Clinical Documentation Basics

Foundational Curriculum:
Cluster 2: Clinical Process
Module 2: Clinical Practice and Documentation
Unit 2: Clinical Documentation Basics
FC-C2M2U2

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Unit Objectives

- Discover how to document role-related and profession-specific information in an electronic health record

- State the types of documentation clinicians use in documentation

- Ensure that documentation in the health record reflects timeliness, completeness, accuracy, appropriateness, quality, integrity and authenticity

- Identify appropriate methods to correct inaccurate information/errors personally entered in an electronic health record

- Review the process for authenticating information entered in an electronic health record

- Differentiate between structured and unstructured data in electronic records documentation, along with the risks, benefits and limitations of each

- Review examples of health record documentation requirements of external agencies and organizations

What is Clinical Documentation?

- **Clinical documentation** is a record of the care and the clinical assessment, professional judgement and critical thinking used by a health professional in providing that care.
  - It includes any and all forms of documentation by a clinician recorded in a professional capacity in relation to the provision of patient care. It also includes appropriate documentation in the patient care record by a non-clinician, such as an orderly, researcher, coder or chaplain
- It should record both the actions taken by clinical staff and the patient's needs and/or their response to illness and the care they receive

What is Clinical Documentation? (cont'd)

- Clinical documentation must be patient-focused, based on first-hand professional observation, and include assessments that do not have any basis in unfounded conclusions or personal judgements

- It should record both the actions taken by clinical (and non-clinical) staff and the patient's needs and/or their response to illness and the care they receive

Importance of Clinical Documentation

- Documentation and record keeping is a fundamental part of clinical practice

- It demonstrates the clinician's accountability and records professional practice

- It is the basis for communication between health professionals that informs of the care provided, the treatment and care planned and the outcome of that care as a continuous and contemporaneous record

Examples of Clinical Documentation

- Standard documentation includes:
  - electronic and non-electronic health records (including written, scanned and other non-structured data, or **hybrid records** – a combination of electronic and written records)
  - Prescriptions and medication data
  - Laboratory results, referral reports and records, and clinical correspondence
  - SOAP and HPIP reports (as discussed in C2M2U1)
  - observation lists, checklists and worklists
  - flow charts and clinical assessments
  - rounding reports, handoff reports, and shift/management reports
  - incident reports
  - clinical anecdotal notes
  - hospital reports

Examples of Clinical Documentation (cont'd)

- Clinical documentation may also include:
  - emails, texts and electronic messaging
  - facsimiles (faxes)
  - digital or analog images (including radiographs (x-rays), scans, photographs and diagrams)
  - **PACS**: media from picture archiving and communications systems electronic media related to the patient records or results, such as digital or analog audio and video content (e.g., Holter monitor data, etc.)
  - patient supplied data or results
  - data interfaced from computer or smart phone applications
  - any other type or form of electronic, digital or other documentation pertaining to the care provided to the patient or family

The Basic Six Hospital Reports

The basic six hospital reports are the main reports filed during the hospitalization of a patient. They include:

1. **admission summaries:** a report that defines the baseline status and reason for admission of a patient, along with initial instructions for patient care, often completed by a nurse

2. **history and physical examination reports:** the initial physician's report including medical history, review of systems, vital signs, and physical examination of each of the body's systems

3. **pathology reports:** reports completed in the pathology or laboratory unit of the hospital by a pathologist.

    - A **pathologist** is a physician who examines tissues, reads lab tests, and interprets the results in order to facilitate the patient's diagnosis and treatment.

4. **radiology reports:** reports that describe any diagnostic radiology procedure i.e., x-rays (roentgen), nuclear medicine, ultrasound, CT, MRT and results from said procedure. These are read and interpreted by a radiologist.

   - A **radiologist** is a physician who uses cutting-edge imaging technology to examine organs and tissues inside the body in gentle, noninvasive ways. Their expertise in physics, anatomy and the disease process allow them to diagnose injuries and illnesses for treatment.

5. **operative reports:** reports made after any operation or surgery performed on the patient, usually completed by surgeons or perioperative personnel.

