

# How to document well

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## Clinical documentation and how to document medical information well

***“If it’s not documented, then it didn’t happen!”*** We’ve all heard this mantra. It’s used almost threateningly to junior doctors to encourage them to strive for better clinical documentation to protect against potential lawsuits. Yet, it’s impractical to implement in everyday practice, despite being such an immensely over-used phrase. Logging every single action of a medical team, every conversation, and every encounter? It’s near impossible to do in the busy day-to-day lives of [junior doctors](#).

Therefore, the key to excellent clinical documentation is the ability to know exactly what is relevant to document. Couple this with being able to succinctly summarise and report main issues and you will document medical information well.

This guide will provide a brief overview of the process of medical documentation. Hopefully, it will make the task of documentation slightly less daunting.

## Fundamental reasons for good clinical documentation

First, understanding the critical importance of good documentation is key. There is so much more to documentation than mere legal protection. Medical records are a crucial form of communication. And the importance of complete, accurate, concise, timed and dated documentation cannot be overstated.

The quality of medical documentation has several far-reaching impacts, from directly affecting the quality of patient care, to influencing hospital funding. Unfortunately, good documentation can become a low-priority for busy junior doctors.

There are three fundamental reasons to keep in mind when striving for excellent documentation:

### 1. It’s a form of communication

Good documentation promotes continuity of care through clear communication between all members involved in patient care. The medical record is a way to communicate treatment plans to other providers regarding your patient. This ultimately ensures the highest quality of patient care. Conversely, poor records can have negative impacts on clinical decision-making and the delivery of care.

## 2. It's a legal document

A medical record is a legal document. So, understand that what you write is memorialised permanently. In the case of any legal proceedings, documentation is heavily scrutinised to help support an argument either way. Documenting sensitive discussions regarding limits of care, prognosis, and treatment decisions clearly and transparently is crucial. We will cover this in more detail below.

## 3. It's a document of service

This is a point often missed. Medical documentation is a document of service that has huge implications for hospital funding. Each issue that is documented is coded and then translated into a cost for the hospital system. Thorough documentation of all medical issues and treatments is therefore crucial for hospital funding. Particularly in discharge summaries.

## Elements of good clinical documentation

When writing a record, it's useful to keep in mind the potential audience. The audience is your consultants, allied health staff, after-hours doctors and nursing staff. This will help you achieve clarity and allow you to focus on the details that are most relevant to include. Note that more detail is not necessarily better. An after-hours doctor reviewing a deteriorating patient has no time to read through paragraphs of text. They breathe a sigh of relief when they come across a clear list of all the current inpatient issues!

## The basics of clinical documentation

- **Date, time and sign every entry.**
  - **Although simple, its importance cannot be overstated. The timing of events and reviews is often crucial in piecing together information about deteriorating patients.**
- **Write your name and role as a heading and the names and roles of all others present at the encounter.**
- **Make entries immediately or as soon as possible after care is given.**
  - **Prompt documentation reduces the risk of you forgetting key details.**
  - **It ensures all other team members are aware of any changes to a patient's condition or management plan.**
  - **In reality, this isn't always possible. If you are returning to the patient's notes later, document clearly in the heading that it was written in retrospect, with the current date and time.**

- Be legible.
  - There's no point documenting well if no one can decipher it.
- Be thorough, accurate, and objective.
- Maintain a professional tone.
  - Sarcasm, attempted joking or a casual tone may reflect badly on you.
- Only use approved abbreviations.
  - It is better to use no abbreviations at all to avoid confusion.
- Addenda.
  - If an addendum is made, this should also be verbally communicated to other teams and nursing staff.
  - Sign off any addenda with the time and your full details.
- Mistakes.
  - If a mistake is made, correct it with a single strikethrough.
  - Follow that by clearly signing and dating the correction.

## Documenting a ward round

A ward round is the most common activity that a junior medical officer is required to document on a daily basis. You should begin by documenting all the members of the team present. Also, add whether there are any relatives or friends of the patient present to witness the encounter.

Start by summarising the main presenting issue for the present. For example, *"81 year old male from nursing home presenting with pneumonia."* Then continue by using the SOAP method below to help structure your documentation in a clear and consistent manner.

## The SOAP method

SOAP stands for Subjective, Objective, Assessment, and Plan.

- **Subjective**
  - This section describes the patient's current condition in a narrative form. Include the patient's chief complaints, including onset, chronology, quality, and severity. It is important to document what the patient tells you about how they are feeling, in their own words. Use quotations if appropriate, using quotation marks.
- **Objective**
  - Here, you should document objective, repeatable and measurable facts about the patient's status.
  - You may include objective observations about how the patient appears from the end of the bed. For example, *"Patient appears pale and in discomfort."*
  - In this section, also include observations and vital signs.

