Health Records Procedures and Documentation Management

Application

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Approved / Reviewed

Key Policy Writer	

Policy Review group members	Allowah Leadership Team

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Document Control

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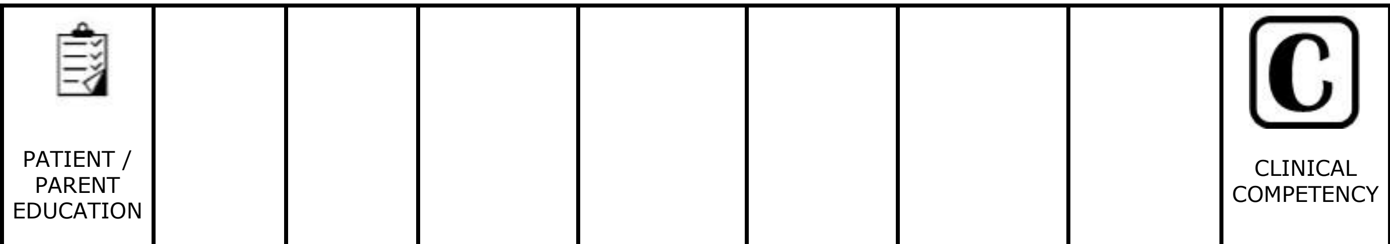
1	April 2015	E McClean	First amalgamation of policies and procedures
2	March 2016	S Hurren	Review and additional information for content
3	March 2018	G Gilchrist	Scheduled Review
4	March 2021	G Gilchrist, M Ong	Review, inclusion of documentation

Other relevant policies

Health Records Policy
Abbreviations List

Safe Work Practices



Document Summary / Key Points:
- Documentation from Pre-admission to Discharge
- Documentation process and requirements

Change Summary:
- Addition of new forms and folders and associated procedures
- Addition of documentation standards and requirements

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1 REFERS TO

These procedures refer to all staff and Visiting Medical Officers at Allowah Presbyterian Children's Hospital.

2 PURPOSE

To ensure the use and maintenance of the health records is according to relevant legislation is in the best interests of the patient and is functional in terms of their use for patient care and outcomes.

3 POLICY STATEMENT

Allowah Presbyterian Children's Hospital will use and maintain all health records according to relevant legislation in the best interest of the patient.

Health records promote patient safety, continuity of care across time and care settings, and support the transfer of information when the care of a child is transferred e.g. at clinical handover, during escalation of care for a deteriorating patient.

4 RESPONSIBILITIES

4.1 Director of Nursing

The DON is responsible for ensuring that all staff are aware of the requirements of these procedures and adhere to them. Exceptions are to be reported using the Hospital's risk management system.

4.2 All employees

All employees who work with health records are to ensure they are familiar with and comply with these procedures at all times.

5 DOCUMENTATION OVERVIEW

5.1 Privacy and confidentiality

All information in a health record is confidential and subject to prevailing privacy laws and policies. Allowah's Privacy and Confidentiality Policy and Health Records Policy set out key considerations regarding privacy of health records. Staff should only access a health record and use or disclose information contained in the record when it is directly related to their duties and is essential for the fulfilment of those duties, or as provided for under relevant legislation.

5.2 Auditing

Health records must be audited for compliance with these procedures. Allowah maintains a schedule of regular audits of health records overseen by the Clinical Governance Unit and with results reported regularly to staff, the Allowah Leadership Team and the Social Service Committee.

5.3 Education

Allowah maintains a schedule of regular education on documentation and management of health records. All staff who document or manage health records are provided with appropriate orientation and ongoing education on the documentation and management of health records.

The content and delivery of education programs is informed by health record audits. The results of these audits are used to target problem areas relating to particular groups of health care personnel or parts of documentation.

Specific education is conducted for the introduction of any new complex health record forms and for changes in documentation models.

6 PRINCIPLES OF DOCUMENTATION

6.1 Identification on every page / screen

The following items must appear on every page of the health record, or on each screen of an electronic record (with the exception of pop up screens where the identifying details remain visible behind):

a) Unique identifier (e.g. 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.

6.2 Standards for documentation

Documentation in health records must comply with the following:

a) Be clear and accurate.
b) Legible and in English.
c) Use approved abbreviations and symbols.
d) Written in black ink that is readily reproducible, legible, and difficult to erase and write over for paper-based records.
e) Time of entry (using a 24-hour clock – hhmm).
f) Date of entry (using ddmmyy or ddmmyyyy).
g) Signed by the author, and include their printed name and designation. In a computerised system, this will require the use of an appropriate identification system e.g. electronic signature.

h) Entries by students involved in the care and treatment of a patient / client must be co-signed by the student's supervising clinician.
i) Entries by different professional groups are integrated i.e. there are not separate sections for each professional group.
j) Be accurate statements of clinical interactions between the patient / client and their significant others, and the health service relating to assessment; diagnosis; care planning; management / care / treatment/ services provided and response / outcomes; professional advice sought and provided; observation/s taken and results.
k) Be sufficiently clear, structured and detailed to enable other members of the health care team to assume care of the patient / client or to provide ongoing service at any time.
l) Written in an objective way and not include demeaning or derogatory remarks.
m) Distinguish between what was observed or performed, what was reported by others as happening and / or professional opinion.
n) Made at the time of an event or as soon as possible afterwards. The time of writing must be distinguished from the time of an incident, event or observation being reported.
o) 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.
p) Be relevant to that patient / client.
q) Only include personal information about other people when relevant and necessary for the care and treatment of the patient / client.
r) 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.

s) 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.

