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Coroners Court of Victoria
Level 11, 222 Exhibition Street
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Dear Sir/Madam

Inquest into the death of [redacted]
Coroner's Reference: COR 2012 003776

We refer to the findings without an inquest of the Honourable Judge Gray in relation to the death [redacted] delivered on 10 April 2013.

The following recommendations were made pursuant to section 72(2) of the *Coroners Act 2008* (Vic):

Recommendation 1:

'That Peninsula Health should ensure all medical, nursing and allied health personnel are adequately trained in, informed of and adhere to the PHMHS Clinical Practice Guidelines'

Recommendation 2:

'That patient's notes are the official record of the patient's care. They are the medico-legal record of the interaction between the patient (including family) and the health service. In this respect, I note that the Progress Note Report Documentation lists a number of guidelines that should be followed in completing the Progress Notes, however, formal consideration should be given to include in the guidelines the types of information that should be documented including reasons for decisions to be set out on the patient's file.'

We provide the following response to the Coroner's recommendations.

Recommendation1:

In response to this recommendation, Peninsula Health has developed and implemented a new Mental Health Clinical Practice Guideline entitled 'Communication, Education and Distribution of New and Revised Mental Health Clinical Practice Guidelines". This new Clinical Practice Guideline is **enclosed** for the Court's reference (**Enclosure A**).

In particular, we refer to the Communication, Training and Education of the CPG sub-heading, under which is a set of guidelines to ensure that all nursing, allied and medical staff are properly informed of and trained in Clinical Practice Guidelines.

In addition, to ensure that Clinical Practice Guidelines are adhered to, Peninsula Health conducts regular audits as required in the 'Evaluation' section of individual Clinical Practice Guidelines. **Enclosed** for the reference of the Court is the aggregated audit results of Mental Health Clinical Practice Guidelines for the period of January to May 2013 (**Enclosure B**). This audit activity is ongoing. Where compliance issues are identified, clear action plans are put in place to resolve them in a timely manner.

Further, we **enclose** the Peninsula Health Medical Record Documentation policy (**Enclosure C**). This policy mandates specific documentation requirements for, inter alia, mental health client files.

Recommendation 2:

In response to this recommendation, Peninsula Health has approved for circulation an updated Report Documentation Guideline to be inserted as point 8 on the top left corner of the Progress Note. This new point 8 reads: 'Refer to Medical Record Documentation Policy (7.1.19) for specific documentation requirements'.

Peninsula Health believes that the addition of this new point 8 will trigger further awareness of the Medical Record Documentation policy to meet with the intent of this recommendation.

We trust that this is of assistance to the Court.

Please do not hesitate to contact me if you have any queries.

Yours faithfully

Mr David Goldberg
General Counsel
Peninsula Health

Enclosure A

CLINICAL PRACTICE GUIDELINE

MENTAL HEALTH SERVICE

Peninsula Health

COMMUNICATION, EDUCATION AND DISTRIBUTION OF NEW AND REVISED MENTAL HEALTH CLINICAL PRACTICE GUIDELINES

1. INTRODUCTION

This Clinical Practice Guideline (CPG) outlines the responsibilities of mental health staff when a new or revised CPG is developed within the service.

2. PURPOSE

To provide a process within the Peninsula Health Mental Health Service (PHMHS) that ensures all staff has access to new and revised Clinical Practice Guidelines to support and guide them in their clinical practice.

3. DEFINITIONS

None

4. RELATED POLICIES/ CLINICAL PRACTICE GUIDELINES

None

5. RESPONSIBILITIES

5.1. **Employer** – The Chief Executive of Peninsula Health is ultimately responsible for ensuring that policies, procedures and clinical practice guidelines are implemented to support and guide staff in their practice.

5.2. **Departmental** – The Clinical Director of PHMHS is responsible for ensuring the Mental Health Communication, Education and Distribution of New and Revised Clinical Practice Guideline (CPG) is implemented consistently in the service, and that clinical staff are aware of and have access to the CPG.

5.3. **Department Head/Manager** – The Program Managers, Team Managers/Leaders, Nurse Unit Managers (NUMs), and the Associate Nurse Unit Managers (ANUMs)/2IC's are responsible for the implementation of the Mental Health Mental Health Communication, Education and Distribution of New and Revised CPG.

5.4. **Employee** - All relevant clinical staff are responsible for ensuring they are aware of and adhere to this CPG during their clinical practice.

6. CLINICAL PRACTICE GUIDELINE

Process for review and development of CPGS in Mental Health:

CPGs that have been identified for review will be via the scheduled CPG review process. CPGs that have been identified to be developed are usually as a result of a recommendation from the Mental Health (MH) Executive Group

The Mental Health CPG Committee meets on a monthly basis and the CPGs that are identified for review/development are discussed at this meeting. Tasks associated with the review/development are delegated to specific members of the committee. The Committee has representation from all areas of the Mental Health Service including Allied Health staff.

The reviewed or newly developed CPG is approved by the CPG Committee.

COMMUNICATION, EDUCATION AND DISTRIBUTION OF NEW AND REVISED MENTAL HEALTH CLINICAL PRACTICE GUIDELINES

The CPG is sent to the Mental Health Executive Committee for final review and sign off.

