Good record keeping

Anita Courtney, Principal

Monday, 10 September 2018

Overview

- The role and purpose of records
- Why have good records?
- What are good records?
- Case studies
- TIPS!

PART 1:

THE ROLE AND PURPOSE OF RECORDS

Role of records

- Function of client records:
  - Storage of clinical data and other information
  - Means of communication between health care providers

Purposes of records

- Delivery of care and services
- Communication between service providers and health care team
- Planning
- Administration
- Litigation and complaints
- Compliance with legal obligations
- Claims
- Research

"Facts mean nothing unless they are rightly understood, rightly related and rightly interpreted."

– R. L. Long

PART 3:

WHAT ARE GOOD RECORDS?

Fit for purpose

- Remember who the records are for:
  - Other staff
  - Other carers
  - Funding bodies
  - Clients and representatives!
    - First thing unhappy clients do is to request their records
    - Poor records increase risk of complaints and civil suits

Clear, adequate and accurate!

- WHO
- WHAT
- WHEN
- WHERE
- WHY
- HOW (if relevant)

9

Example of unclear records

- *Case conference with family. Family's concerns discussed. Agreed to contact NDIS*
- *Daughter was aggressive/complaining*
- *Worker said she had touched based with client*

Actual examples from doctor's notes:

- *Occasional, constant, infrequent headaches*
- *Patient was alert and unresponsive*

10

Say what you saw/heard

- Distinguish what you ***witness*** (ie see, hear) from what you are ***told***
- For example:
  - ✓ "*Mrs Jones told me she fell out of bed.*"
  - ✓ "*X reported that Mrs Jones said she fell out of bed.*"
  - X *"Mrs Jones had a fall."*

11

Contemporaneous

- More likely to be accurate
- Courts and regulators place more weight on contemporaneous records than witness accounts
- Prompt reporting shows efficiency and more likelihood of honesty and frankness

12

Relevant

- Information should be relevant to the client and/or their care and services
- Client records are **not** the place to record:
  - Disputes with colleagues or third parties (service providers, funding bodies)
  - Outcome of disciplinary matters
  - Political opinions
- Remember the client can access their file

13

Avoid subjective language

- In general, you should **avoid** subjective language such as:
  - "stable"
  - "doing well"
  - "losing weight"
  - "confused"
- If you are going to use terms like this, justify them and be precise

14

Justify your opinions

- Don't express opinions you are not qualified to make:
  - Eg "Molly [a carer] says the client has mental health issues".
- Where they are appropriate, opinions should be substantiated. Eg if you think a client needs to go to residential care due to failing memory:
  - *"Mrs Jones was not at home today when staff attended. She returned soon later but seemed confused about staff being there and told them that she did not know she had an appointment today. She was not dressed suitably for the weather". It was 30 degrees and she was wearing a coat. Mrs Jones had limited food in the cupboard and said that she was hungry. She asked staff to give her food which is not part of the services we provide under Mrs Jones' package."*

15

Avoid inflammatory or critical language

- "Abusive"
- "Intoxicated"
- "Aggressive"
- "Rude"

Always think, what if the client read this?

16

Example of poor language…

- Example *Medical Board of Australia v Roberts* [2014]
- Pediatrician treating twins with ADHD wrote in consultation notes:
  - *"it[']s not they [sic] they want to be men, they don't"*
  - *"they don't want to have any testes ..."*
  - They should be told to *"toughen up princess"*
  - They are *"indulging in self-pity" and "self-indulgent thinking" ("oh woe is me")*
  - He is a *"sooky-sooky-la-la"*

17

Don't use sarcasm

- Dr Roberts' consultation notes:

  Swearing .. vulgar .. is so .. not on .. I can't even begin to describe it .. I recommend to your husband that he beat (physically) each and any of you our [sic] sons who swear and offend his wife (that is Mother) .. to within in [sic] an inch of his life.
- Tribunal said Dr R "should have realised there was a risk that the father might not have recognised the metaphoric or hyperbolic nature of R's recommendation….and that the recommendation was therefore putting the patients' health, safety and welfare at risk".
- Dr R held to have engaged in unprofessional conduct

18

Legible…

- Records should be able to be read by others
- **Article: Cause of Death: Sloppy Doctors**
  - http://content.time.com/time/health/article/0,8599,1578074,00.html
  - Messy handwriting kills >7,000 annually in USA.
  - Be careful with abbreviations

…versus illegible

EVERY 4TH WORD LEGIBLE:

EVERY WORD MUST TOUCH LINE MARGINS:

TEENY TINY:

20

Errors

- Cross them out and re-write
- Use extra pages if necessary
- Make it clear when corrections were made and by who
  - Don't give someone cause to say you "doctored" the notes.