   For electronic records the history of audited changes must be retained and the replacement note linked to the note flagged as "written in error". This provides the viewer with both the erroneous record and the corrected record.

6.3 Documentation by medical practitioners

Documentation by medical practitioners must include the following:

a) Medical history, evidence of physical examination.
b) Diagnosis/es (as a minimum a provisional diagnosis), investigations, treatment, procedures / interventions and progress for each treatment episode.
c) A principal diagnosis must be reported for every episode of admitted patient care.
d) Medical management plan.
e) Where an invasive procedure is performed and / or an anaesthetic is administered, a record of the procedure including completion of all required procedural checklists. Where a general anaesthetic is administered, a record of examination by a medical practitioner prior to the procedure is also required.
f) Comprehensive completion of all patient / client care forms.
g) A copy of certificates, such as Sick and Workers Compensation Certificates, provided to patients / clients must be retained in the patient / client's health care record.

6.3.1 Visiting Medical Officer

The Visiting Medical Officer (VMO) 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 VMO remains responsible for ensuring documentation is completed to an appropriate standard that would satisfy their professional obligations.

The VMO should 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 VMO's duty of care to the patient / client.

6.4 Documentation by nurses

Documentation by nurses must include the following:

a) Care / treatment plan, including risk assessments with associated interventions.
b) Comprehensive completion of all patient / client care forms.
c) Any significant change in the patient / client's status with the onset of new signs and symptoms recorded.
d) 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.

e) Documentation of medication orders received verbally, by telephone / electronic communication including the prescriber's name, designation and date / time.

6.5 Frequency of documentation

The frequency of documentation entries should conform to the following as minimum requirements.

6.5.1 Acute Care Patient / clients

a) Registered Nurse / Enrolled / Endorsed Nurse should make an entry in the patient / client's health care record a minimum of once a shift. An entry by an Assistant in Nursing should not be the only entry for a shift.

   Entries should reflect in a timely way the level of assessment and intervention. The results of significant diagnostic investigations and significant changes to the patient / client's condition and/or treatment should be documented as these occur.

b) Medical practitioners should make an entry in the health care record at the time of events, or as soon as possible afterwards, including when reviewing the patient / client.
c) Other health care personnel should make entries to reflect their level of assessment and intervention consistent with the medical management plan.

6.6 Alerts and allergies

Clinicians must flag issues that require particular attention or pose a threat to the patient / client, staff or others including:

a) Allergies / sensitivities or adverse reactions, and the known consequence.
b) Infection prevention and control risks.
c) Behaviour issues that may pose a risk to themselves or others.
d) Child protection / wellbeing matters including:
   i. children at risk of significant harm
   ii. where NSW Police or the Department of Family and Community Services have issued a general alert to Allowah.
e) Where patients / clients have similar names and other demographic details.

Allowah has in place systems for the identification of such alerts and allergies. If a label is used on the outside folder of a paper-based health 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 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 must be standardised within Allowah in line with the list of approved abbreviations.

A flag should be reviewed at each admission. When alerts and allergies are no longer current this must be reflected in the health record and inactivated where possible.

6.7 Tests – requests and results

The health record must document pathology, radiology and other tests ordered, the indication and the result.

When tests are ordered the name of the ordering medical practitioner / approved clinician and their contact number must be clearly printed (if written) or entered (if computerised) on the request form.

Pathology, radiology and other test results must be followed up and reviewed by the RN in Charge with notation as to action required. The RN in Charge should determine whether the results need to be brought to the attention of the VMO.

6.8 Patient / client clinical incidents

All actual clinical incidents must be documented in the patient / client's health record.

Staff must document in the health record.

a) Tickit on Demand incident number.
b) Clinically relevant information about the incident.
c) Interactions related to open disclosure processes.

6.9 Complaints

Complaint records are not to be kept with the patient's health record. Complaints records are kept in a separate client file.

6.10 Telephone / electronic consultation with patient / clients

When clinical information is provided to a patient / client, or their carer / guardian / advocate, the consultation must be documented in the health record. The identification of the caller must be documented.

Where the caller is not the patient / client, or their carer / guardian / advocate obtain consent from the patient / client, or their carer / guardian / advocate prior to the consultation. Document the

a) Caller's name,
b) Relationship to the patient / client, and
c) That the patient / client, or their carer / guardian / advocate has consented to the caller seeking clinical information about the patient / client in the patient / client's health record.