The Communication, Training and Education Plan include the following:

New staff during Mental Health Orientation are provided with information on how to access CPG's via the intranet.

PHMHS also informs all staff via email when a new CPG is introduced and/or updated.

PHMHS also highlights new and updated CPG's via the PHMHS newsletter.

New and/or updated CPG's are a standard agenda item for regular team/staff meetings.

Team Managers also provide their team/s with a sign off sheet attached to new and/or updated CPG that staff sign to acknowledge they have read same.

Mental Health CEDU provides the education of CPG's to all team members including content and processes associated with the CPG. An attendance record of the education session is maintained and stored by CEDU.

7. EVALUATION

- VHIMS Incident Reporting
- Clinical Risk Meetings
- Clinical Documentation Audits

8. REFERENCES

None

9. CLINICAL PRACTICE GUIDELINE HISTORY

- New CPG developed July 2013

10. KEY PERFORMANCE INDICATORS/ OUTCOME

None

Enclosure B

CLINICAL RECORD AUDIT – 2 WEST 2013
AUDIT SUMMARY & COMPARISSON

	Jan 2013 % Compliant	Feb 2013 % Compliant	Mar 2013 % Compliant	April 2013 % Compliant	May 2013 % Compliant	Comments
ASSESSMENT						
Intake Assessment completed	100↔	100↔	100↔	100↔	100↔	
MSE documented in Intake Assessment	100↔	100↔	100↔	100↔	100↔	
Substance use issues assessed	96.5↓	96.5↔	100↑	100↔	95↓	CPIC and NUM have reminded staff at team meeting to complete this on discharge, ANUM's to ensure this is being completed
Alerts recorded ***(on CMI, IPM, CLOVeR)***	100↔	100↔	100↔	100↔	100↔	
Allergies Recorded on CLOVeR (Sensitivity label applied)	100↔	100↔	100↔	100↔	100↔	
Diagnosis provided	100↔	100↔	100↔	100↔	100↔	
Information dissemination form completed	96.5↓	100↑	100↔	100↔	100↔	
Provision of rights & responsibilities	100↔	100↔	100↔	100↔	100↔	
Risk Assessment Screen	100↔	100↔	100↔	100↔	100↔	
HoNOS	100↔	100↔	100↔	100↔	100↔	
Acute Management Plan Part A completed	100↔	100↔	96.5↓	100↑	100↔	
Needs assessment, risk management care plan	100↔	100↔	100↔	100↔	100↔	
Falls Risk assessment	100↔	100↔	96.5↓	96.5↔	98↑	Overall improvement of completion of this assessment.
Physical Assessment	100↔	96.5↓	96.5↔	100↑	100↔	
TREATMENT & INTERVENTIONS						
Treatment Plan Completed	100↔	100↔	92↓	100↑	100↔	
Treatment Plan signed by consultant and consumer/carer	82.75↑	79.3↓	92↑	96.5↑	98↑	Improvement noted.
Consumer involved in treatment decision process	100↔	100↔	100↔	100↔	100↔	
Evidence of Treatment Plan enacted	100↔	100↔	100↔	100↔	100↔	
MSE completed regularly	100↔	100↔	100↔	100↔	100↔	
Risk Assessment completed per shift	100↔	100↔	100↔	100↔	100↔	
Medical review/Consultant review	100↔	100↔	100↔	100↔	100↔	

Clinical review	100↔	100↔	100↔	100↔	100↔	
GP liaison	93↓	96.5↑	88↓	96.5↑	92↓	
Family meeting	93↑	93↔	100↑	100↔	92↓	All patients have had family liaison, family meetings are planned to occur early next month.
Family liaison	100↔	96.5↓	100↑	100↔	100↔	
Therapeutic interventions documented	100↔	100↔	100↔	100↔	100↔	
Clinician clearly identified (Signed, name printed, designation)	100↔	100↔	100↔	100↔	100↔	
DISCHARGE PLANNING						
Evidence of discharge planning enacted	100↔	100↔	100↔	100↔	100↔	
Community Clinician attended the ward	70↓	85.7↑	100↑	60↓	100↑	7 patients have recovery clinicians already assigned and all have attended the ward to assess there patients.

COMMENTS MAY:

Summary

- **Overall improvement of clinical documentation on 2west**
- **ANUM's need to ensure that staff are completing all assessments on admission and throughout the patient stay**
- **Family meetings have decreased for the month, due to family dynamics, further meetings are planned to take place early next month**
-

Enclosure C

POLICIES & PROCEDURES

INFORMATION MANAGEMENT

Peninsula Health

7.1.19 MEDICAL RECORD DOCUMENTATION

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7.1.19 MEDICAL RECORD DOCUMENTATION

PURPOSE AND SCOPE

This policy outlines a multidisciplinary approach to medical record documentation and provides a set of minimum standards for documentation for all services provided by Peninsula Health.

Documentation encompasses all written and/or electronic recordings of all aspects of a patient's care that reflects what was communicated, planned or given to that patient.

