



Victorian Healthcare Association

Clinical Documentation In Community Health

Rebecca Smith

The Barwon Health experience CHACE



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- In 2005, CH developed our CHACE guidelines which summarise for clinicians and teams, the Division's expectations within 8 essential elements for ensuring we provide a quality service for consumers
- CHACE = CH Assessment, Care and Evaluation guidelines
 1. Seamless access into and between services
 2. Comprehensive assessment of consumer need
 3. Care planned in partnership with consumers
 4. Care coordinated within and between interdisciplinary teams
 5. Measurement of Health outcomes
 6. Integrated information management systems
 7. Evaluation of service system response
 8. Clinical governance
- Each element has clear process indicators, that each service is expected to be able to evidence how they meet.

The Barwon Health experience Annual Clinical Audit



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- The process indicators identified within CHACE are included in our Annual Clinical audit.
- For the past 5 years, Community Health, along with Mental Health has completed an annual clinical audit
- For the first 2 years, we audited a random sample of discharge files and focused on professional documentation expectations, a selection of process indicators from CHACE and whether documents were actually completed.
- This was completed on behalf of the C & MH QI and RM committee, to inform both Divisions on where additional emphasis, facilitation or training were needed to ensure our client records were legal and readers were able to follow the client journey, and also perform safe and effective care/treatment.
- In 2006 and again in 2008, the clinical audit focused on care planning as this was an area across both divisions, that needed improvement.

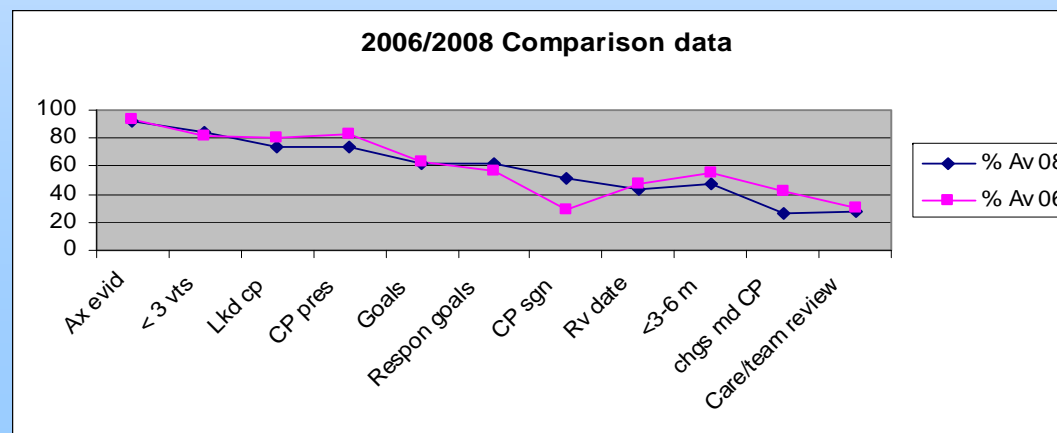
The Barwon Health experience Annual Clinical Audit



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Criteria within audit focused on:-

1. Establishing whether there was a linking of information between assessment, care planning and review.
2. Consumers were involved in development and finalisation of the care plan.
3. As you can see there was not a lot of change between the two audits.
4. Post 2006 audit, teams were instructed to ensure that each client had a care plan and that it was signed, and as you can see this was the only overall improvement since the previous audit.



The Barwon Health Experience Since August 2008



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In response to the outcomes of this audit, and in absence of an electronic clinical database, we have established our Documentation system which :-

Plan

- Been making the move to the Digital Medical Record, which has provided the impetus for consistency in content within documentation across teams, disciplines and sites!

Do

- This has provided opportunities to ensure our documents meet required Health record standards, eg room for client labels on each side of form, space for clinicians and clients to sign, printed name of form and colour coded strip at side of form, space to hole punch.
- We have been able to add prompts for clinicians to complete required our process indicators, eg all care/treatment/service plans that are used have prompts to add a planned review date within 3 months and space to add actual date of review.
- We held a number of short refresher sessions on Quality Professional Documentation sessions as part of our annual training calendar at each site (4).