6.11 Telephone / electronic consultation between clinicians

Where a clinician involved in the care and treatment of a patient / client formally consults another clinician, via telephone / electronic means, about the patient / client and the consulted clinician provides advice, direction or action, that advice, direction or action must be documented in the health record by the clinician seeking the advice. The name and designation of the consulted clinician, and the date / time of the consultation must also be documented as soon as practical following consultation with the other clinician and in a manner as to ensure continuity of care for patients.

6.12 Leave taken by patients / clients

Any leave taken by the patient / client should be documented in their health record with the date / time the patient / client left and returned. The patient / client should be assessed before proceeding on leave and the outcome of that assessment documented in the health record, together with the documented approval of the RNIC noting the assessment.

6.13 Leaving against medical advice

A patient/client who decides to leave the health service/program against medical advice must be asked to sign a letter to that effect with the letter filed in the patient/client's health record. If the patient/client refuses to sign the form this must be documented in the health record, including any advice provided.

Examples of advice that could be provided to the patient/client include:

a) The medical consequences of the patient's decision, including the potential consequences of no treatment
b) The provision or offering of an outpatient management plan and follow-up that is acceptable and relevant to the patient
c) Under what circumstances the patient should return, including an assurance that they can elect to receive treatment again without any prejudice.

7 PROCESS – FROM PRE-ADMISSION TO DISCHARGE

7.1 Pre-Admission

A Pre-Admission interview is held with the parents of any child (with the child present) who has not previously been admitted to the Hospital. At this interview, among other things:

- The Director of Nursing or delegate will complete the Pre-Admission Form;
- the parent is interviewed by a Visiting Medical Officer, who completes a full medical history examination and ensures the Preadmission form is complete;
- a principal diagnosis and associated co-morbidities or complications of care are documented by the admitting Visiting Medical Officer; and
- using the information from this form, the Administration Manager puts together the patient notes and the patient master index card.

7.2 Admission

Upon admission:

- A health record is created for a patient on their first admission. The same record is used for all subsequent admissions. All documents (medical, nursing and allied health) relating to a patient's treatment are kept in the one health record.
- After the Pre-Admission meeting when a definite admission has been booked:
    - the patient is allocated a health record number;
    - health record labels are printed;
    - a letter of request for medical information is sent to medical officer or specialist (accompanied by parent's permission for release of information) – this may be done before the Pre-admission meeting if parents do not have copies of reports.
    - (Cash's) name tags are ordered if required; and
    - A Patient Master Index Card is completed.
- All inpatient details are completed by the Administration Manager during office hours. After hours the admission details are completed the next day.
- A health record consists of:
    - Black A4 health record folder
        - Dividers
        - Inpatient Record
            - Principal Diagnosis Summary form
            - Telephone Information Update
            - Pre Admission form
            - Medical Review form
            - Consent forms
            - Medical History continuation
            - Parents/Carers direction form

            - Admission History
            - Progress Notes
            - Discharge Summary
            - Health Fund Claim form
            - Immunisation schedule
            - Patient incident/hazard form
            - Adapted Glamorgan Pressure Ulcer Risk Assessment Scale
            - Guidance on using the Glamorgan Scale
            - Paediatric Fall Risk Assessment
            - Risk Score
            - Paediatric Nutrition Screening Tool
            - Mental State Deterioration Form A
        - Allied Health
            - Percentile charts
            - Therapy programs / assessments
                - Physiotherapy
                - Occupational Therapy
                - Speech therapy
                - Dietetics
                - Psychology
        - Case Conference / Patient Care Review forms
        - Medical Reports
        - Correspondence
            - Correspondence in
            - Correspondence out
        - Diagnostic Reports
            - Pathology Results
            - X-ray Results
            - Other diagnostic results & reports
    - Red A4 health record folder
        - Dividers
            - Observation Chart
            - Relevant Information
            - Child Care Management Plan
            - Care Pathway
            - Fluid Balance Chart
            - Seizure chart
            - Sleep Chart
            - Medication Chart

- The black file is completed from Pre-Admission notes and requires the addition of addressograph labels, showing name, health record number, date of birth, address, home, mobile and business phone numbers, allergies, Medicare number, admitting doctor and health fund information.
- When a patient is admitted, the red folder should contain Observation Chart, Relevant Information, Child Care Management Plan, Care Pathway, Fluid Balance Chart, Seizure chart, Sleep Chart and Medication Chart.

- A photo is taken of the patient for their medication chart and Client Identification Chart. A photo is also attached for their bed tag.
- Each new admission begins on an Admission Form stamped with "Admission No. stamp" for the next admission. The previous admission number is checked and one added to this for the next admission number.
- An Inpatient Statistics Form (Morbidity Form 12a) is begun for each child at the beginning of the admission and retained in the patient's health record file at discharge. The hospital copy of the morbidity form is kept on the computer in the ICS data program.
- The Inpatient Statistics Form (12a) is placed at the beginning of each admission, followed by the Admission History for that admission, the progress notes, any temperature or observation charts, and finally the Discharge Summary which is placed behind the last page of each admission.
- When a patient is to be admitted, a member of the Administration staff collects the patient records for the coming day from the Health Records Room and place them in a lockable cupboard at the Nurse's Station.
- If a patient is admitted after hours, the Registered Nurse in Charge will collect the patient record from the Health Records Room.
- The admission of a patient is recorded in the Admission / Discharge book at the nurses' station by the admitting nurse, with date and time of the admission.
- Statistics are sent to the Department of Health monthly via email by the Administration staff.
- All filing is filed into an A-Z concertina file at the Nurse's station awaiting filing in the patient's health record. The administration clerk/manager will file these into the patient's health record