- Findings from a physical examination. For example, “*Widespread expiratory wheeze on auscultation of the chest.*”
  - If relevant, also include laboratory results, fluid balance, and other measurements. (E.g. urine, IV fluids, NG feeds, drain outputs, age/weight)
- **Assessment**
    - Summarise the salient points and the primary medical diagnosis in this section. If the diagnosis has already been made, comment on whether the patient is clinically improving or deteriorating. For example, “*Impression: Resolving community-acquired pneumonia.*”
    - A complete list of all diagnoses and issues should ideally be completed in this section every 1-2 days, or whenever a new issue arises. This is extremely useful, especially for after-hours staff who may need to rapidly assess a deteriorating patient.
- **Plan**
    - Document a clear plan, including further investigations, referrals procedures, and new medications to be charted.
    - If possible, include an estimated discharge date. This is immensely beneficial information for your Nursing Unit Manager to plan for the week ahead.

## Documenting a phone conversation

Documenting phone conversations is often overlooked. It's important to document phone conversations with other medical teams, relatives of patients, or General Practitioners involved in the care of your patient. After the phone conversation, write a note clearly stating who was involved in the conversation, including their role.

Document the clear question that was posed. Summarise the main information and points that were gained from the conversation. It's important to note the pager number/telephone number of the person who was contacted to facilitate further contact if they need to be contacted again.

## Documenting a consult

Documenting a clear request for a consult can save immense time and frustration in a busy hospital environment. Make sure to document the relevant patient identifiers and medical background. And then, succinctly summarise or list the current issues during admission. Most importantly, document the clear clinical question that is being posed to the consulting team. Leave your full name and contact details for the team to contact you.

## Documenting a family meeting

Documenting a family meeting can be challenging due to the unstructured and conversational format. However, clear documentation is especially crucial in this setting as key management discussions often take place. These conversations can change the course of a patient's care.

Begin by documenting exactly who is present in the meeting, and their roles. For example, family members, medical staff, social workers. Document if a translator is present for the meeting. List each point as it is raised, and the general decisions that are made about each point. Use quotations where relevant, using quotation marks. Summarise the key agreements that were made at the conclusion of the meeting. Then, clearly document a plan forward. Whether there has been a change in the patient's treatment plan, or whether it is for ongoing discussion at a later stage.

## Documenting a procedure

Document all procedures clearly in the patient notes. From IV cannulation to more complex bedside procedures such as lumbar punctures. Document whether consent was gained and if it was verbal or written. Also document whether a chaperone was present. This is particularly relevant for sensitive procedures such as rectal examinations.

Document all equipment that was used, clearly and with specifications. Document any medications that were administered, including the dosages and the amounts used. For example: "*A 16 Fr urinary catheter was inserted using aseptic technique. 10ml water injected for balloon inflation with nil procedural complications*".

Note whether you encountered any difficulties or complications during the procedure and if the patient remained comfortable and stable throughout.

## Documenting a mistake

Finally, doctors are human and mistakes do happen. Rather than brushing over them or attempting to hide them, all mistakes must be formally documented. This allows us to maintain transparency and ensures that the appropriate action can be taken.

Document exactly what happened, including all persons involved. Document your assessment of the patient immediately afterward. This is particularly relevant in the case of medication errors. Make note of who was notified about the mistake. For example, the patient themselves, the relatives, and the treating consultant. Lastly, document if you lodged an incident report.

## The discharge summary

The discharge summary is the most comprehensive document surrounding a patient's admission. It is a crucial form of communication between the medical team and all other individuals who will be involved in the patient's care. This is largely for the General Practitioner but also allied health and any future medical teams. Keep these audiences clearly in mind when writing a discharge summary. This will help you to draw out the most salient issues of a patient's admission and to direct a clear plan for other health professionals to follow.

The most important points to include in a discharge summary are:

- **Principal diagnosis** - the condition which was found to be the cause for the admission after investigation.
- **Co-morbidities** - any conditions present on admission and treated. These conditions resulted in a change to the patient's treatment, care or length of stay.
- **Complications** - conditions that arose during the admission and affected the patient's treatment and length of stay.
- **Procedures** - surgical, non-operative, diagnostic, therapeutic procedures that required anaesthesia, sedation or injected contrast.
- **Discharge medication list** - clearly outline any medication changes that were made.
- **Discharge plan** - including follow-up appointments and instructions to return to the hospital if unwell. Specify **exactly** what you would like a general practitioner to do post-discharge. For example, organise follow-up blood tests, imaging or weaning certain medications.

As with all skills, effective clinical documentation is a skill that takes time to master. Take your time, actively gain feedback from your registrars and consultants, and in no time you'll be the pride of the Medical Records department!

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