SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Documentation in the Health Care Record
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/336
DATE OF PUBLICATION	November 2021
RISK RATING	High
LEVEL OF EVIDENCE	N/A
REVIEW DATE	November 2023
FORMER REFERENCE(S)	Former SESIAHS 'Documentation in the Health Care Record' PD 057
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records and Medico-Legal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Co-Chairs, SESLHD Health Records & Medico Legal Committee Donna.Martin@health.nsw.gov.au
KEY TERMS	Health care record, documentation, documentation audit, medical record, clinical record, electronic medical record, paper medical record, document in the health care record
SUMMARY	The health care record shall be the primary source of information that supports patient/consumer care and safety in SESLHD. This procedure also outlines the requirement to orientate and educate all health care personnel who document in health care records.

1. POLICY STATEMENT

Documentation in health care records must provide an accurate description of each patient/client's episode of care or contact with health care personnel. The NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy requires that a health care record is available for every patient/client to assist with assessment and treatment, continuity of care, clinical handover, patient safety and clinical quality improvement, education, research, evaluation, medico-legal, funding and statutory requirements.

It also facilitates coding and accurate case-mix assignment and subsequent funding to SESLHD.

This procedure ensures that high standards for documentation in health care records are maintained, consistent with common law, legislative, ethical and current best practice requirements.

2. BACKGROUND

It is mandatory for SESLHD clinicians to comply with the NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy

In particular, the NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy specifies in Point 1.4 that both electronic and paper records must be audited for compliance with the policy. This procedure outlines a framework and schedule for auditing in SESLHD. The audit criteria and associated standards is in section 7.1 Documenting/Recording.

Health care records are legal documents that may be accessed under the Health Records and Information Privacy (HRIP) Act or subpoenaed.

This procedure also outlines the need to orientate and educate all health care personnel who document in health care records.

3. DEFINITIONS

Attending medical practitioner	Visiting medical officer, clinical academic or staff specialist responsible for the clinical care of the patient for that episode of care
Approved clinician	A clinician, other than a medical practitioner, approved to order tests e.g. nurse practitioner
Health care personnel	A person authorised by the SESLHD, to provide care, assessment, diagnosis, management and/or professional advice and are responsible for legibly documenting and dating this activity in the patient's/client's health care record. This group includes clinicians (nursing, medical and allied health) and non-clinicians such as ward clerks, clinical support officers, technical assistants, multicultural health workers, aboriginal health workers and health care interpreters
PHO	Public Health Organisation
Health care record	The main purpose of a health care record is to provide a means of communication to facilitate the safe care and treatment of a patient/client. A health care record is the primary repository of information including medical and therapeutic treatment and intervention for the health and well-being of the patient/client during an episode of care and informs care in future episodes. The health care record is a documented account of a patient/client's history of illness; health care plan/s; health investigation and evaluation; diagnosis; care; treatment; progress and health outcome for each health service intervention or interaction. The health care record may also be used for communication with external health care providers, and statutory and regulatory bodies, in addition to facilitating patient safety improvements; investigation of complaints; planning; audit activities; research (subject to ethics committee approval, as required); education; financial reimbursement and public health. The record may become an important piece of evidence in protecting the legal interests of the patient/client, health care personnel, other personnel or PHO. The health care record may be paper, electronic form or in both. Where a health care record exists in both paper and electronic form this is referred to as a hybrid record. Where PHOs maintain a hybrid record health care personnel must at all times have access to information that is included in each part. This policy applies to health care records that are the property of, and maintained by, PHOs, including health care records of private patients

	seen in the PHO. The policy does not apply to records that may be maintained by patients/clients and records that may be maintained by clinicians in respect of private patients seen in private rooms
Patient/client	Any person to whom a health service provider owes a duty of care in respect of the provision of health services.
Electronic Health Records	Includes all electronic health record systems including but not limited to eMR Cerner, eMaternity, eRIC, MOSAIQ or ARIA.
eMR	Cerner Electronic Medical Record
NSQHS Standards	National Safety and Quality Health Service Standards

4. RESPONSIBILITIES

4.1 General Managers/Clinical Service Directors are responsible for:

Ensuring compliance with the NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy and this procedure, with specific regard to auditing of documentation and implementation of audit results.

4.2 Clinical Service Managers are responsible for:

Consulting with relevant stakeholders, to ensure that all staff have completed the Health Education and Training Institute (HETI) module titled 'Clinical Documentation – Getting it Right' based on the NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy.

Ensuring the completion of the audit cycle. Reviewing results and implementing outcomes and recommendations from the audits as per Section 7. Auditing of Health Care Records.

Clinical Service Managers may delegate the completion of the audits to their staff however the manager is still required to review the audit results and implement any actions arising from the audit outcomes.

4.3 Health care personnel are responsible for:

Documenting in the health care record as per NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy.