7.3 Discharge

Upon discharge:

- A discharge form shall be completed when a patient is being transferred to another hospital, a respite home/centre, or into the care of parents / carers.
- The carbon copy is given to the other facility or parent and the original is filed in the patient's health record file.
- The date and mode of separation are completed on the Inpatient Statistic Form (Morbidity 12A) by the Administration Clerk/Manager.
- All health records are to be removed from the ward and placed in the lockable cupboard at the nurse's station. The Administration staff will collect these records and return them to the Health Records Room.
- All discharge records are to be correlated with the current admission.
- Discharge records are stamped at the end of the last entry with a "Discharged" stamp and a line is ruled across the page. A line is also drawn across any unwritten lines on the page and on the back of the current page.
- The records are filed in the filing cabinet in the Health Records Room.

7.4 Day care patients – admission and discharge

For day care patients:

- A Day Care Admission and Discharge form is to be completed by the person bringing the child into Allowah and the admitting nurse upon arrival and upon discharge.
    - Child Care Management Plan
    - Care Pathway
    - Parents/Carers direction form
    - Progress Notes
    - Seizure chart

- No other documentation is required unless further information is provided upon admission that is not included on the Admission and Discharge form.

7.5 Principal Diagnosis Review

The attending Visiting Medical Officer is responsible for recording details of the patient's principal diagnosis and any associated co-morbidities or complications of care:

- This detail is reviewed / recorded at least annually, or more frequently as required for patients admitted for discrete periods of time.
- This information must be completed on the Morbidity Form before the health record is filed.

7.6 Health Record Number

A unit system is maintained:

- On a patient's first admission they are assigned a health record number, which is retained for all subsequent attendances.
- The record number is a unique identifier and is used to identify all clinical documents.
- An alphabetical card system 'Patient Master Index' (PMI) is maintained in the administration office. Only the Administration Manager (or their delegated person) is able to assign new health record numbers on the P.M.I.
- The Registered Nurse in Charge is able to access the health records room and obtain the relevant health record, after hours, if an unexpected admission occurs.

7.7 The tracer card system

In any record system, control over the movement of records is of the utmost importance. If adequate procedures of record control are not implemented, file location and confidentiality may be breached. When a record is removed from the file, it must be replaced by a tracer card which contains the following details:

- Health record number

- Patient's name
- Record destination
- Date record was removed
- Name of borrower

When the record is returned to the storage area the tracer card is removed.

The Administration Manager / Administration Clerk are responsible for the movement of records. Outside office hours, the nursing staff handle all enquiries and remove records using the tracer system.

7.8 Clinical classification - coding

- At the conclusion of a patient's stay in hospital, each admission is assigned classification codes based on the patient's diagnoses and interventions received during their stay. These codes are obtained from The International Statistical Classification of Disease and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and The Australian Classification of Health Interventions (ACHI). This is undertaken by either a Health Information Manager, the Director of Nursing or an authorised delegate.
- These codes are collated into the Hospital Casemix Protocol (HCP) data, which is sent to all health funds and the NSW Department of Health, also the Private Hospitals Data Bureau (PHDB) data and the Commonwealth Department of Ageing and Health each month.

7.9 X-rays

- X-rays remain the property of the patient / parent and should be given to the parent on the patient's discharge. Old x-rays left in the hospital may be destroyed after (3) three years.
- The x-ray report is filed as part of the patient's permanent health record.
- X-Rays will be stored in the medical records storage area if needed

7.10 Weekend stationary

Administration staff will ensure that sufficient supplies are left for weekend staff at the nurses' station. This includes:

- Inpatient Progress Notes;
- Admission History Forms;
- Pens and Note Paper;
- Fluid Balance Charts;
- Medication Charts;
- Interim Medication Chart; and
- Discharge Forms.
- Care Management Plan

- Care Pathway
- Observation Chart
- Seizure Chart
- Sleep Chart

8 STORAGE – ACCESS AND ADMINISTRATION

8.1 Access

Access to Health Records is restricted to authorised personnel. Parents / carers and others are not permitted to have access to Health Records outside the provisions of the Health Records Policy. Please refer to the Director of Nursing for more information.

- Personnel who have direct access to the health records storage area are:
  - Clerical staff responsible for filing and retrieving health records;
  - Director of Nursing;
  - Registered Nurses and
  - Allied Health Staff
  - In addition a number of operational staff have keys which give access to the records storage area, however these staff are only expected to access the area if there is an operational need – not to access the health records.
- Records are only removed from the Medical Records Room if required for direct patient care, room meetings or quality assurance activities.
- Registered Nurses have access to the records after hours. Keys to various areas are kept in the locked key cupboard in the administration office.