The purpose of documentation is:

- To provide an account of the patient's diagnosis, treatment and care and enable care delivery to be tracked, monitored and evaluated
- To facilitate continuity of care through the communication of information between health care professionals
- To meet medico-legal and statutory requirements
- To provide information for audits, quality management, education, research and clinical and resource management

DEFINITION

For the purpose of this document, "Patient" refers to "Patient, Client and/or Resident"

POLICY

- Medical records must be sufficiently detailed to clearly identify the patient, the date and time of all consultations, the patient's needs, consents given, legal status, care planned, care and advice provided, progress, follow up and outcomes, while avoiding repetitive and / or redundant information.

- All health professionals involved in a patient's episode of care are responsible for ensuring that documention in the medical record is in compliance with ACHS (Criterion 1.1.8) and/or Health Service standards, relevant professional guidelines and statutory requirements including National Standards for Mental Health.

- In accordance with Australian Standard 2828 all documentation in the medical record must be chronological, pertinent, timely, accurate, factual and objective.

- The use of Clinical Pathways is restricted to those that are approved medical record forms (as aproved by Manager, Health Information Services).

- The Medical Record is the property of Peninsula Health and as such cannot be removed from the premises without appropriate authorisation from the Manager, Health Information Services. For off site services (i.e HITH) medical records must remain in the service offices and documentation in the medical record must be completed on returning from a home visit.

- Information contained within a medical record should be held in confidence and viewed only by those who are directly involved in the care of the patient, or require access to fulfill their duties, in accordance with legislation including the Victorian *Health Records Act* 2001, *Mental Health Act 1986 and the Health Services Act 1988*.

- All patient data is to be kept strictly confidential and the storage of the medical record should be in accordance with the above legislation.

- Regular training and education sessions will be provided for all Peninsula Health clinical staff regarding the minimum standards of documentation.

7.1.19 MEDICAL RECORD DOCUMENTATION

- Medical Record Audits will be conducted twice yearly by Health Information Services, to ensure that minimum standards are met.

PROCEDURE

Medical records must contain the following:

MANDATORY INFORMATION

1. Each medical record page must contain the patient's name, UR number, location of care, and DOB.
2. Before documenting in the medical record, ensure that it is the correct patient for which the entry refers.
3. Each medical record entry (including alterations) must be legible and made with permanent black ink in accordance with Australian Standard 2828 unless another colour has been approved by the Manager, Health Information Services.
4. Each medical record entry must be in English.
5. Each medical record entry must include date (dd/mm/yy), time (hh:mm), signature, surname in capitals, discipline/specialty and designation.
6. Entries should include only objective data and expression relating to the patient. They should be based on fact, observation and/or the patient's own statements. Vague, meaningless, ambiguous, judgmental or emotive statements are inappropriate in the medical record.
7. Correct spelling to be used, particularly of drug names.
8. Documentation should occur chronologically and as close as possible to the time that treatment was given to the patient.
9. For paper record entry errors (alterations or deletions including bradma/patient labels) must be crossed through with a single line and accompanied with a written "error", date, time, initials and brief explanatory statement (i.e wrong patient). The error should not be erased, scribbled or written over, and correction fluid must not be used. If labels have the correct name, address etc. but wrong UR number then new labels with the correct UR number should be printed and placed over the top of the incorrect one. For electronic entry errors a new e-progress note must be created detailing correction.
10. Information omitted from a previous entry may be included by documenting with the date and time of the additional entry, and the date and time the entry refers to. E.g. "Addendum to note of 6/02/03, 1500 hours….."
11. Information material must not be removed from the medical record.
12. Where possible, originals of documents are to be scanned in the medical record. In circumstances where the original document cannot be scanned, ensure a photocopy of it is scannedin the medical record. Incident Reports are not to be scannedin the medical record.
13. Paper medical record entries must not contain gaps and empty lines between entries. Blank spaces at the end of a line should be ruled out with a single line. If large areas are blank on a page, they should be ruled out by a single diagonal line.
14. Only abbreviations from the agreed Peninsula Health Abbreviations, Acronyms and Symbols Policy (7.1.18) can be used. The full listing will be available in hard copy in clinical areas.
15. All information in a medical record must be recorded on official medical record forms only and separate working notes are strongly discouraged. Log books and separate record keeping practices should only be used where they have been endorsed by the health service. Approved electronic forms can be used in authorised Peninsula Health Enterprise Systems only. i.e Clinical Information System & Digitised Medical

7.1.19 MEDICAL RECORD DOCUMENTATION

Record System. Patient information must not be documented and saved on personal computers or shared hard drives. (Refer 7.1.26 Establishment and Revision of Medical Record Forms & 7.1.35 Digitised Medical Record System).

16. All verbal orders, messages or communication with patients and significant others must be documented in the medical record. Each entry must include date, time, and content of patient related conversation; and the name, designation and contact details of the communication source. Any verbal medical orders must be followed up and documented by the medical practitioner within 24 hours or within 72 hours in Residential Aged Care Facilities.

17. Document involvement of patient and/or carer in all aspects of care including assessment, care planning, discharge planning and referral.