5. PROCEDURE

5.1 Education

All staff should complete the HETI module titled 'Clinical Documentation – Getting it Right'

5.2 Discharge Summaries

Medical discharge summaries are completed and audited as per SESLHD PR/223 - Medical Discharge Summary, and are not included in the scope of this procedure.

6. DOCUMENTATION

Patient/clients' health care record
District Audit Tool - Documentation in the Health Care Records

7. AUDITING OF HEALTH CARE RECORDS

Medical, nursing, midwifery, health information management, allied health, mental health and community/non-admitted health disciplines should conduct audits preferably using the District Audit Tool Form F243. The audit has been split into the following sections:

A. Medico-Legal / Health Information Management
B. Nursing / Midwifery
C. Medical
D. Allied Health
E. Emergency Department
F. Theatres
G. Anaesthetics
H. Community Health/Non-Admitted
I. Mental Health
J. Drug and Alcohol

It is preferable that audits concentrate on the current episode of care. For example, the current admission for inpatients or the current episode of treatment for allied health/community health/non-admitted. Mental health and Drug & Alcohol records will be assessed by individual teams / wards. Long stay patients should be audited for the past month.

Professional groups should audit entries for their discipline. A minimum of 60 records should be audited annually. For example, 60 records should be audited annually per ward for nursing staff and 60 records should be audited annually per medical specialty, program, stream or service line (as determined by the General Manager/Director). For Allied Health, 60 records should be audited annually per allied health discipline per hospital or facility. Where appropriate, interdisciplinary audits may be completed. It is preferable that a minimum number of audits are completed monthly by each discipline to spread the total number of 60 across the calendar year.

Community Health units and health information managers should also complete their sections per month with a minimum of 60 records to be audited annually. Mental Health and Drug and Alcohol services should complete 60 audits for each team / service / ward annually. This may be an interdisciplinary audit.

The attached documentation audit tool should be used as a baseline audit tool and additional elements or criteria can be added in by sites and specialties. This includes women's and children's health, mental health and drug and alcohol.

Persons with responsibility for ensuring the completion of the audit for their areas/ disciplines need to be able to demonstrate that they have meet the audit criteria in some other way if they have not completed this audit. The National Safety and Quality Health Service (NSQHS) Standards related to the patient record are described in Appendix 1 NSQHS Table 7: Summary of actions related to the patient clinical record.

Governance

All documentation audit results should be collated centrally as directed by the General Managers/Clinical Service Directors and distributed to the site/stream/service peak quality committees and respective site/sector patient safety and clinical quality committees monthly, and to site CPIU staff. In addition to this, a biannual report outlining results should be made available to the General Managers/Clinical Service Directors for review.

There must be a system in place that ensures feedback to clinical staff inclusive of results and recommendations for improvement. A sample template is provided in Appendix 2

7.1 DOCUMENTING/RECORDING

The following criteria outline the mandatory documentation standards and supporting policies/guidelines for the audit. They should be used as a guide for clarifying expectations of audit criteria found on **District Form F243**:

A. Medico-Legal / Health Information Management

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / S	Patient's ID label is on both sides of every page or minimal I.D. information is written: MRN, Surname, given name/s, DOB and sex	The following items must appear on every page of the health care record, or on each screen of an electronic record a) Unique identifier (e.g. Unique Patient Identifier, Medical Record Number) b) Patient / client's family name and given name/s c) Date of birth (or gestational age / age if date of birth is estimated) d) Sex	NSW Health PD2009_072 State Forms SESLHDPR/335 Clinical forms - creation and/or revision of Patient Matters manual - Section 9.2.1 NSQHS Standards version 2 - 1.16 & 6.5
P / E / S	All entries are legible	Includes scanned documents	Patient Matters manual – Section 9.20 NSQHS Standards version 2 - 1.16 & 6.5

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E / S	All entries are written in English	Includes scanned documents	Patient Matters manual – Section 9.20 NSQHS Standards- version 2 1.16, 6.1 & 6.2
P / E	Only SESLHD accepted abbreviations are used (as per District Abbreviations Policy) in progress notes dated within 3 calendar days of admission	Use approved abbreviations and symbols	SESLHDPR/282 Clinical abbreviations procedure NSQHS Standards- version 2 1.16, 6.1 & 6.2
P	All paper-based entries are written in dark ink		Australian Standard - Paper Based Health Records (AS2828) NSQHS Standards- version 2 1.16, 6.1 & 6.2
P	All entries contain time of entry	Time of entry (using a 24-hour clock – hhmm)	NSW Health PD2009_072 State Forms Australian Standard - Paper Based Health Records (AS2828) NSQHS Standards- version 2 1.16, 6.1 & 6.2
P	All entries contain date of entry	Date of entry (using ddmmyy or ddmmyyyy)	NSW Health PD2009_072 State Forms Australian Standard - Paper Based Health Records (AS2828) NSQHS Standards- version 2 1.16, 6.1 & 6.2