8.2 Location

Records are located in the following areas:

- Current Inpatients:
  - Named A4 Black ring binders in cupboard at the nurses' station.
  - A4 Red ring binders in lockable cupboard in child's room labelled with allocated Room and Bed number.
  - An additional file for particular children in the care of the Minister of Community Services will be kept in the lockable cupboard at the nurses' station (Medical reports, In/ Out correspondence, Hospital Reports and Diagnostic)
- Old notes (multiple volumes): lockable cabinets in Health Records Room in (numerical order)
- Short Stay Patients: Named A4 Black and A4 Red ring binders in lockable cabinets in Health Records Room in first name order.
- Discharged Patients: By destruction date in archive boxes filed in the locked compactus in archive room.

8.3 Retention

Disposal schedules are in accordance with the NSW Health Department guidelines:

- Children's Inpatient Records: To be retained for (50) fifty years after they reach the last admission.
- Patient Master Index: Retain permanently.
- X Rays: Return to parent or retain for three (3) years. X-rays of current patients are stored in the Health Records Room.

8.4 The volume system

Old records are filed in a volume system:

- When culling of records occurs at the child's birthday, the previous 12 months' health record becomes one admission.
- This is filed in a manila folder with a divider stating first admission and the dates of that admission.
- Each subsequent years' documents are then added in order, e.g. second admission 1991 –1992, third admission 1992 –1993.
- As bulk increases new volumes or records are commenced and numbered in sequential order i.e. Volume 1, Volume 2 of 2, Volume 3 of 4 etc. to ensure there is an accurate tally of all existing volumes for an individual patient over time.

8.5 Culling

The type of hospital care offered by Allowah Presbyterian Children's Hospital leads to frequent short admissions which can result in bulky records that are too cumbersome for effective use. An artificial time base has been introduced to allow culling of the record in order to prevent the problems of handling bulky records:

- Each patient's admission number reverts back to 1 from the first admission after their birthday each year. At this time some of the health record forms (excepting 'in correspondence') are removed from the current active record. They then become part of the old record using the volume system.
- The records remain active whilst the patient is continuing to use Allowah Presbyterian Children's Hospital.
- A Care Pathway is done within the first twelve (12) months, this is reviewed annually.
- The same procedure is used for long term patients and day patients.
- The culling process is carried out by the administration clerk/manager.

8.6 Prevention of damage

Storage areas and systems at the Hospital enable the storage of records for at least as long as required by legislation:

- Damage to paper records is minimised by ensuring that light, humidity, heat, vermin and moisture, and that fire prevention practices and detection systems are used.
- The Compactus area in the hospital meets these requirements.
  - Any damage sustained by normal handling processes will be repaired according to the Australian Standard 2828.1 – 2012 (Health records - Paper-based health records)

8.7 Destruction

All records will be retained for the period set out in these procedures. When records are to be destroyed:

- They will be divided in such a way as to render them unreadable and leave them in a form from which they cannot be reconstructed in whole or part, after an appropriate length of time.
- The Medical Officers notes are retained permanently, while the progress notes, correspondence, allied health, medication charts, temperature charts, food and fluid balance charts and so on are securely shredded.
- A 'Destroyed' tag is attached to the record.
- The divided health record remains stored in the Compactus area of the hospital.
- The Patient Master Index is kept permanently.

8.8 Transportation

All health records transported within the hospital are to be transported by appropriate personnel i.e., medical, nursing, therapy staff. A trolley should be used when transporting a heavy load of records. No health records shall be removed from the hospital building for any reason except as set out in the Health Records Policy (e.g. subpoena).

9 CONTENT – RULES FOR WRITING AND MAKING ENTRIES INTO RECORDS

All entries in Health Records are to be made in accordance with the standards set out in this procedure.

9.1 Entries at Admission

Patient history

History of current illness/injury (i.e. reason for current admission), relevant past history, allergies and reactions, medications, immunisation status and family and social history must be documented upon admission. For neonates and infants consider maternal history, antenatal history, delivery type and complications if any, APGAR score, resuscitation required at delivery.

Patient assessment

A nursing assessment is to be completed and documented on the admission and discharge of each patient.

An admission assessment should be completed by the nurse with a parent or care giver, ideally upon arrival to Allowah, but must be completed within 24hours of admission. The admission assessment is to be documented on the nursing admission form.

The admission assessment will include Adapted Glamorgan pressure risk assessment scale, Paediatric Fall risk assessment, Paediatric Nutrition Screening Too and Mental State Deteriorating Form A.

General Appearance

Assessment of the patient's overall physical, emotional and behavioural state should be documented. Considerations for all patients include: pale or flushed, lethargic or active, agitated or calm, compliant or combative, posture and movement.

- Neonate and Infant
    - Parent-infant, infant-parent interaction
    - Body symmetry, spontaneous position and movement
    - Symmetry and positioning of facial features
    - Strong cry
- Young Child
    - Parent-child, child-parent interaction
    - Mood and affect
    - Gross and fine motor skills
    - Developmental milestones
    - Appropriate speech
- Adolescent
    - Mood and affect
    - Personal hygiene
    - Communication

For example: 2/7/2014 - 1500 NURSING. Alert and interactive early morning. Mum reported that child was withdrawn and had returned to bed at 1030hours. Mum left ward at 1315 hours. Child settled and watching iPad at time of report.