6. **discharge summaries:** reports completed at the conclusion of a hospital stay that elaborate all processes of the overall stay. This includes the initial patient complaint, all reports, treatment plan for the duration of the stay, diagnostic findings, therapy administered and the patient's response, prognosis as well as recommendations upon discharge for further treatment.

Types of information clinicians use in documentation

- **Patient data:** Information that is specific to an individual person such as whether he or she has allergies, a history of diabetes, or a heart murmur. Patient data is obtained from the patient, from family or friends, from health records, or from the clinician's own observations while conducting the history and physical examination.
- **Population statistics**: Data that has been aggregated from individual patients. One version of population statistics is a clinician's informal knowledge of recent local history, such as recent flu outbreaks or a resurgence of measles, which may be relevant to the findings in a particular case.
- **Medical knowledge:** The rules or conclusions about health and healthcare that are not just relevant to the individual patient, but are generalizable to many persons. This information may be obtained from texts, whether electronic or in print form; from reviews in journal articles; or from the medical literature.

FC-C2M2U2

Types of information clinicians use in documentation (cont'd)

- **Logistical information:** This focuses on how to get things done, rather than on what to do. This type of information may be available from informal sources, such as the organizational knowledge of staff in the clinic or hospital, or formal sources, such as policy and procedure manuals, directories, or other institutional documents.

- **Social influence:** This includes the impact of others' work and job performance on the clinician's decisions. Clinicians may not always conform to the practices of others, but in general they like to know how other clinicians are managing particular problems and whether their own practices align relatively well with those of others.

Types of information clinicians use in documentation (cont'd)

Patient Data	refers to one person	patient, family, records, observation
Population Statistics	aggregated patient data	colleagues, public health dept, EHR
Medical Knowledge	generalizable to many persons	texts, journal articles, MEDLINE
Logistical Information	how to get things done	people, policy and procedure
Social Influence	how others get the job done	observe and discuss with colleagues

Steps in the Documentation Process

- Clinicians go through the following steps when performing their evaluation of the patient in preparation for documentation:
    - What is the matter?
    - What can be done about it?
    - What will happen?

- These questions correspond to the classic steps that clinicians take to make a diagnosis, recommend a treatment, and make a prognosis

- The steps also correspond to the history, review of systems and physical examination, leading to an assessment/impression (diagnosis), and plan, including next steps (treatment recommendations and prognosis)

A Successful Documentation

- In order to ensure that the health record reflects timeliness, completeness, accuracy, appropriateness, quality, integrity and authenticity, documentation should:

  ✓ be clear, concise, consecutive, correct, contemporary, complete, comprehensive, collaborative, centered on the patient (patient-centered) and confidential

  ✓ promote appropriate sharing of information among interdisciplinary and interprofessional teams

  ✓ Be accurate and comprehensive documentation is a valuable source of data for data coding, health research and a valuable source of evidence and rationale for resource management

A Successful Documentation (cont'd)

1. Precautions must be taken to ensure that clinicians are fully informed of appropriate, safe and secure use of electronic information systems

   – Potential risks and ways to mitigate any risks involved in using such systems must be identified to ensuring and maintain usability, integrity and confidentiality

2. After proper log in and authentication, only one patient record at a time should be accessed and documented upon

3. Use the **2-ID rule**: Use at least two identifiers (e.g., name and date of birth), when documenting on a patient, and prior to the administration of care, according to the standards/policies of your facility

   – All eHealth workers have the primary responsibility to check the identity of patients and match the correct patients with the correct care (e.g., laboratory results, specimens, procedures) before that care is administered or documented.

Correcting Inaccurate Information or Errors Entered in an EHR

- Always check with your organization's policies and procedures for specific methods, rules and regulations regarding correcting inaccurate information or errors personally entered in an electronic health record

- Generally speaking, information documented during or immediately after care is provided, or an event has occurred, is considered to be more reliable and more accurate than information recorded later, based on memory

- Ensuring entries are made as close to the time of the care or the event is essential

  - Where this has not occurred, staff may make late entries

  - The late entry time should be an accurate record of the correct time of the event

FC-C2M2U2

Correcting Inaccurate Information or Errors Entered in an EHR (cont'd)

- Late entries must only be made when the clinician can accurately recall the care provided or the event. For this reason, making a late entry into the patient records must be voluntary and should be clearly identified as a late entry.