18. When documenting a patient's compliance, specify the observed behaviours that indicate the patient was compliant with treatment or refused treatment.
19. Document each time patient and/or carer education is provided and the format of the education, e.g. instruction sheet, information booklet, verbal instructions including use of interpreter where required. .
20. Health professionals must not document on behalf of others or sign another health professional's name to an entry.
21. Allied Health Assistants document in the medical record routinely with regard to participation in therapy programs. These entries are not required to be counter signed.

22. All student entries (Medical, Nursing and Allied Health) must be countersigned by a qualified professional of the same discipline. If using electronic forms create a new e-progress note to support student entry.).
23. For all inpatient care definitively record the patient's principal diagnosis (which was established after study to be responsible for admission), complicating diagnosis (arising during the admission) and additional diagnoses (which affected patient care/increased length of stay).
24. With the implementation of the Digitised Medical Record (DMR) documentation in inpatient areas will continue to be performed on paper and at discharge the paperwork will be scanned into the system. The use of e-forms will be implemented in outpatient and ambulatory care areas. There will be interfaces between some other computer systems such as the Electronic Medical Dictation and Transcription System (EMDAT) and the Clinical Information System (Cerner). Where other systems do not interface with the DMR it is important that staff continue to print off hard copies of the information to be scanned into the system to support the care provided and assist in clinical decision making.
25. Electronic records are to be managed in accordance with the standards set by the Public Record Office Victoria (PROS99/007).
26. Refer to UR number as opposed to individual's name when documenting about co-patients.

WHAT IS PART OF THE MEDICAL RECORD?

- Information collected as part of the patient's episode of care including -
    - Registration
    - Assessment
    - Admission
    - Treatment & Progress

7.1.19 MEDICAL RECORD DOCUMENTATION

- Investigation results
- Referrals
- Discharge (details & plan)
- Mental Health Act forms

- Radiological Examinations (eg X-Rays, CT Scans, MRI)
- Print-outs from monitoring equipment (in some circumstances such as bladder scans, information from print outs must also be documented in the progress notes as the paper quality used is not scanner friendly)
- Videos & photographs
- Correspondence between doctors and other health professionals relating to the episode of care
- Clinical information received from other Hospitals
- Letters/notes written by patients

WHAT IS NOT PART OF THE MEDICAL RECORD?

- Incident Reports
- Staff Injury information
- Complaints (from patients or staff) with the exception of Mental Health
- Freedom of Information requests
- Requests for the medical record (eg Subpoenas)
- Requests for medical or court reports
- Requests for information for research or audit purposes or Registries (unless routinely provided during the episode of care).
- Any information that is not relevant to the patient's clinical care including commentary on other staff members or other persons not relating to the patient's treatment episode.

DOCUMENTATION FREQUENCY

The frequency should not be limited to the times outlined below, but should be based on the condition of the patient, Health Service policy and in accordance with state legislation.

I. Nursing Documentation:

Best practice for nursing documentation is once per shift in the progress notes of the medical record. Minimum frequency in the progress notes must be once per Morning and Night shift in an acute or sub-acute setting. Minimum frequency for Mental Health is once per shift. If the patient's condition is not stable or there are other issues to report, then progress notes should be documented as often as necessary.

On every shift the Nurse responsible for the patient should make entries on approved charts and forms (e.g. nursing flow charts, observations, pathways) as required. All entries on charts and forms must contain date, time, printed surname and signature of staff member.

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If there are no charts or pathways in the medical record, nursing staff should document in the progress notes on every shift. It must be clear from the medical record which nurse has been responsible for looking after the patient on each shift.

II. Medical Documentation:

The minimum frequency of documentation into the progress notes must be at least once per day in the acute setting, and at least once weekly for sub-acute patients. If patients require further assessment or treatment it is required that notes are written for each consultation with another unit, to ensure the record is continually updated. Documentation must be completed for every patient contact in Residential Aged Care and Mental Health (in accordance with the Mental Health Act 1986).

Note - Acute inpatients awaiting Nursing Home transfer may be considered as sub-acute for the purposes of documentation frequency with the exception of Mental Health patients as documentation should occur everyday.

III. Allied Health Documentation:

Acute Allied Health Setting:

For inpatients and outpatients, the initial assessment will be documented on the day of assessment onto the progress notes.
Every patient contact thereafter (review and/or intervention) will be documented directly into the medical record and will include the ongoing care-plan.

Sub-acute & Residential Aged Care Allied Health Setting:

For inpatients and outpatients, record the initial patient contact on day of intervention. Initial Assessment documentation is to be made as soon as possible from date of referral and will include a summary of interventions and proposed care plans. With the exception of Residential Aged Care, Functional Independence Measure (FIM) assessment documentation must be scored within 2 working days of admission. Subsequent specific assessments and progress notation is to be completed as per guidelines for each discipline with a minimum standard of every five working days for patients seen regularly on a weekly basis, but at the conclusion of each intervention if patient is seen less than once weekly. Any significant changes to patient status and/or care plan will be documented on the day. Electronic Discharge Summaries are to be completed within 24 hours prior to discharge where applicable.