Vital Signs

Baseline observations are recorded as part of an admission assessment and documented on the patient's observation chart.

- Temperature
- Respiratory Rate: Count the child's breaths for one full minute. Assess any respiratory distress.
- Heart Rate
- Blood Pressure: Should be obtained on a needs basis or if indicated by other observations. Selection of the cuff size is an important consideration. A rough guide to appropriate cuff size is to ensure it fits a 2/3 width of upper arm. For neonates without previous hospital admissions do a blood pressure on all 4 limbs.
- Oxygen Saturation
- Pain: As Appropriate use FLACC, Faces, numeric scale, Neonatal Pain Assessment Tool. Current pain relief medications/practices

For example: 2/7/2014 - 09:40 NURSING. Billie is describing increasing pain in left leg. Pain score increased. Paracetamol given, massaged area with some effect. Education given to Mum at the bedside on providing regular massage in conjunction with regular analgesia. Continue pain score with observations.

9.2 Shift Assessment

At the commencement of every shift progress notes should be read. An assessment of each patient must be completed and documented in the progress notes for each patient during each shift. The shift assessment includes:

- Airway: noises, secretions, cough, artificial airway
- Breathing: bilateral air entry and chest movement, breath sounds, respiratory rate, rhythm, work of breathing, spontaneous/ supported/ ventilator dependent, oxygen requirement and delivery mode
- Circulation: pulses (rate, rhythm and strength); peripheral temperature, colour and capillary refill time; skin, lip, oral mucosa and nail bed colour.
- Disability: Use assessment tools such as, Alert Voice Pain Unconscious scale (AVPU). Any aids, mobility or transfer requirements, prosthetics/orthotics required. Blood sugar levels as clinically indicated.
- Focused: assessment of presenting problem(s) or other identified issues, e.g. Cardiovascular, respiratory, gastrointestinal, renal, eye, etc.
- Pain: FLACC, Faces, numeric scale, Neonatal Pain Assessment Tool.
- Hydration/Nutrition: oral, nasogastric, gastrostomy, jejunal, fasting, breast fed, diet.
- Output: urine, bowels, drains, losses, fluid balance
- Risk: pressure injury risk assessment, falls risk assessment, ID bands
- Wellbeing: Mood, sleeping habits and outcome, coping strategies, reaction to admission

- Social: family/ guardian, discharge plan

For example: 2/7/2014 - 09:40 NURSING A) Patent airway B) RR 28/min. SaO2 96% Nil respiratory distress. C) Colour pink. Good capillary return. HR90-100. D) Alert and interactive. E) Afebrile. F) Tolerated diet and fluids. Passed urine in nappy once this shift. G) Seen by Dr NAME. Nil visitors this shift.

9.3 Plan of Care

Allowah has a Child Care Management Plan for each patient. Taking into consideration the patient assessment, clinical handover, previous patient documentation and verbal communication with the patient and family. The plan of care, the Care Pathway must be signed off each shift as tasks are completed.

9.4 Real time progress notes

Documentation is captured in the patient's progress notes in 'real time' throughout the shift instead of a single entry end of shift. Any relevant clinical information is entered in a timely manner such as;

- Abnormal assessment, e.g. uncontrolled pain, tachycardic, increased WOB, poor perfusion, hypotensive, febrile etc.
- Change in condition, e.g. Patient deterioration, improvements, neurological status, desaturation, etc.
- Adverse findings or events, e.g. vomiting, rash, pressure areas, incontinence, fall, pressure injury; wound infection, electrolyte imbalance, +/-fluid balance etc.
- Change in plan (Any alterations or omissions from plan of care on patient care plan) e.g. Rest in bed, increase fluids, fasting, any clinical investigations (bloods, x-ray), mobilisation status, medication changes.
- Patient outcomes after interventions e.g. dressing changes, pain management, mobilisation, hygiene, overall improvements, responses to care etc.
- Family centred care e.g. parent level of understanding, education outcomes, participation in care, child-family interactions, welfare issues, visiting arrangements etc.
- Social issues e.g. accommodation, travel, financial, legal etc.

For example: 2/7/2014 - 09:40 NURSING. Billie is describing increasing pain in left leg. Pain score increased. Paracetamol given, massaged area with some effect. Education given to Mum at the bedside on providing regular massage in conjunction with regular analgesia. Continue pain score with observations.
10:15 NURSING. Episode of urinary incontinence. Billie quite embarrassed. Urine bottle placed at bedside.

Progress note entries should include nursing content and evidence of critical thinking. That is, they should not simply list tasks or events but provide information about what occurred, consider why and include details of the impact and outcome for the particular patient and family involved.

The structure of each progress note entry should follow the ISOBAR philosophy with a focus on the four points of Assessment, Action, Response and Recommendation.