The Barwon Health Experience Since August 2008



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Check

- Recommendations from the audit from the C & MH QI and RM committee were that each service must complete a monthly audit on a selection of clinical files and report findings and action as part of their monthly line management reporting. Both a hard copy or electronic template were available for teams to use. We are now looking at whether we could use something like survey monkey.
- One team has taken this seriously, and have positive reactions from staff as all results are discussed at the monthly meetings and each team member takes a turn in auditing. They have begun changing the focus of their monthly audit. They have just completed a six month series on BH documentation standards. This month they are focusing on medication issues, next month they are looking at how staff are using their version of progress notes.
- Another team are using their case review meetings to also review standards within a couple of files – action research in action!
- Repeat of Care Planning audit with addition of some clinical documentation standards in November 2009.
- Establishment of a practice improvement group particularly focusing on documentation issues and internal process within CH. Our first discussion will be on internal referrals – being clear on how this is done and consistently within all services within CH.

Barwon Health experience



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Act

- Revised and updated the CH Order of files guideline and CH Medical record management of CH files as issues were raised during the audits. Some examples were 1) where in the file do you put certain documents, 2) when is a client file to be made up, 3) what happens if a carer turns up in the place of a client, on who do we record the notes?
- I became part of the VHA Clinical governance working group looking at Informed consent and Clinical Documentation and this has led me here today to talk about Client record documentation.

Definition



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Client record documentation includes:

'all forms of documentation recorded by a service provider in a professional capacity in relation to the provision of client care'

Modified from WHO, 2007

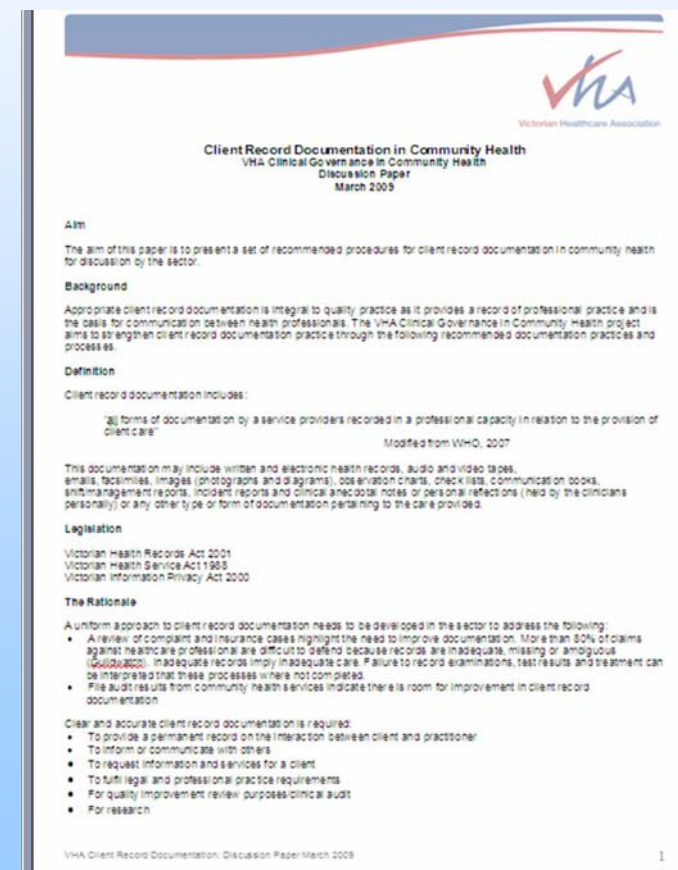
VHA Clinical Documentation Discussion Paper



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VHA Clinical Documentation Discussion Paper

- Draft document developed by working group
- Limited references/resources in this area



VHA Clinical Documentation Discussion Paper



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General Principles

- Contemporaneous
- Chronological order
- Date (time)
- Objective
- Clear, accurate, concise and complete
- Legible
- Corrections
- Identification of recorder
- Signature of recorder
- Colour of pen
- Accepted abbreviations

VHA Clinical Documentation Discussion Paper



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Specific Documentation Principles

- Client Profile
- Assessment Forms
- Discipline/Program Specific Assessment Forms
- Progress Notes
- Referral Reports
- Discharge/Transfer Summary
- Care Plans