IV. Outpatients and Community Health Documentation:

For all patients regardless of what service they are requiring from Peninsula Health, healthcare professionals involved in patient care must document in the patient's medical record (either on an approved Peninsula Health paper medical record form or e-progress form in the DMR) at every patient contact or contact regarding the patient as it occurs.

V. Mental Health Services Documentation:

7.1.19 MEDICAL RECORD DOCUMENTATION

For inpatients and outpatients, the initial assessment will be documented (subsequent to the assessment) onto the progress notes and/or approved Peninsula Health Mental Health Service documents (e.g. Intake Assessment form, Client Management Interface (CMI)). Every client contact thereafter (review and/or intervention) will be documented directly in the progress notes and will include the ongoing care plan.

1. EMERGENCY DEPARTMENT DOCUMENTATION

I. Clerical Documentation

- Full demographic details
- Date, time and means of arrival

II. Nursing Documentation

- Emergency care given prior to arrival including Ambulance Reports
- Triage score and details
- Date and time seen
- Physical examination, vital signs, alert documentation and current medication
- Treatment given and management plan
- Relevant history of the illness or injury
- Clinical observations
- Discharge arrangements, time and destination
- Signature, surname (in capitals), discipline/specialty and designation of clinician

III. Medical Documentation

- Date and time seen
- Investigations requested and relevant results
- Treatment given and management plan
- Diagnosis, patient's condition on discharge and instructions given to patient / family for follow-up care
- Discharge arrangements, time and destination
- Signature, surname (in capitals), discipline/specialty and designation of clinician.

2. OUTPATIENT & COMMUNITY HEALTH DOCUMENTATION

Any clinician who documents in the outpatient section of the medical record (either on an approved Peninsula Health paper medical record form or e-progress form in the DMR) should observe the following:

2.1. First Attendance or visit for a Condition/Injury

The following information should be documented:

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- Date and time of service
- Relevant history of the illness or injury
- Physical examination, assessment findings and diagnosis
- Treatment given and management plan
- Investigations requested and relevant results
- Signature, surname (in capitals), discipline/specialty and designation of clinician.

2.2. Subsequent Attendances or visits for the same Condition/Injury

The following information should be documented:

- Date and time of service
- Diagnosis or summary of problem
- Treatment given and management plan
- Investigations requested and relevant results
- Signature, surname (in capitals), discipline/specialty and designation of clinician.

3. INPATIENT MEDICAL OFFICERS' DOCUMENTATION

3.1. Admission Documentation

The following information is to be included in the multidisciplinary documentation or designated admission forms within the medical record:

- Presenting health problem – nature, extent and chronology
- Relevant past medical history – lifetime summary of significant illnesses, operations and medical treatment
- Family history – relevant hereditary or family conditions and health status of near blood relatives
- Current treatment including medications, other treatments and services
- Assessment including physical, cognitive, psychosocial, mental state examination, social, cultural and functional status both prior to this illness and current
- Risk screen / assessment including allergies and alerts (eg. VRE status, Clinical Trial Patient)
- Management plan including provisional diagnosis, orders and client goals and documentation of discussion with Consultant On Call
- Expected date of discharge and follow up services
- Relevant contacts, eg. family, other nominated person(s), general practitioner, other health professional.

3.2. Surgical Requirements

The following information should be included for patients undergoing surgical intervention:

- Written consent for surgery – complies with ethical and legal obligations and Peninsula Health Policy 6.1.3
- Pre-anaesthetic assessment (ref ANZCA 1996 – Minimum requirements for the anaesthesia record)
- Anaesthesia record (ref ANZCA 1996 – Minimum requirements for the anaesthesia record)
- Operative record – diagnosis, findings, procedure performed, prosthetic detail, tissue removed, orders, documenting times

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- Recovery record – monitoring of vital signs and status of patient, documenting times.

3.3. Regular Progress Documentation

The following information is to be written in the progress notes as well as the care plan on regular clinician rounds (at least daily for acute patients and once weekly for sub acute patients):
If a patient is reviewed with other staff present, note this in the progress note

- Summary of patient condition, including mental status and health problem being treated
- Management plan, including planned and achieved outcomes
- Discussions and management decisions made with the Consultant need to be documented
- Care requested, delivered and ceased
- Investigations requested and results
- Specific intervention details, results and other outcomes
- Reasons for variation from planned care
- Response to care
- Include relevant information for clinical handover purposes
- Any liaison or referrals to external agencies, community therapists or services
- Patient education
- Review and update of discharge plan including referrals to community services and reasons for delay in discharge
- The estimated discharge date box located on the progress notes must be completed (excluding Mental Health)
- When documenting during a ward round/clinical review meeting, do not write "Ward Round" only, you must document names of other doctors (including Specialist, Registrar) who are also present during the ward round.