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P	All entries are signed by the author	In a computerised system, this will require the use of an appropriate identification system e.g. Electronic signature.	NSW Health PD2009_072 State Forms Australian Standard - Paper Based Health Records (AS2828) NSQHS Standards- version 2 1.16 & 6.1
P	All entries include their name printed		NSW Health PD2009_072 State Forms Australian Standard - Paper Based Health Records (AS2828) NSQHS Standards- version 2 1.16 & 6.1
P / E	All entries include their designation		NSW Health PD2009_072 State Forms Australian Standard - Paper Based Health Records (AS2828) NSQHS Standards- version 2 1.16 & 6.1
P	There are no spaces between entries	Sequential - where lines are left between entries they must be ruled across to indicate they are not left for later entries and to reflect the sequential and contemporaneous nature of all entries.	NSQHS Standards- version 2 1.16 & 6.1

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P	**Addendum A** - Where an entry was omitted, additional details are documented next to the heading 'Addendum', including the date and time of the omitted event and the date and time of the addendum	If an entry omits details any additional details must be documented next to the heading 'Addendum', including the date and time of the omitted event and the date and time of the addendum. For hardcopy records, addendums must be appropriately integrated within the record and not documented on additional papers and / or attached to existing forms	NSQHS Standards- version 2 1.16 & 6.1
E	**Addendum B** - Where an entry was omitted, additional details are documented in an additional note with the heading "Addendum"	If an entry omits details any additional details must be documented next to the heading 'Addendum', including the date and time of the omitted event and the date and time of the addendum	NSQHS Standards- version 2 1.16 & 6.1

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	**Written in error** - The history of audited changes must be retained and the replacement note linked to the note flagged as “written in error”.	Written in error - all errors must be appropriately corrected. No alteration and correction of records is to render information in the records illegible. An original incorrect entry must remain readable i.e. do not overwrite incorrect entries, do not use correction fluid. An accepted method of correction is to draw a line through the incorrect entry or ‘strikethrough’ text in electronic records; document “written in error”, followed by the author’s printed name, signature, designation and date / time of correction	Patient Matters manual – Section 9.20 NSQHS Standards- version 2 1.16 & 6.1

P / E	Where an allergy is noted, there is an alert added in the electronic system and/or a sticker on the record cover	If a label is used on the outside folder of a paper based health care record this does not negate the need for documentation in the health care record of the alert / allergy, and known consequence. Any such issue should be 'flagged' or recorded conspicuously on appropriate forms, screens or locations within the health care record. Where alerts relate to behaviour issues or child protection matters the alert should be discreet to ensure the privacy and safety of the patient / client, staff or others. These flags, especially where codes or abbreviations are used, must be apparent to and easily understood by health care personnel; must not be ambiguous; and should be standardised within the PHO. A flag should be reviewed at each admission. When alerts and allergies are no longer current this must be reflected in the health care record and inactivated where possible. **Use known sources of alert data to cross reference e.g. eMR or iPM**	Patient Matters manual – Section 9.2.6 NSQHS Standards version 2 - 6.4c

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	If an IIMS event has been recorded, documentation of open disclosure processes is present	Can use IIMS database to cross-reference The IIMS reference number should be entered in the record	NSW Health PD2020_047 Incident Management Policy NSW Health PD2014_028 Open Disclosure NSQHS Standards version 2 – 1.11a, 1.11g & 1.12b

B. Nursing / Midwifery

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Progress note entries by students involved in the care and treatment of a patient / client are endorsed or co-signed by the student's supervising clinician	Note, excluding Community Health and MOSAIQ, as these have no co-sign facility	Clinical Placements in NSW Health Policy [PD2016_057] NSQHS Standards version 2 – 1.16
P / E	Progress note entries are written in an objective way and do not include demeaning or derogatory remarks	Excludes quotes by patient which are relevant to the patient's care	NSQHS Standards version 2 – 6.1
P / E	All patient / client care forms are comprehensively completed		NSQHS Standards version 2 – 6.1
P/E	All identified risks have documented evidence of interventions		NSQHS Standards version 2 – 6.4c

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	A Nursing/Midwifery Care Plan has been completed		NSW Health PD2019_020 Clinical Handover NSW Health PD2011_015 - Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals NSQHS Standards version 2 – 5.2 & 6.3
P / E	The Nursing/Midwifery Care Plan has been signed		NSW Health PD2019_020 Clinical Handover NSW Health PD2011_015 - Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals NSQHS Standards version 2 – 5.2 & 6.3
P / E	A PACE call is made for any observation charted in the red zone of the observation chart, unless alterations to calling criteria are documented	Any significant change in the patient / client's status with the onset of new signs and symptoms recorded	NSQHS Standard version 2 – 8.4 & 8.5