> Assessment: What does the patient look like? What has happened?
>
> Action: What have you done about it? Interventions, investigations, change in care or treatment required?
>
> Response: How has the patient responded? What has changed? Improvement or deterioration?
>
> Recommendation: What is your recommendation or plan for further interventions or care?

9.4.1 Nursing Progress Notes

The Nursing Progress Notes (MR 89) are to be used by nursing staff to guide the writing on progress notes. A Nursing Progress Notes form is to be completed for each shift. Each area of the Nursing Progress notes should be addressed during the shift and / or marked as Not Applicable (N/A) for that shift.

The back page of the Nursing Progress Notes allows space for additional notes to be made about the care of the children during the shift and can be completed by up to three different staff. Staff must sign the yellow highlighted space when completing the notes in this section.

Medication: any notes for medication should be detailed in the spaces on the back page of the Nursing Progress Notes form.

Behaviour notes are to be made in the Mood/Behaviour section and Behaviour charts are also to be completed for children who use them.

Any wounds identified in Skin Integrity notes should be noted on a Wound Assessment chart.

Observations are to be recorded in the Nursing Progress Notes as well as charted on the child's observation chart.

If a child uses a fluid balance chart, any fluid intake or wet nappies recorded in the Nursing Progress Notes must also be recorded on the fluid balance chart.

Any care, equipment use etc. recorded in the Nursing Progress notes, must also be recorded in the child's Care Management Plan / Care Pathway.

Incident numbers should be recorded on the Nursing Progress Notes, after they have been entered into the Tickit on Demand system.

Completion of risk assessments is to be noted on the Nursing Progress Notes, however the risk assessments must be undertaken using the applicable risk assessment form or tool.

Note: Nursing staff are advised not to mark sections of the Nursing Progress Notes as N/A until the end of their shift. This allows for anything you might need to note, or any changes that might take place throughout the shift.

Nursing Progress Notes

MR 89

All entries must be legible, written in black pen and include writers printed name, designation and signature.

Observation / Detail	My Interventions / Rationale (why)	Document Completed
Medications		
Given as charted ☐ PRN administered ☐ Missed ☐		Yes / NA
Mood / Behavior		
		Yes / NA
Skin Integrity		
		Yes / NA
Observations		
HR: O2: Temp:		Yes / NA
Pain		
		Yes / NA
Feeding and Fluid intake (Tick all appropriate)		
Oral ☐ Gastro ☐ Jejunostomy ☐		Yes / NA
Toileting		
Bowels Opened ☐ Wet Nappy ☐		Yes / NA
Communication from Doctor		
		Yes / NA
Communication from parents / carers		
		Yes / NA
Dental / Oral Hygiene		
		Yes / NA
Equipment Use & Patient Response- specify equipment in use (Standing frame, wheel chair, AFO's etc)		
		Yes / NA
Incident / Near Miss		
Ticket number:		Yes / NA
Risks		
Infection control ☐ Mental Health ☐ Pressure area ☐ Falls ☐		Yes / NA
Other (incorporating Pathology results, Periods, Showering, Outings and appointments		
		Yes / NA

Signature/Name: ______________/_______________ Delegation: __________ Time: _________ **Date:** __________

MR 89 Nursing Progress notes 22.03.2021, Version 3.0 for implementation

Nursing Progress Notes

MR 89

All entries must be legible, written in black pen and include writers printed name, designation and signature.

Time	Extra space for additional progress notes (cross out all unused lines)
Signature/Name: ____________/______________ Delegation: __________ Time:__________ **Date:** __________	
Signature/Name: ____________/______________ Delegation: __________ Time:__________ **Date:** __________	

Signature/Name: ____________/______________ Delegation: __________ Time:__________ **Date:** __________

MR 89 Nursing Progress notes 22.03.2021, Version 3.0 for implementation

9.5 Documentation by Doctors

When a Visiting Medical Officer records in a patient's health record they write in the progress notes sign at the end of the entry. Documentation by medical practitioners must include the following:

a) Medical history, evidence of physical examination.

b) Diagnosis/es (as a minimum a provisional diagnosis), investigations, treatment, procedures / interventions and progress for each treatment episode.

A principal diagnosis must be reported for every episode of admitted patient care.

9.6 Tests – requests and results

The health care record must document pathology, radiology and other tests ordered, the indication and the result. When tests are ordered the name of the ordering medical practitioner / approved clinician and their contact number must be clearly printed (if written) or entered (if computerised) on the request form. 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.

