even though there is no single model or template for records, it should contain all vital information regarding patient care. Good documentation is therefore, both product of good team work and an important tool in promoting high quality care. There are some key principles which underpin good record keeping.

PURPOSE

The purpose of this guideline is to encourage the adaptation of best practice for managing clinical documentation by all registered health facilities.

SCOPE

Management of clinical documents by all registered health facilities and to ensure proper documentation is maintained at all health facilities where patient care is provided.

CONTENTS AND STYLE

There are number of factors for effective clinical documentation. The documents should:

- Be factual, consistent and accurate
- Be written as soon as possible after an event has occurred, focusing on the patient's condition
- Be written clearly in a manner that it cannot be erased. Do not using tipex. If needed to cut in a single line.
- Accurately documenting events in a timely manner in a patient centered manner.
- Be written in a manner that alterations or additions are dated, timed and signed in such a way that original content may still be read clearly.
- Be accurate and dated along with signature on alongside of the last entry
- Not include abbreviations, jargons and meaningless phrases
- Be clearly readable on photocopies, even if it is handwritten.

In addition, the patient chart should have:

- Present medical history
- Past medical history
- Family history of illness
- Personal history
- Medication allergies
- Physical examination
- Diagnosis at admission
- Treatment and management plan
- Laboratory investigation reports
- Radiology reports
- Consent forms
- Final diagnosis
- Discharge summary – (as per the standard guidelines of discharge summary)
- Death certificate (if deceased)

LEGAL MATTERS

Patient clinical documents are evidence before court of laws. Therefore, all documents should demonstrate:

- A full account of assessment and the care provided
- Relevant information about patient's condition and measures taken to respond to their needs
- Evidence that all reasonable measures have been implemented to cater for patient's needs
- The arrangements made for continuing care for patient.

ACCESS AND OWNERSHIP

The organization holds ownership of all clinical documents. However, no staff in the organization have automatic access to the documents, and it should be via a system which the organization has set to retrieve clinical documents.

Inter-professional access to record

- The health care team involved in patient care can access clinical documents. They can access clinical documents while respecting patient's confidentiality.

Retention

- According to medical law 2019/R-1070 it is obligatory to keep the medical records of the patient for a lifetime. Past medical records of the patients' need to be archived for future use. However, after the demise of the patient the medical records of the patient needs to be kept for 6 years

Research and teaching

- Clinical documents may be used for research and teaching purpose. However, all the ethical principles apply and that must be respected.

METHOD OF DOCUMENTATION

- All clinicians should document the patient's progress in the patient's file/ folder.
- This file/ folder should be approved by MoH. (Universal format for all registered health facilities)

MANAGEMENT OF HEALTH RECORDS

- All clinical documents should be maintained for every patient, including, newborns, or patient admitted for care and patients in the emergency or outpatient services.
- Clinical documents may be maintained in paper or in an electronic device.
- Store data / information as per the legislation, regulation, guideline and rules of procedures
- Have a mechanism in place for information dissemination
- Have a mechanism for open disclosure with availability of patient information
    - All patient prescription should have the minimum information as per prescription standard.
    - All entries should be in written legibly and in a timely manner
    - All entries shall be signed or initiated by the clinician.
    - All timings should be recorded based upon 24-hour time
    - Chart to be filled after the delivery of care, not before
    - Use only hospital approved abbreviations. And universally accepted abbreviations
    - Never erase information with correction fluid or makers. To cut in one line if need to be cut/ corrected.
    - Notes to be written in blue or black ink, not felt pen.
    - Every entry must be dated, timed and signed by the clinician
    - Write in way that can be read easily
    - Each page, if two sided must be dated, with patient name, hospital number, page number etc.

- Draw a line through the incorrect information and mentioned at a corner so the next attending clinician would be alert
- When a patient was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.
- Ensure that that new entry is identified as “late entry” or enter as “retrospective note” with proper timing, date and clear details of chronology of events and name(s) of personal who entered the details as well as names of all those who attended the patient.

RECORD KEEPING

- Maintain records in an easily retrievable manner
- Health records should be stored securely to provide protection from loss, damage, unauthorized use and theft.
- Handling and transferring health records should be achieved in a manner to ensure information security and patient confidentiality.
- The health facility should have in place policy and procedures for data security and protection, confidentiality, handling, storage, archiving and destruction of both paper and e-health records

INPATIENT HEALTH RECORDS

- Inpatient health record contents are applicable only to health facilities providing inpatient care
- Inpatient Health records may include:
  - Patient contact details
  - Patient guardian/ bystander information
  - Date and time of admission and discharge
  - Adequate identification (including hospital number assigned to patient)
  - A signed informed consent by the patient or patient party. (where applicable)
  - History, physical, special examinations, and diagnosis recorded prior to operation (where applicable) / during admission