Media P = Paper E = Electronic S = Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	If a change in the patient / client's status has been reported to the responsible medical practitioner documentation of the name of the medical practitioner and the date and time that the change was reported to him / her		SESLHDPR/697 – Management of the Deteriorating ADULT inpatient (excluding maternity) SESLHDPR/284 – Management of Deteriorating PAEDIATRIC inpatient SESLHDPR/705 Management of the Deteriorating MATERINTY woman SESLHDPR/ 340 Management of the Deteriorating NEONATAL inpatient NSQHS Standards version 2 – 5.4 & 8.5
P / E	Where an invasive procedure is performed or administered, a record of the procedure including completion of all required procedural checklists exist		NSQHS Standards version 2 – 6.6

C. Medical

Media P = Paper E = Electronic	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Progress note entries by students involved in the care and treatment of a patient / client are endorsed or co-signed by the student's supervising clinician	Note, excluding CHOC and MOSAIQ, and ARIA as these have no co-sign facility	Clinical Placements in NSW Health Policy [PD2016_057] NSQHS Standards version 2 –1.16 & 6.1b
P / E	Progress note entries are written in an objective way and not include demeaning or derogatory remarks	Excludes quotes by patient which are relevant to the patient's care.	NSQHS Standards version 2 –1.16
P / E	Medical history and evidence of physical examination is documented on admission		NSQHS Standards version 2 –1.16 & 6.1
P / E	A principal diagnosis is reported for every episode of admitted patient care		NSQHS Standards version 2 –1.16
P / E	Medical management plan is documented		NSQHS Standards version 2 -6.2 & 5.2
P / E	Where an invasive procedure is performed or administered, a record of the procedure including completion of all required procedural checklists exist		NSQHS Standards version 2 –6.6
P / E	Comprehensive completion of all patient / client care forms is included		NSQHS Standards version 2 –5.2

Media P = Paper E = Electronic	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	General anaesthetic - a record of examination by a medical practitioner prior to the procedure	Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required.	NSQHS Standards version 2 –6.1

Media P = Paper E = Electronic	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	The Attending Medical Practitioner (AMP) has reviewed the preceding medical entries and made a written entry in the health care record (print name, signature, designation and date/time) to confirm they have been read at the same time as they are reviewing the medical management plan	The Attending Medical Practitioner (AMP) is responsible for the clinical care of the patient / client for that episode of care and is responsible for ensuring that adequate standards of medical documentation are maintained for each patient / client under their care. When documentation is delegated to a medical practitioner e.g. Intern, Resident, Registrar, the AMP remains responsible for ensuring documentation is completed to an appropriate standard that would satisfy their professional obligations. The AMP must review the preceding medical entries and make a written entry in the health care record (print name, signature, designation and date/time) to confirm they have been read at the same time as they are reviewing the medical management plan for the patient / client to ensure it remains current and clinically appropriate, consistent with the AMP's duty of care to the patient / client.	NSQHS Standards version 2 –1.16

Media P = Paper E = Electronic	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	The health care record includes documentation of pathology, radiology and other tests ordered, including the indication for the test and the result of the test		NSQHS Standards version 2 –1.16 & 6.1
P / E	Pathology, radiology and other test results have been followed-up and endorsed	Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner / approved clinician, with endorsement involving the name, signature, designation of the medical practitioner / approved clinician, and date / time. Note: cross referencing with eMR should be used to verify the above	NSQHS Standards version 2 –1.16 & 6.1
P / E	Critical / unexpected/abnormal results have been documented in the health care record	Critical/unexpected/abnormal results should be documented in the patient / client's health care record by the responsible medical practitioner / approved clinician as soon as practicable and any resultant change in care / treatment plans documented. Note: cross referencing with eMR is required.	NSQHS Standards version 2 –1.16 & 6.1

D. Allied Health

Media P = Paper E = Electronic	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Progress note entries by students involved in the care and treatment of a patient / client are endorsed or co-signed by the student's supervising clinician	Note, excluding CHOC & MOSAIQ, and ARIA as these have no co-sign facility	NSQHS Standards version 2 –1.16
P / E	Written in an objective way and not include demeaning or derogatory remarks	Excludes quotes by patient which are relevant to the patient's care.	NSQHS Standards version 2 –1.16
P / E	A care / treatment plan has been completed		NSW Health PD2019_020 Clinical Handover NSW Health PD2011_015 - Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals NSQHS Standards version 2 –5.1, 5.2 & 5.3

Media P = Paper E = Electronic	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	All patient / client care forms are comprehensively completed		NSW Health PD2019_020 Clinical Handover NSW Health PD2011_015 - Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals NSQHS Standards version 2 –5.2
P/E	All identified risks have documented evidence of interventions		NSW Health PD2019_020 Clinical Handover NSW Health PD2011_015 - Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals NSQHS Standards version 2 –1.16d & 6.4