- Changes or additions should be minimized, as they can lead to confusing records and perceptions of poor care and decision making practices

- Changes or additions should be clearly marked as such and should not obscure or delete any previously recorded entry or data

- Changes must <u>only</u> be made to the clinician's own documentation (never to another person's documentation).

Correcting Inaccurate Information or Errors Entered in an EHR (cont'd)

- Clinical information must not be deleted from the health record.
- In general, where information is incorrect, for example information is written in the wrong patient's record, consult the organizational rules and regulations to **cull** (reduce by removal) or amend the record
  - <u>Never</u> delete information written by others, or written by yourself prior to the current documentation event
  - Write an explanatory note such as 'wrong record' or 'error'
  - Record the correct information
 - Authenticate the entry

Reviewing the Process for Authenticating Information Entered in an EHR

- Always review the process for logging on, logging off, activating patient records, and **authenticating** (proving or demonstrating something to be real or authentic) information entered into an electronic health record per your organization or facility's policies and procedures

- Clinical staff must able to communicate effectively and competently with individuals and groups using formal and informal channels of communication

  – Clinicians need to ensure documentation is accurate and maintains confidentiality
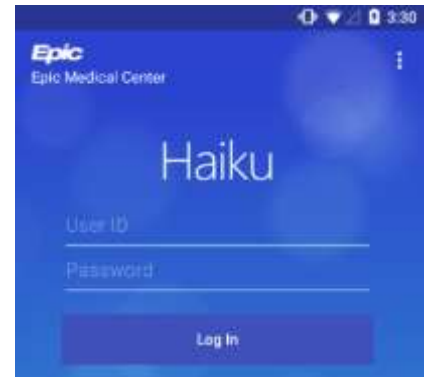
Reviewing the Process for Authenticating Information Entered in an EHR (cont'd)

- Clinical staff are required to make and keep records of their professional practice in accordance with standards of practice of their profession and organizational policy and procedure

- Documentation is often used to evaluate professional practice as a part of quality assurance mechanisms such as performance reviews, audits and accreditation processes, legislated inspections and critical incident reviews

- Clinical staff have regulatory, professional and ethical obligations to protect patient confidentiality
  - This includes maintaining confidential documentation and patient records

Structured Versus Unstructured Data

- It is important to be able to differentiate between structured and unstructured data in electronic records documentation, along with the risks, benefits and limitations of each

- Laboratory results and data, systems reviews, history and physical examination data, and clinical diagnoses documented in the electronic medical record (EMR) are frequently entered as **structured data**
  - Therefore, this data is captured in fields, codified, formatted, and structured in a way that can be searched and indexed
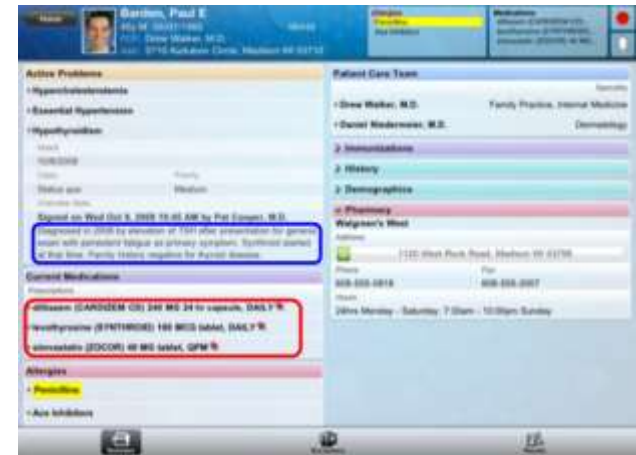
Above: Unstructured Data, in blue Structured Data, in red

Structured Versus Unstructured Data (cont'd)

- Historical data, assessment and impression information, however, are typically entered as **textual data,** such as descriptions. The data is **unstructured data** and not discretized

  - Therefore it cannot be searched or indexed, or used efficiently to implement quality measures or to support research