10 FORMS – COMMON FORMS AND THEIR DESIGN, REVIEW & CONTENT

10.1 Common forms

The following are the most common forms used in health records:

- Pre-Admission Form.
- Clinical Deterioration of Patient and possible transfer
- Consent for Treatment.
- Consent for Release of Medical History and Assessments.
- Consent for outings.
- Consent Form for Use & Disclosure of Personal Information
- Integrated Progress Notes.
- Privacy Acknowledgement and Consent Form
- Management Care Plan
- Care Pathway
- Admission Form
- Discharge Summary
- Percentile Chart

- Fluid Balance Chart
- Seizure Chart
- Observation Chart
- Temperature, General observation chart
- Immunisation Schedule Form
- Medication Chart
- Medications on Admission and Telephone Order Form
- Equipment form
- Feeding Behaviour Chart
- Transfer form
- Gate pass form
- Adapted Glamorgan Pressure Ulcer Risk Assessment Scale
- Guidance on using the Glamorgan Scale
- Paediatric Fall Risk Assessment
- Risk Score
- Paediatric Nutrition Screening Tool
- Mental State Deterioration Form A
- Nursing Progress Notes

10.2 Health Fund forms

Allowah Presbyterian Children's Hospital uses a program called Direct Control:

- This program creates a hospital claim form and numbered invoice, which is used for all health funds.
- It is printed out on discharge with all relevant details for the health fund member to sign.
- These forms are then photocopied and filed in the patient's health record, the original going to the appropriate health fund.
- At the end of each month, the Administration Manager sends the Hospital Casemix Protocol (HCP) data to all health funds and the NSW Department of Health. Additionally, Private Hospital Data Bureau (PHDB) data is sent to the Commonwealth Department of Ageing and Health for the hospital statistics.
- Included in the information sent to the health funds, the NSW Department of Health and the Commonwealth Department of Ageing and Health, are the classification codes obtained from The International Statistical Classification of Disease and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) and The Australian Classification of Health Interventions (ACHI).

10.3 Form design, review and content

The Director of Nursing / Registered Nurses review all forms annually or as required. The introduction of any new medical forms or revisions to old forms requires to be approved by the CEO before removing the draft watermark and being used in the health records.

11 STATIONERY

11.1 Purchasing

Stationery for health records is purchased from:

- Fuji Xerox Hospital and Medical Forms:
    - Temperature Charts
    - Observation charts
- Gowens Printing:
    - Admission Form
    - Progress notes
    - Medical Continuation Notes
    - Discharge Summary
- Rolls Printing:
    - Stickers for Physiotherapy, Occupational Therapy, Speech Pathology, Pastoral, Social Worker, Dietician, Team meetings, Medical etc.
    - Dividers: 1st – 5th admission - MR682/4/6/8/0
    - Dividers Blank - MR692/3
    - Dividers (correspondence) - MR700
    - Dividers (diagnostic) - MR704
    - Number Register - MR760
    - Tracer Cards – MR662
- Winc:
    - Identification labels
    - Black plastic A4 Folders
    - Red plastic A4 Folders

The following forms are printed in-house:

- Transfer form – MR018
- Fluid Balance Worksheet – MR195
- Adapted Glamorgan Pressure Ulcer Risk Assessment Scale
- Guidance on using the Glamorgan Scale
- Paediatric Fall Risk Assessment
- Risk Score
- Paediatric Nutrition Screening Tool
- Mental State Deterioration Form
- Nursing Progress Notes
- Sleep charts
- Seizure charts
- Behaviour charts

12 QUALITY ACTIVITIES

Quality Activities in relation to health records may be undertaken by the Quality Audit, WHS and Consumer Relationship Officer. All results and recommendations relating to quality activities for the health record service/content will be

presented to the Allowah Leadership Team. For further details relating to the quality cycle, refer to the Quality Management Plan.

13 EXPECTED OUTCOMES

All health records are created, maintained, managed, retained and destroyed in such a way that all legislative and other requirements are adhered to, patient-centred care is maximised and privacy is maintained.

14 REFERENCES

- Health Records and Information Privacy Act 2002 (NSW) (HRIP Act)
- Commonwealth Privacy Act 1988 (Federal Privacy Act)
- The Australian Privacy Principles (APPs)
- Health Privacy Principles (HPPs)
- NSQHS 2nd Edition Standards
- Presbyterian Social Services - Confidentiality and Privacy Policy & Procedure
- Private Health Facilities Act 2007 (NSW)
- Private Health Facilities Regulations 2010 (NSW)
- Health Practitioner Regulation (New South Wales) Regulation 2010 (NSW)
- Public Health Act 2010
- The Australian Council on Healthcare Standards (ACHS) EQuIPNational Standards Book, Sydney Australia; ACHS; 2012 Standard 14: Information Management 14.3.1.
- The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) Alphabetic Index of Diseases, Tabular List of Diseases, Seventh Edition – 1 July 2010. National Centre for Classification in Health, Faculty of Health Sciences, The University of Sydney, NSW 1825 Australia.
- The Australian Classification of Health Interventions, Alphabetic Index of Interventions, Tabular List of Interventions, Sixth Edition – 1 July 2008, National Centre for Classification in Health (Sydney), Faculty of Health Sciences, University of Sydney, NSW 1825 Australia.
- Australian Coding Standards (ACS) Sixth Edition – 1 July 2008, National Centre for Classification in Health (Sydney), Faculty of Health Sciences, University of Sydney, NSW 1825 Australia.
- Policy Directive: Health Care Records – Documentation and Management, Strategic Relations and Communications, NSW Department of Health, Dec 2012.

15 KEY PERFORMANCE INDICATORS

Admission Forms completed correctly – 95%

Discharge Forms completed correctly – 100%