E. Emergency Department

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Emergency documentation must include medical and nursing assessment and /or midwifery and allied health assessment where applicable		NSQHS Standards version 2 –1.16 & 5.4
P / E	Emergency documentation must include a record of the pathology, radiology and other tests that were ordered. There must be evidence of follow up and a notation as to action required.	Pathology, radiology and other tests ordered. Pathology, radiology and other test results must be followed up and reviewed with notation as to action required.	NSQHS Standards version 2 –1.16 & 6.4
P / E	Emergency documentation must include details of treatment		NSQHS Standards version 2 –1.16 & 6.2
P / E	Emergency documentation must include follow up treatment, where applicable		NSQHS Standards version 2 –1.16 & 6.2
P / E	Emergency documentation must include, for each transfer of care, the date and time, destination (e.g. home, other level of health care), method and whether accompanied is recorded		NSQHS Standards version 2 –1.16 & 6.5

F. Theatres

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Operation / procedure reports must include date of operation / procedure is recorded		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include pre-operative diagnosis		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include post-operative diagnosis		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include indication for operation / procedure		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include procedure safety checklist		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Operation / procedure reports must include surgical operation / procedure performed		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include names of personnel involved in the operation / procedure		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include outline of the method of surgery / procedure		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include product / device inserted and batch number		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include changes to, or deviations from, the planned operation / procedure, including any adverse events that occurred		NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include operative / procedural findings		NSQHS Standards version 2 –1.16 & 6.2

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Operation / procedure reports must include details of tissue removed		NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include pathology ordered on specimens		NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 –1.16 & 6.2
P / E	Operation / procedure reports must include post-operative orders		NSQHS Standards version 2 –1.16 & 6.2

G. Anaesthetics

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Anaesthetic reports must include pre-operative assessment, including patient anaesthetic history is recorded		NSQHS Standards version 2 –5.11
P / E	Anaesthetic reports must include risk-rating e.g. American Society of Anaesthesiologists (ASA) score is recorded		NSQHS Standards version 2 –5.11
P / E	Anaesthetic reports must include date and time anaesthetic commenced and completed		NSQHS Standards version 2 –1.16 & 6.5
P / E	Anaesthetic reports must include anaesthesia information and management i.e. medications, gases, type of anaesthetic		NSQHS Standards version 2 –1.16 & 6.4
P / E	Anaesthetic reports must include evidence that NSW safety checklists have been completed	NSW safety checklists including patient assessment and equipment checklists, consistent with Australian and New Zealand College of Anaesthetists requirements.	NSW Health PD2017_032 Clinical Safety Procedure NSQHS Standards version 2 – 6.2

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Anaesthetic reports must include operative notes / monitor results		NSQHS Standards version 2 –5.4
P / E	Anaesthetic reports must include post-operative notes / orders		NSQHS Standards version 2 – 6.4

H. Community Health/Non-Admitted

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P / E	Progress note entries by students involved in the care and treatment of a patient / client are endorsed or co-signed by the student's supervising clinician	Note, excluding CHOC and MOSAIQ, as these have no co-sign facility	NSW Health PD2016_057 Clinical Placements in NSW Health NSQHS Standards version 2 –1.16
P / E	Progress note entries are written in an objective way and do not include demeaning or derogatory remarks	Excludes quotes by patient which are relevant to the patient's care.	NSQHS Standards version 2 –1.16
P / E	A care / treatment plan has been completed		NSW Health PD2019_020 Clinical Handover NSW Health PD2011_015 - Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals NSQHS Standards version 2 –5.2 & 6.3
P / E	All patient / client care forms are comprehensively completed		NSQHS Standards version 2 –5.2 & 6.3

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P/E	All identified risks have documented evidence of interventions		NSQHS Standards version 2 –5.11

I. Mental Health

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
E	All PowerNote entries by clinicians including students involved in the care and treatment of a consumer is endorsed and signed, and/or co-signed by the student's supervising clinician.	Nil	NSW Health PD2016_057 Clinical Placements in NSW Health Policy SESLHDPR/509 Procedure Student documentation within Cerner eMR NSQHS Standards version 2 –1.16
E	Progress note entries are written in a recovery oriented way and are non-judgemental and respectful.	Progress note entries are written in an objective way and do not include demeaning or derogatory remarks. Excludes quotes by patient which are relevant to the consumer's care. Also excludes acronyms. The use of Acronyms must follow SESLHD Procedure Clinical Abbreviations procedure	MHCC Recovery Oriented Language Guide 2019 SESLHDPR/282 Clinical abbreviations procedure and Clinical Abbreviation List NSQHS Standards version 2 –1.16