21

Examples from actual records

- *The patient has been depressed ever since she began seeing me in 1983*
- *Rectal examination revealed a normal sized thyroid*
- *She stated that she had been constipated for most of her life, until she got divorced*
- *Large brown stool ambulating in the hall*
- *Patient has two teenage children, but no other abnormalities*

Examples from actual records

- *Patient was seen by Dr X, who felt we should sit on the abdomen and I agree*
- *Discharge status: Alive but without permission*
- *She has had no rigor or shaking chills but her husband said she was very hot in bed last night*
- *Patient refused autopsy*
- *Patient has left white blood cells at another hospital*
- *Patient had waffles for breakfast and anorexia for lunch*

PART 4:

CASE STUDIES

Case study 1

"I went to Mrs Smith's today but I couldn't get in the house because her son was there. He was aggressive and rude and he swore at me. I think he was drunk (?)."

25

Try this instead…

I attended at Mrs Smith's home today at 1.45pm. Her son, John Smith, was present and answered the door. When I told him I was there for his mother's care, he said (in a loud voice) "she's busy, I don't want you coming in". I explained that we had an appointment with Mrs Smith to assist with her ADLs but he again told me to leave in a loud, threatening voice and told me to "piss off".

I tried to talk to him but he repeated his request that I leave (at least 3 more times).

During our conversation Mr Smith was slurring his words. I smelt alcohol on his breath and I believed he was affected by alcohol. I felt intimidated by his behaviour so I decided to leave. I left at about 1.50pm.

26

Case study 2

"Short-term memory not good"

27

Case study 3

"Worker stated that client was intelligent enough to put up her case herself rather than spending the money on lawyers"

28

PART 6:

If client *not* taking advice

- Do document issues.
- If you are concerned a client is not listening to your advice in relation to what care and services they are receiving, it is important to have records of the following:
  - The advice given to the client and/or their family/carer
  - A record that shows an acknowledgement of receiving the advice by the client – whether signed or otherwise – ensure you record their response

30

Incident reports

- Date and time of incident
- Place where incident occurred
- Name/s of all those involved
- Full and accurate accounts of what the writer experienced
- If a client was harmed, their condition before the incident
- Any harm caused and to whom or what it was caused (objective observations)
- Any action taken and by whom it was taken (doctor/ relative/ carer/ambulance)
- Any further treatment/care/services/assessments ordered

31

Take-home points

- Ensure you understand the purpose for which you are making a record
- Ensure your record fulfills the purpose of why you are documenting
- Ensure your record is accurate and factual
- Record relevant information only
- Use approved forms
- Use time and date – provide an *exact record* of the time of interactions

32

Take-home points

- Be contemporaneous
- Be comprehensive but concise
- Be conscious of whether readers will understand what you are trying to say, that you are providing them with the necessary information and, if there is an action point, it is clearly stated
- Records should be written in your words and should not be convoluted, jargonistic or abbreviated

33

Take-home points

"*"Speak English" said the Eaglet. I don't know the meaning of half these long words and, what's more, I don't believe you do either.*"

- Lewis Carroll

34

Take-home points

- Record observations and events promptly or as soon as possible after they occur
- Ensure your records are dated, including with the time if appropriate, and signed legibly so that the author can be identified
- Ensure your documentation is in order and follows the consistent practice of the service
- Follow the policies and procedures of the service and the recording of information
- Write legibly and in ink

35

Take-home points

- Ensure there is a differentiation between fact and opinion and that opinions are justified
- Do not record anything insulting, embarrassing or rude
- Ensure records are consistent, uniform and placed where other users would expect the documentation to be found
- If amendments are necessary, do not erase or white out the error – place a strike out line through it, record the correction and properly author it

36

Remember…

"*Words, once printed, assume a life of their own.*"

- Wilma Askinas

37

Questions?

38

Disclaimer

The information contained in this presentation is intended as general commentary and should not be regarded as legal advice. Should you require specific advice on the topics or areas discussed, please contact the presenter directly.

39

PRESENTER

Anita Courtney
Principal
Russell Kennedy Lawyers
T: 8602 7211
E: acourtney@rk.com.au

40