- Admission diagnosis
- Care plan
- Reports of consultation by consulting physicians/ specialists in a timely manner
- Anesthesia record, including post-anesthetic condition signed and stamped by the anesthesiologist, or surgeon (where applicable)
- Signed permission for surgery, anesthesia (where applicable)
- Treatment charts
- Complete description of operative procedures and findings including postoperative diagnosis recorded and signed and stamped by the attending surgeon following the operation
- Admission diagnosis, final diagnosis, secondary diagnosis, complications and condition on discharge
- Signature and official stamp of attending physician.
- Operative procedures and complications during surgery (if any) and any other relative information such as amount of blood loss during operation, etc

NURSING RECORDS

- Initial Nursing Assessment Form
- Nursing Care Plan
- Nurses Notes Form (progress notes)
- Observation chart
- Pediatric Observation and Assessment Charts (where applicable)
- Medication Chart (Drug Chart)
- Nursing notes
- Pain Assessment
- Patient/family education
- Pre-operative checklist (where applicable)
- Labor record
- Fluid Balance Chart
- New-born identification form
- ICU (intensive care unit) Chart

- Infection chart
- Pressure sore charts
- NICU (neonatal ICU) chart
- Neonatal intensive care unit/Intravenous (IV) fluid intake/output chart
- Feeding chart
- Transfer slips

OBSTETRIC RECORDS

- Record of previous detailed obstetric history and pre-natal care including blood serology and Rhesus factor determination (Rh).
- Admission, obstetric examination, report describing condition of mother and fetus, including ultrasound report or any other related tests
- Complete description of progress of labor and delivery, including reasons for induction and operative procedures
- Records of anesthesia, analgesia, and medications given during the course of labor and deliver
- Cardio records of contraction and fetal heart rate records
- Progress notes including description of involution of uterus and report of condition of infant following delivery
- Names of nurses/ assistants (healthcare professionals) present during delivery

NEWBORN RECORDS

- Records of newborn infants should be maintained as separate records and should contain the following
- Date and time of birth, birth weight and length, period of gestation, sex, APGAR score and blood group
- Parents' names and addresses
- Description of complications during pregnancy or delivery which includes; premature rupture of membranes; condition at birth including color, quality of cry, method and duration of resuscitation.

- Detailed and complete initial physical examination report, including any abnormalities, signed by the attending physician Progress notes including temperature, weight, and feeding charts; number, consistency, and color of stools; condition of eyes and umbilical cord; condition and color of skin; and motor behavior

DISCHARGE SUMMARY

- Each health facility should provide a discharge summary to the patient upon discharge
- Date and time of admission and discharge
- Adequate identification (including record number assigned to patient)
- Admission diagnosis
- Final diagnosis, secondary diagnosis, complications
- Operative procedures (where applicable)
- Condition on discharge with medication along with duration
- Summary of inpatient care with important clinical details in a chronological order
- Follow up plan – Including any follow up consultation.
- Signature and official stamp of attending physician/ Specialist.
- When a patient has been advised to seek additional care for further assessment, treatment, and follow-up, the patient's health record will contain documentation of the given advice.

Assessment findings should be integrated and documented in the patient's health record and readily available to those responsible for the patient's care.

ACCESS/ RELEASE OF PATIENT INFORMATION

- Health records can only be accessed by the patient
- The patient has the right to request for copies of medical reports, but not the originals. The health records should be maintained by the health facility as per medical records regulation.

DATA PROTECTION AND CONFIDENTIALITY

Clinical records, including patient identifiers and data on the diagnosis prognosis or treatment of any patient are considered confidential and can only be shared with the prior written consent of the patient or with the person who the record is maintained.

DESTRUCTION OF HEALTH RECORDS

- In order to ensure the patient's right of confidentiality, health records should be destroyed or disposed of by shredding deletion, or another effective protective measure.
- According to the medical records regulation 2019/R-1070 all diseased patient's medical records of the patient need to be discarded after 6 years in secure manners. Hence the discarded documents (name of the patient, Identification number or Passport number, date of death, and the date medical records were discarded) needs to be recorded and maintained for any further use. The only responsibility for the destruction of all health records should exist in the health facility. A legal representative for the health facility should be consulted prior to the destruction of health records.

TRAINING AND QUALITY ASSURANCE

- All new staff should be given health records training as part of their induction process.
- Health facilities need to ensure that their staff are fully trained in health records and have an understanding of:
  - What they are recording
  - how it should be recorded
  - Why they are recording it.
  - How to confirm the information of the patient that staff are recording the correct data.
  - How to identify and correct errors so that staff know how to correct errors and report errors if they find them.
  - How to update information and add in information from other sources.
  - Whom to report any observed concerns with regards to managing health information.

- How important it is to keep the confidentiality

REFERENCE

Australian Commission on Safety and Quality in Health Care (2017). National Safety and Quality Health Service Standards: Guide for Hospitals (2nd Ed.). Sydney: ACSQHC.

General Medical Council. Good Medical Practice. London: GMC; 2013

Joint Commission. (2017, January). Edition Joint Commission. Retrieved January 21, 2021, from www.editionjcrin.com.

Kargul, G. J., Wright, S. M., Knight, A. M., McNichol, M. T., & Riggio, J. M. (2013). The hybrid progress note: Semiautomating daily progress notes to achieve high-quality documentation and improve provider efficiency. American Journal of Medical Quality, 28(1), 25-32.