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
E	All mandatory documents relating to the care of consumers are completed and signed – Based Documents: Triage, Assessment, Care Plan and/or Review.	Triage may be N/A in some circumstances for example, if the consumer has been referred from a clinic or community setting, a triage document may have already been completed and on admission, the consumer would only undergo an Assessment	NSW Health PD2021_0039 Mental Health Clinical Documentation NSW Health GL2014_002 Mental Health Clinical Documentation Guidelines NSQHS Standards version 2 –1.16 & 5.3
E	(i) Mental health legal paperwork (including consumer with any legal orders) is current and available in the paper file. (ii) Mental health legal status has been recorded in eMR in either MH Triage 'Legal Status/Forensic Issues' OR MH Current. Assessment 'Current Legal Issues'	Completion of Mental health legal paperwork is mandatory in all NSW hospitals. Originals must be kept in the paper file (except on transfer when the original must travel with the consumer – a photocopy should be retained). Voluntary or involuntary status and any legal issues should be documented in eMR under Triage or Current Assessment.	NSW Health IB2018_019 Rights to access medical record by legal representative – Mental Health Tribunal hearing NSQHS Standards version 2 –1.16
E	Identified risks have been detailed in eMR in either MH Current Assessment 'Formulation and Guidance – Identification of Risks' OR MH Review 'Assessment of Risks'.	Documentation by nurses (and midwives) must include a care/treatment plan, including evidence of an action plan and/or intervention. Identification of risk(s)	SESLHDGL/082 Clinical Risk Assessment and Management

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
		should be documented in Current Assessment and Review. Identification of risk(s) includes risk factors of suicide, self-harm, violence vulnerability/ harm from others, absconding, and risk to children under 18 & other.	NSQHS Standards version 2 –5.11
E	The Senior Medical Officer (Snr MO.) has reviewed the consumer and made an entry in eMR to confirm the review and updated the consumer's medical management plan (relevant to the health care setting)	For Acute, documentation should occur once every 3 days For rehabilitation, consumer documentation should occur once every 7 days For community, documentation should occur once every 13 weeks.	National Standard 9 SESLHDPR/697 – Management of the Deteriorating ADULT inpatient (excluding maternity) SESLHDPR/284 – Management of Deteriorating PAEDIATRIC inpatient SESLHDPR/705 Management of the Deteriorating MATERINTY woman SESLHDPR/ 340 Management of the Deteriorating NEONATAL inpatient NSQHS Standards version 2 –5.1 & 5.3

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
E	Where an operation or procedure is performed (under sedation/anaesthetic) (excluding ECT procedure), a record of the procedure, including completion of all required procedural checklists exists.	Surgical operation/procedure performed and completion of a procedure safety checklist ECT is excluded – The ECT service is responsible for ensuring there is ongoing auditing of ECT, which includes auditing the file of every consumer receiving ECT. This audited data is provided annually to the SESLHD ECT Committee	NSW Health PD2011_003 Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW NSQHS Standards version 2 –6.4 SESLHDPR/310 Practice of Electroconvulsive Therapy ECT
P/E	Pathology, radiology and other test results have been endorsed by the treating team.	Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner / approved clinician, with endorsement involving the name, signature, designation of the medical practitioner / approved clinician, and date / time. Note: cross referencing with eMR is required.	NSQHS Standards version 2 –6.4c

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
P/E	Critical / unexpected/abnormal results have been documented in the health care record.	Critical/unexpected/abnormal results should be documented in the patient/client's health care record by the responsible medical practitioner/approved clinician as soon as practicable and any resultant change in care/treatment plans documented. Note: cross referencing with eMR is required.	NSQHS Standards version 2 –6.4c
P/E	For each discharge &/or transfer of care, a consumer should have a completed MH Admission, Transfer & Discharge Checklist OR a completed eMR MH Transfer of Care Checklist (AdHoc, Mental Health, Additional Tools) in the health care record.	Nil	NSW Health PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services NSQHS Standards version 2 –6.4
E	A mental health diagnosis (using ICD 10 codes not SNOMED) has been added to this encounter under 'Diagnosis, Alerts and Problems'.	Diagnosis code should reflect ICD_10 until 30 June 2019. This is mandatory and cross referenced with documentation on eMR	NSQHS Standards version 2 –6.4

Media P = Paper E = Electronic S= Scanned documents	Audit Criteria	Standards for documentation / further information	References other than PD2012_069
E	The following MH Admission Outcome Measure has been completed within 3 days of inpatient admission and for community, MH Admission or Review Outcome Measure has been completed within 3 days of assessment • Adult – HoNOS, • Child and adolescent – HoNOSCA, • Older person – HoNOSCA65+	Date sighted	NSQHS Standards version 2 –1.16

J. Drug & Alcohol

E	Progress note entries by students involved in the care and treatment of a patient / client are endorsed or co-signed by the student's supervising clinician.		NSW Health PD2016_057 Clinical Placements in NSW Health Policy SESLHDPR/509 Procedure Student documentation within Cerner eMR NSQHS Standards version 2 – 1.16
E	Progress note entries are written in an objective way and do not include subjective, demeaning or derogatory remarks.	Excludes quotes by patients which are relevant to the patient's care.	NSQHS Standards version 2 – 1.16
E	D&A Withdrawal module is completed for clients who have attended for a substance use withdrawal episode of care both non-admitted and admitted		
E	If Child Wellbeing concerns have been noted on the Child Wellbeing Screening module, the Mandatory Reporters Guide (MRG) was completed and the reference number entered.		Child Wellbeing and Child Protection Policies and Procedures for NSW Health Section 73.2
E	Evidence of contact with clinician/case manager within 7 days of commencing service (OTP clients)		
E	Evidence of Missed Doses protocol being followed - (OTP clients only)		Drug and Alcohol - Management of missed consecutive doses of Opioid