4. INPATIENT NURSING DOCUMENTATION

4.1. Nursing Assessment

A registered nurse must assess the patient on arrival or within 24 hours of admission. Some of the relevant assessment information may be available in other documentation within the admission. The following information is the minimum requirement where it has not already been documented in the admission:

- Time of admission
- Current medication
- Reason for admission and diagnosis (as appropriate)
- Patient condition on arrival, including physical injuries
- Allergies or reactions
- Family awareness of admission
- Psychosocial ie emotional state, spiritual/cultural/sexuality (if relevant)
- Contact details of relatives/friends
- Patient accompanied by
- Current community agencies involved with patient
- Language spoken at home, need for interpreter

7.1.19 MEDICAL RECORD DOCUMENTATION

- Relevant past history
- Patient request to see member of clergy
- Treating medical officer
- General practitioner
- (Residential Care only) The manager or program co-ordinator should assess the client on first contact. Documentation and information is collected prior to, or on first attendance.
- Physical assessment including:
  - General appearance – stature, grooming, physical characteristics, nutrition, hygiene, safety issues
  - Observation – behaviour, communication, body system assessment (identify deviation from normal)
  - Activities of Daily Living – aids and any formal or informal assistance
  - Full reassessment conducted for long term patient as necessary but not greater than every 2 weeks.
- Mental Health only - Risk assessment and mental state examination

4.2. Care Plan Documentation

An individualised care plan must be maintained based on the assessment information and alterations that reflect changes in patient condition. Care plans should incorporate the mullti-disciplinary team's management plan and including, but not limited to the following information:

- Admission
- Observations / FBC
- Mobility / Hygiene
- Skin assessment
- Communication ability
- Diet
- Safety risk assessment
- Discharge planning
- Well-being
- Medication administration
- Psychological
- Investigations
- Procedures
- Elimination
- Pain Management
- Wound Assessment
- Intravenous Therapy
- Patient Education.
- Mental state examination
- Dependents
- Drug Use (illicit/prescribed)

4.3. Progress Documentation

Progress notes should provide an accurate and concise record of patient progress and response to care. Entries should be made on the following occasions:

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- Discharge (see **9. Transfer of Patients**)
- Inter-ward transfer (see **9. Transfer of Patients**)
- Pre-operative/procedure – date and time of transfer from ward/unit
- Post-operative/procedure – date and time returned, conscious state, pain status, positioning required, base-line observations, assessment
- Incidents (see **6. Documentation of Incidents and Adverse Events**)
- Change in patient status ie events or interventions/Mental Health Act status
- Recording of variation from Care Plan

5. ALLIED HEALTH DOCUMENTATION

The following information should be written in the progress notes during an inpatient episode.

5.1. Initial Entry

Outline the reason & source of referral, and relevant medical history. If full assessment is not undertaken at the time, provide brief explanation outlining reason.

5.2. Assessment Documentation

It is not expected that each Allied Health discipline documents the same information as previous Allied Health disciplines **where there is overlap of relevant information**, such as current and past medical history, reason for admission, social situation etc. It is acceptable to document that the previous Allied Health entries have been noted before proceeding to document the discipline specific assessment.

The initial assessment to include the following information:

- For initial assessment documentation refer to individual discipline areas but may cover the following areas:
  - Subjective examination (symptomatic)
  - Objective examination (measureable, observable)
  - Assessment (interpretation of current condition)
  - Plan of action
- Written or verbal feedback to the client or other relevant carers
- Agreement to treatment plan – to the best of the patient's cognitive ability.

5.3. Progress Documentation

Progress documentation to include the following information:

- Assessment of patient progress (refer to discipline specific guidelines)
- Written consent obtained for interventions deemed to be 'high risk'
- Change in status or events that may affect discharge plans/goals
- Interventions, including consultation with key personnel
- Minutes of case conferences (or reference) to if documented on another form
- Discharge planning activities.

5.4. Discharge

- Patient condition and current level of function
- Recommendations and actioned referrals for further management
- State discharge destination
- Equipment and resources supplied (including funding source)
- Other arrangements with patient/family

7.1.19 MEDICAL RECORD DOCUMENTATION

- Details to communtiy service areas
- Complete Patient Discharge Information Sheet (MR/35)

5.5. Outpatient Clinic Documentation

Initial assessment, progress and discharge notes to be documented *as outlined above* (either on an approved Peninsula Health paper medical record form or e-progress form in the DMR).

6. DOCUMENTATION OF INCIDENTS AND ADVERSE EVENTS

The staff directly involved in the incident are to complete the following:

- A brief entry in the progress notes should be recorded as well as the completion of an incident report on the Victorian Health Incident Management System (VHIMS)
- Record the date, time it occurred, the patient's name, the family member notified and at what time (if required), the name and contact number of the doctor notified and the time of the call (also if required), document UR number, not name, when there is co-patient involvement
- Record the outcome of the subsequent medical assessment and any treatment provided
- The medical record is not the place for a full account of the circumstances of an incident or adverse event. This information belongs in the VHIMS database. .
- Anything you write in a medical record about an incident or adverse event should be accurate and objective. Stick to the facts and only write about what you directly observed or heard. Use direct quotes where applicable.

7. CLINICAL PATHWAYS/CARE PLANS

Clinical pathways are an accepted tool within Peninsula Health and must be approved for use within the medical record.

- Do not duplicate the information already stated on the pathway but document variances (can be recorded in the patient's progress notes)
- Sign, date, and initial every entry you make on the pathway
- When a patient deviates from the pathway fully document the nature of and response to the variance including treatment and care administered in the progress notes, or variance sheet. This should be recorded at the time of occurrence.
- Patients, Carers and Families will be involved in the care planning process and this must be documented in the progress notes.