VHA Clinical Documentation Discussion Paper



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Specific Documentation Principles

- Assessment Forms
 - The date of visit
 - Time of entry
 - The practitioner signature, name and designation
 - The presenting issue
 - Client goals (client centred)
 - Relevant history
 - Clinical finding and observations
 - Diagnosis/assessment
 - Treatment /interventions options
 - Informed Consent for intervention
 - Proposed Treatment/intervention Plan
 - Referrals
- Discipline/Program Specific Assessment Forms

It is recommended that standardised assessment formats for each program/discipline area are developed/adopted in each organisation based on either evidence, requirements in funding guidelines (where they exist) or in accordance with standards of practice of the profession

VHA Clinical Documentation Discussion Paper



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Specific Documentation Principles

- Progress Notes

- There needs to be an agreed format for progress notes at an organisational/program level.

Options include:

- SOAP (IER) *see appendix in document
- PAR – Problem, Action, Response
- D(R)AP - (Description, Response, Assessment and Plan)
*see appendix in document

VHA Clinical Documentation Discussion Paper



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Specific Documentation Principles

- Care Plans

The following outline the items to be included:

- Client stated/agreed issues/problems
- Client stated/agreed objectives/goals,
- Client stated/agreed strategies/action
- Review date of care plan
- Timeframe for attainment of objectives/goals
- Responsibilities for implementing strategies/action
- Participants in development of care plan
- Consumer Acknowledgement
- Date care plan developed
- Goals Met/Partially Met/Not met

Electronic Notes



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- Principles the same
 - Where possible all correspondence be scanned
 - aim for no separate paper client records
 - If date of entry differs from the date of visit this needs to be clearly documented.
 - Other issues?

Audit tool



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- Working group has updated audit tool developed by QICSA to reflect document
- Liaising with QICSA to review tool

Questions to the sector



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- Any other aspects of clinical documentation to include?
- Electronic records
 - What are the challenges?
 - Any more principles to include?
- Should we develop sector abbreviations?

Abbreviations and Nomenclature



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Physio abbreviations circa 1980's

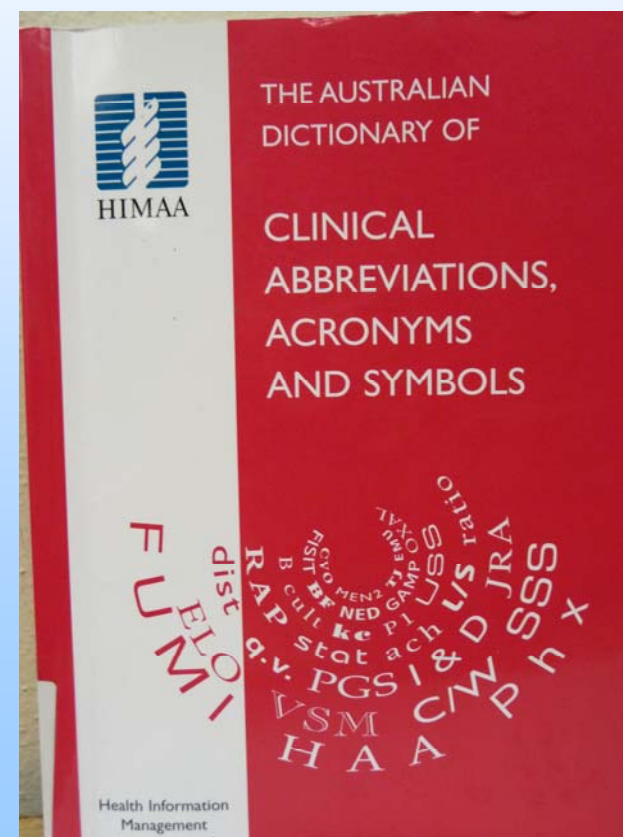
S: Shoulder pain improving,
easier to lift arm

O: (L)Sh → 70° p at EOR

With standard abbreviations

S: shoulder pain improving,
easier to lift arm

O: (L) G/H abd 70 deg, p at EOR



Questions to the sector



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 - What are the challenges?
 - Any more principles to include?
- Should we develop sector abbreviations?

Acknowledgements



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Working Group

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