			Agonist Treatment - SESLHD PR/411 NSQHS Standards Version 2 4.15
E	Evidence of Clinical/Case Conferencing / case review meetings in medical record		NSQHS Standards Version 2 5.13
E	Evidence of follow up as per Business Rule DASBR/03 Follow up pathways after client does not attend an appointment or treatment		Drug And Alcohol Service Clinical Business Rule DASBR/03
E	An assessment has been completed	Assessment should be completed once per encounter (if encounter started at CHOC Go-Live – this will be N/A)	NSQHS Standards Version 2 5.14
E	An ATOP has been completed	An Australian Treatment Outcomes Profile (ATOP) should be completed at assessment and thereafter at least once every 90 days	NSQHS Standards Version 2 5.14 and 5.10
E	A GCP has been completed	A Global Care Plan (GCP) should be updated at least once every 90 days. Risks should be addressed in Global Care Plan.	NSQHS Standards Version 2 5.14
E	Evidence of additional clinical review forms used where applicable (ATOP/3mth review/AWS/DARF)	An ATOP should be completed every three months at a minimum. An AWS should be completed each day that a client completing withdrawal presents to the clinic and/or prior to admission for an inpatient detox.	NSQHS Standards Version 2 5.10

P/E	Pathology, radiology and other test results have been followed-up and endorsed.	Pathology, radiology and other test results must be followed up and reviewed with notation as to action required. The results must be endorsed by the receiving medical practitioner.	NSQHS Standards version 2 – 6.4c
E	Critical / unexpected/abnormal results have been documented in the health care record	Critical/unexpected/abnormal results should be documented in the patient/client's health care record by the responsible medical practitioner/approved clinician as soon as practicable and any resultant change in care/treatment plans documented.	NSQHS Standards version 2 – 6.4c
E	All episodes have a commencement date, and a cessation date (if no recent contact).		Data Dictionary & Collection Requirements for the NSW MDS for Drug and Alcohol Treatment Services

8. REFERENCES

External References

- AS 2828.1-2019 Health records - Paper-based health records
- AS 2828.2(Int)-2012 Health records - Digitized (scanned) health record system requirements
- National Safety and Quality Health Service Standards
- Medical Board of Australia. Good Medical Practice: A Code of Conduct

NSW Ministry of Health Policy Directives

- NSW Ministry of Health PD2012_069 Health Care Records – Documentation and Management Policy
- NSW Ministry of Health PD2017_032 Clinical Safety Procedure
- NSW Ministry of Health PD2019_020 Clinical Handover
- NSW Ministry of Health PD2011_015 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals
- NSW Ministry of Health PD2016_057 Clinical Placements in NSW Health Policy
- NSW Ministry of Health PD2019_045 Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services
- NSW Ministry of Health PD2011_003 Electroconvulsive Therapy: ECT Minimum Standard of Practice in NSW
- NSW Ministry of Health PD2021_039 Mental Health Clinical Documentation
- NSW Ministry of Health PD2020_047 Incident Management
- NSW Ministry of Health PD2014_028 Open Disclosure
- NSW Ministry of Health PD2009_072 State Forms
- NSW Ministry of Health GL2014_002 Mental Health Clinical Documentation Guidelines
- NSW Ministry of Health IB2018_019 Rights to access medical record by legal representative – Mental Health Tribunal hearing
- NSW Ministry of Health Patient Matters Manual

NSW Health Data Collections

- Data Dictionary & Collection Requirements for the NSW MDS for Drug and Alcohol Treatment Services

Internal References

- SESLHDPR/282 Clinical Abbreviations Procedure and Clinical Abbreviations List
- SESLHDPR/335 Clinical forms - creation and/or revision of
- SESLHDPR/697 – Management of the Deteriorating ADULT inpatient (excluding maternity)
- SESLHDPR/284 – Management of Deteriorating PAEDIATRIC inpatient
- SESLHDPR/705 Management of the Deteriorating MATERINTY woman
- SESLHDPR/ 340 Management of the Deteriorating NEONATAL inpatient
- SESLHDPR/509 Procedure Student documentation within Cerner eMR
- SESLHDPR/310 Practice of Electroconvulsive Therapy ECT
- SESLHDGL/082 Clinical Risk Assessment and Management