8. ALERT/ALLERGY DOCUMENTATION

All alert and allergy information must be documented within the medical record and entered into the Patient Administration System (iPM) and/or the Clinical Information System (Clover) in accordance with the Alerts and Adverse Drug Reactions Policy 3.1.37.

9. TRANSFER OF PATIENTS

There are three types of patient transfers:

- **Transfer of patients from one Unit/Specialty to another within the one Peninsula Campus i.e Cardiology to General Medicine, Rehab to Palliative Care**

7.1.19 MEDICAL RECORD DOCUMENTATION

The Unit that is transferring or changing must document in the progress notes:

- Summary of care
- Ongoing plan
- Notification of transfer to relevant contact (eg. family, health carer or other nominated person)
- Transfer destination
- Date and time of transfer

- **Transfer of patients from one Peninsula Campus to another**
  - Discharge plan including arrangements for continuing management, follow-up instructions and education to patient and carer(s)
  - Notification of transfer or discharge to relevant contact, eg. family, health carer or other nominated person
  - Discharge and transfer destination
  - Date and time of separation
  - Reason for transfer
  - Any conversations with receiving Clinicians must be noted including the condition of the patient
  - **Electronic Discharge Summary (Clover), including definitive principal, complicating and associated diagnoses, is to be completed within 24 hours of discharge for all patients (excluding Chemotherapy, Dialysis and Endoscopy)**

- **Transfer of a patient from a Peninsula Campus to an external hospital/agency e.g Frankston Campus to Dandenong Hospital**
  - Discharge plan including arrangements for continuing management, follow-up instructions and education to patient and carer(s)
  - Notification of transfer or discharge to relevant contact, eg. family, health carer or other nominated person
  - Discharge and transfer destination
  - Date and time of separation
  - Reason for transfer
  - Any conversations with receiving hospital/agency must be noted including the condition of the patient
  - Electronic Discharge Summary (Clover), including definitive principal, complicating and associated diagnoses, is to be completed within 24 hours of discharge for all patients (excluding Chemotherapy, Dialysis and Endoscopy)

10. COMPLETION OF DISCHARGE INFORMATION

- **Completion Requirement**
  - Electronic Summaries are to be completed for all separations excluding Chemotherapy, Haemodialysis and Same Day Surgical patients.
  - Patients who are transferred, discharged at own risk or deceased also require a discharge summary to be completed.

- **When to complete**

7.1.19 MEDICAL RECORD DOCUMENTATION

- The discharging Unit is responsible for completion of the discharge summary in a timely manner, normally within 24 hours post discharge.
- Should a Unit transfer a patient to Hospital in the Home, the Unit transferring is responsible for completing the discharge summary. Hospital in the Home assume responsibility for updating the summary once the patient is discharged.
- Completion of discharge summaries is to be by the doctor rostered on for the day of patient discharge regardless of whether that doctor attended the patient.
- Discharge Summaries are to be commenced on day of admission and progressively updated throughout their stay. Summaries must be reviewed thoroughly when completing at discharge to ensure information is accurate and up to date.

- **Who should complete**
  - Should no Junior Medical Officers (JMO) be rostered on duty for the day of patient discharge HIS will allocate responsibility to an appropriate Medical Officer from the Unit.
  - When JMOs change Unit but remain on site at Frankston Hospital they retain responsibility for completing their outstanding summaries for the previous rotation.
  - If summaries are outstanding from a previous rotation and the JMO responsible is no longer employed at Peninsula Health then the successor(s) for that unit will assume responsibility to complete.
  - Discharge summaries for ICU patient separations must be completed by the ICU HMO/JMO.

11. INFORMATION REQUIRED FOLLOWING A PATIENT DEATH

When a patient dies the doctor certifying the patient death must complete the relevant paperwork , either a death certificate (refer to Peninsula Health Policy 6.1.14 Completion of Death Certificate) or a Coroner's deposition (refer to Peninsula Health Policy 6.1.09 Reportable Death). The doctor must also make an entry in the medical record about the death ensuring to include the following;

- Date and time of death
- Events and details relevant to death
- Notification of LMO, relatives and /or next of kin
- Other details, eg. autopsy, coronial reporting and organ donation
- Electronic Discharge Summary (Clover), including definitive principal, complicating and associated diagnoses, is to be completed within 24 hours of every patient death

12. MEDICAL RECORD AUDITS

Health Information Services will conduct twice yearly random medical record audits assessing date, time, signature, printed name and designation compliance with this policy. A number of medical record entries for each professional group will be audited from Frankston, Rosebud and CCC. The results will be presented to the relevant areas.

The Clinical Documentation Steering Committee and/or nominees will conduct medical record audits using the Interdisciplinary Audit Tool which assesses compliance with this policy in relation to clinical documentation.

It is expected that all disciplines/specialties throughout Peninsula Health will conduct their own focused medical record audits and provide results to their relevant departmental meetings.