Structured Versus Unstructured Data (cont'd)

- Many organizations are taking measures to make fields for entry of structured data for areas of the record that would be typically unstructured
  - Although these tools can provide Best Practices Advisories and other clinical decision support to providers and other interdisciplinary staff (benefits), they can also restrict latitude in descriptiveness, and can subject some clinicians to heightened vulnerability for records integrity (risks and limitations)

Health Record Documentation Requirements of External Agencies and Organizations

- You should become familiar with health record documentation requirements of external agencies and organizations
- These may include:
  - Credentialing organizations (such as Joint Commission)
  - Regulatory agencies (such as European Medicines Agency (EMA), US Food and Drug Administration (FDA), US Centers for Medicare and Medicaid (CMS), etc.)
  - Global health agencies (such as the World Health Organization (WHO))
  - Trade associations and organizations (such as American Nurses Association (ANA), European Specialist Nurses Organization (ESNO), European Federation of Medical Informatics (EFMI), American Health Information Management Association (AHIMA), International Federation of Health Information Associations (IFHIMA), American Medical Informatics Association (AMIA), International Medical Informatics Association (IMIA), etc.)
  - National, regional, state and local agencies (such as law enforcement agencies, health departments, public reporting agencies, etc.)

- Examples of documentation requirements by external agencies and organizations include:
  - Records and documentation that is subpoenaed by a court of law
  - Reporting patient physical abuse to law enforcement agencies
  - Reporting contagious and communicable diseases to public health agencies
  - Documenting adverse reports arising from clinical trials

Unit Review Checklist

- ☐ Discovered how to document role-related and profession-specific information in an electronic health record (HB04)
- ☐ Stated the types of documentation clinicians use in documentation
- ☐ Ensured that documentation in the health record reflects timeliness, completeness, accuracy, appropriateness, quality, integrity and authenticity (HB05)
- ☐ Identified appropriate methods to correct inaccurate information/errors personally entered in an electronic health record (HB10)
- ☐ Reviewed the process for authenticating information entered in an electronic health record (HB13)
- ☐ Differentiated between structured and unstructured data in electronic records documentation, along with the risks, benefits and limitations of each (HB03)
- ☐ Reviewed examples of health record documentation requirements of external agencies and organizations (HB02)

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Unit Review Exercise/Activity

- On the diagram below, indicate which data is structured and which data is unstructured:

Current Problems (diagnoses):
- ☐ Structured
- ☐ Unstructured

Allergies:
- ☐ Structured
- ☐ Unstructured

Medications:
- ☐ Structured
- ☐ Unstructured

Past Medical History:
- ☐ Structured
- ☐ Unstructured

Subjective:
- ☐ Structured
- ☐ Unstructured

27

Unit Exam

1. The basic six hospital reports include all of the following <u>except</u>:
   a. History and Physical Examination
   b. Radiology Report
   c. Incident Report
   d. Pathology Report

2. Which of the following statements is true about clinical documentation?
   a. Documentation demonstrates the clinician's accountability
   b. Documentation includes only information from clinicians but would not include information from orderlies, researchers, coders or chaplains
   c. Documentation includes primarily second-hand information
   d. Documentation has its basis in unfounded conclusions and personal judgements

Unit Exam (cont'd)

3. Which of the following statements best describes patient data as a form of documentation?

    a. Data that has been aggregated from individual patients

    b. Data that is obtained from the patient, from family or friends, from health records, or from the clinician's own observations

    c. Information available from informal sources, such as the organizational knowledge of staff in the clinic or hospital

    d. Conclusions about health that are generalizable to many persons

4. Which of the following statements is true about documentation?

    a. Late entries are mandatory and are required to be completed based on memory or best guess

    b. Late entries can be made even when the clinician cannot accurately recall the care provided or the event

    c. Changes can be made to other clinicians' documentation when needed

    d. Changes or additions should be clearly marked as such and should not obscure or delete any previously recorded entry or data

Unit Exam (cont'd)

5. Which of the following is a typical example of unstructured data?

   a. Laboratory data

   b. History of the Present Illness

   c. Electrocardiogram (ECG) results

   d. ICD diagnoses