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
March 2013	0	Donna Martin Sector Manager Clinical Information and Administrative Services St George and Sutherland Hospitals and Health Services, SESLHD
Feb 2014	1	Kim Brookes Patient Safety and Consumer Feedback Manager Clinical Governance Unit, SESLHD Maria Jessing Clinical Improvement Manager Clinical Governance Unit, SESLHD Sophia Adamo Medical Record Manager Randwick Campus (POW/SCH/RHW) Robyn Counter Medical Record Manager War Memorial Hospital
Mar 2014	1	Revised and re-formatted by District Policy Officer. Revised by Sophia Adamo, Medical Records Manager, POW/SCH/RHW)
June 2014	1	Kim Brookes Patient Safety and Consumer Feedback Manager Clinical Governance Unit, SESLHD Maria Jessing Clinical Improvement Manager Clinical Governance Unit, SESLHD Sophia Adamo Medical Record Manager Randwick Campus (POW/SCH/RHW)
August 2018	2	Therese Finch Co-Chair SESLHD Health Records and Medico-Legal Committee Patricia Bradd SES PICHD Ambulatory & Primary HC Exec Clinical Efficiency Evaluation Director Flora Karanfilovski Director ICT/CIO
September 2018	2	Major Review endorsed by Executive Sponsor.
Oct 2018 – Nov 2018	2	Draft for Comment period.
Dec 18/ Jan 19	2	Executive Sponsor changed to Director Health ICT. Draft endorsed by Executive Sponsor. Formatted by Executive Services before progressing to Clinical and Quality Council for approval prior to publishing.
March 2019	2	Approved by Clinical and Quality Council
May 2019 – Jan 2020	3	National Standards updated to National Standards 2 – Lyn Woodhart Patient Safety Manager SESLHD Clinical Governance Unit Section J added by SESLHD Drug & Alcohol Service Updates to document approved by SESLHD Health Records and Medico legal Committee

November 2021	4	Minor review: updates to definitions and wording; responsibilities made clearer, hyperlinks and polices updated. Endorsed by Executive Sponsor.
November 2021	4.1	Further update of hyperlinks and references. Endorsed by Executive Sponsor.

Appendix 1

NSQHS Table 7: Summary of actions related to the patient clinical record
The table below will assist health service organisations to identify criteria and actions relating to patient clinical records.
Key: C = Core action; D = Developmental action

This criterion will be achieved by:	Actions required:	C/D
1.9 Using an integrated patient clinical record that identifies all aspects of the patient's care	1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	C
	1.9.2 The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	C
1.18 Implementing processes to enable partnership with patients in decision about their care, including informed consent to treatment	1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent	C
4.6 The clinical workforce taking an accurate medication history when a patient presents to a health service organisation, or as early as possible in the episode of care, which is then available at the point of care	4.6.1 A best possible medication history is documented for each patient	C
4.7 The clinical workforce documenting the patient's previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care	4.7.1 Known medication allergies and adverse drug reactions are documented in the patient clinical record	C
4.8 The clinical workforce reviewing the patient's current medication orders against their medication history and prescriber's plan, and reconciling any discrepancies	4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	D
4.14 Developing a medication management plan in partnership with patients and carers	4.14.1 An agreed medication management plan is documented and available in the patient's clinical record	D
7.5 As part of the patient treatment plan, the clinical workforce accurately documenting: • relevant medical conditions	7.5.1 A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	C

This criterion will be achieved by:	Actions required:	C/D
• indications for transfusion • any special product or transfusion requirements • known patient transfusion history • type and volume of product transfusion • patient response to transfusion	7.5.2 The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	C
	7.5.3 Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	C
7.6 The clinical workforce documenting any adverse reactions to blood or blood products	7.6.1 Adverse reactions to blood or blood products are documented in the patient clinical record	C
7.11 Implementing an informed consent process for all blood and blood product use	7.11.1 Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	D
8.5 Identifying risk factors for pressure injuries using an agreed screening tool for all presenting patients within timeframes set by best practice guidelines	8.5.2 The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	C
8.6 Conducting a comprehensive skin inspection in timeframes set by best practice guidelines on patients with a high risk of developing pressure injuries at presentation, regularly as clinically indicated during a patient's admission, and before discharge	8.6.1 Comprehensive skin inspections are undertaken using an agreed assessment tool and documented in the patient clinical record for patients at risk of pressure injuries	C
8.7 Implementing and monitoring pressure injury prevention plans and reviewing when clinically indicated	8.7.1 Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	C
	8.7.3 Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	D
8.8 Implementing best practice management and ongoing monitoring as clinically indicated	8.8.2 Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	C
	8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	C

This criterion will be achieved by:	Actions required:	C/D
9.8 Ensuring that information about advance care plans and treatment-limiting orders is in the patient clinical record, where appropriate	9.8.2 Advance care plans and other treatment-limiting orders are documented in the patient clinical record	D
10.7 Developing and implementing a multifactorial falls prevention plan to address risks identified in the assessment	10.7.1 Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	C

Appendix 2

Sample template for recording completed audit results and analysis, feedback and remedial quality improvement activities.

Site and Stream	Clinical Service	Date	Audited Sections	Analysis and Findings	Action taken