13. RELATED POLICIES

- 3.1.37 Alerts and Adverse Drug Reactions

7.1.19 MEDICAL RECORD DOCUMENTATION

- 6.1.04 Medication Management
- 6.1.05 Discharge Planning
- 6.1.09 Reportable Death
- 6.1.14 Completion of Death Certificate
- 7.1.17 Faxing of Patient Sensitive Information
- 7.1.18 Abbreviations, Acronyms and Symbols
- 7.1.20 Transfer of Medical Records
- 7.1.21 Patient Confidentiality
- 7.1.22 Medical Record Safety and Security
- 7.1.23 Missing Medical Records
- 7.1.24 Freedom of Information & Approval Process
- 7.1.26 Establishment and Revision of Medical Record Forms
- 7.1.35 Digitised Medical Record
- 6.1.44 Assessment
- 6.1.45 Care Planning
- 6.1.46 Referral
- Peninsula Health Privacy Statement

7.1.19 MEDICAL RECORD DOCUMENTATION

14. FURTHER INFORMATION

- EQuIPNational (2012) Australian Council of Healthcare Standards
- Aged Care Act 1997
- Alerts Management Policy
- Australian and New Zealand College of Anaesthetists P6 (1996) Minimum Requirements for the Anaesthesia Record
- Australian and New Zealand College of Anaesthetists PS7 (1998) The Pre-Anaesthesia Consultation
- Australian Commission on Safety & Quality in Healthcare (2012) National Safety and Quality Health Service Standards
- Australian Nursing Council Inc. (1995) Code of Professional Conduct for Nursing in Australia
- Australian Nursing Council Inc. (1998) 2nd Ed. National Competency Standards for the Registered Nurse
- AS ISO 15489 Records Management
- Commonwealth Privacy Act 1988 (amended by the Commonwealth Privacy Amendment (Private Sector) Act 2000).
- Drugs Poisons and Controlled Substances Act 1981
- Drugs Poisons and Controlled Substances Regulations 2006
- Guardianship and Administration Act
- Health Act 1958
- Medical Treatment Act 1989
- Mental Health Act 1986
- Peninsula Health Psychiatric Service Documentation Suite "Peninsula Pathways" (Available in Psychiatric Services)
- Public Records Office Victoria, Management of Electronic Records, PROS 99/007
- Refusal of treatment (Medical Record Form – Refusal of Treatment: Competent Patient or Refusal of Treatment: Incompetent Patient)
- Standards Australia, Australian Standard – Healthcare Record AS2828, 2010; Part 1 Paper based health care records & Part 2 Technical Specification Digitised/Scanned Health Record Systems Requirements
- Victorian Health Records Act 2001

7.1.19 MEDICAL RECORD DOCUMENTATION

- Victorian Information Privacy Act 2000

7.1.19 MEDICAL RECORD DOCUMENTATION

ONE PAGE GUIDE

POLICY

- Medical records must clearly identify the patient, the date and time of consultation, the patient's needs, care planned, care provided, progress and outcomes.
- All health professionals involved in patient's care are responsible for ensuring that documentation in the medical record is compliant with relevant standards, guidelines and statutory requirements.
- The Medical Record is the property of Peninsula Health and cannot be removed from the premises without authorisation from the Manager of HIS.
- Medical records should be viewed only by those who are directly involved in the care of the patient.

PRACTICAL APPLICATION

- This policy applies to all services provided by Peninsula Health
- Each medical record page must contain patient label or identifying details
- Written entries (including alterations) must be legible and made in black ink
- Verbal medical orders must be followed up and documented by the medical practitioner within 24 hours
- If a patient is seen with a number of staff present (eg. ward round/clinical review meetings), the names and designations of the other staff must be noted in the medical record
- The frequency of making entries should be based on the condition of the patient, health service policy and in accordance with any statutory requirements:

Nursing	At least once per AM & Night shift (acute & sub-acute) At least once per shift for Psychiatry
Medical	At least once per day (acute) At least once weekly (sub-acute)
Allied Health	Acute - Initial Assessment at first contact, every contact thereafter Sub Acute - Initial Assessment as soon as referral, FIM Assessment within 2 days of admission, any significant changes to patient status and/or care plan will be documented on the day, subsequent specific assessments to be completed every five working days.
Outpatients and Community Health	Every patient contact or contact regarding the patient as it occurs
Residential Aged Care	Documentation completed for each attendance by the Medical Officer

DO:

- Include date (dd/mm/yy), time (hh:mm), signature, surname in capitals, discipline/specialty and designation of author on every entry.
- Be objective and factual
- Cross through errors with a single line, and identify who made the correction (paper record).

Create new e-progress note entry detailing correction (DMR).

- Rule a single line through blank spaces (paper record)
- Only use approved abbreviations, acronyms and symbols
- Countersign all student entries

DON'T:

- Erase, write over or use correction fluid to remove errors
- Remove information from the medical record
- Leave gaps or empty lines between entries
- Document on behalf of others (unless you are examining the patient with other staff, in which case you must note all staff present and their designations)
- Criticise the treatment provided by other staff, or write derogatory comments about patients.

This summary is intended to assist with education. To fully understand the policy, please read this page in conjunction with the rest of the policy.