What You Should Know About Clinical Documentation - in Acute Care Hospitals

Good patient care and health outcomes are dependent on accurate, clear, complete and timely documentation of a patient's diagnosis, functional status, interventions, problems, treatment and progress. Global studies have shown that quality information contained within a patient's health record improves patient care and outcomes.

For example:

- the risk of re-hospitalization decreases when patients are assessed for follow-up by a physician who has access to the full health record, or who has received a discharge summary

- visits to an Emergency Department of a teaching hospital were longer on average for patients with an information gap in their health records.

- when shared in a timely manner, the patient's health record can avoid negative consequences, such as adverse medication events.

Given the importance and impact that quality clinical documentation can have on patient care, this information sheet will provide tips for providing optimal documentation within the health record of a patient in an acute care hospital.

The following are considered minimum standards for patient documentation:

- All documents must be legible.
- Use of abbreviations is strongly discouraged.
- Every entry made within the patient record must be signed and dated by the author.
- The use of dictated and transcribed documents is recommended.

The following are considered key elements of an inpatient health record, and indicate specifics that should be contained within each report.

History and Physical Examination

All patients should have a history and physical examination available on the health record.

This includes:
- name of patient
- unique patient identifier number
- patient gender
- patient date of birth
- patient demographics (i.e., primary language, race, ethnicity, etc)
- name of author and professional qualification (e.g., M.D., D. O.)
- description of presenting illness and patient complaint
- past medical history, including illnesses, surgeries, medications and allergies
- family medical history
- physical examination by body system (cardiovascular, musculoskeletal, respiratory, etc.) and findings for each
- provisional diagnosis
- functional status
- treatment plan

Operative Report

Any patient undergoing surgery should have a report explaining the procedure documented by the surgeon on the same day as surgery.

This report must include:

- identifying patient information as indicated in "History and Physical" above (name of patient, unique patient identifier, patient date of birth and gender)
- name of author and professional qualification.
- Date of procedure.
- Preoperative diagnosis.
- Proposed operative procedure.
- Procedure performed.
- Detailed description of the procedure performed, including the condition of the patient during and at the conclusion of the procedure.
- Postoperative diagnosis.
- Anesthetic Record/Report.
-

Discharge Summary

A Discharge Summary or Final Note is completed for all discharged inpatients.
This document must be signed/ authenticated by the responsible care provider.

This report must include:

- identifying patient information as indicated in "History and Physical" and "Operative Report " above.
- Summary of the management of each of the active medical problems during the admission, including major investigations, treatments, operative procedures and outcomes.
- Details of discharge medications, including reasons for prescribing or altering medications, frequency of dosage and proposed length of use.
- Follow-up instructions and plans for after discharge, including a list of follow-up appointments with consultants, further ambulatory investigations, and any tests and reports that may require follow-up.
- Main condition or principal diagnosis
- External cause of injury – if treatment was provided for same
- Distribution of copies to the referring physician and/or family physician/other appropriate health care providers
- Date of completion of the discharge summary by the author.

It is the opinion of the WHO-FIC/IFHIMA Joint Collaboration that there is a need to emphasize the importance of optimal clinical documentation, and to highlight the positive results this has on patient care and outcomes, as well as on data collection systems and clinical coding. It is our hope that you will apply the tips contained in this simple document, to support the collection of clinical information within your health care facility.

This document has been produced by the *WHO Family of International Classifications Network* [http://www.who.int/classifications/en/] and the *Joint Collaboration with the International Federation of Health Information Management Associations.*