All Entries

All entries you complete should be a clear account of your reasoning especially that which leads to important treatment decisions.

Timely – Document in real time.
If a Retrospective entry is documented the current date and time is indicated in the left hand column of the progress note, with the actual date/time the patient was seen in the body of the text.

Complete – include all relevant information

Accurate – double check your information

Legible - handwriting must be identifiable and legible

Make Sure you include

- Date
- Time (24hr clock)
- Type of entry (eg: nursing entry, ward round, consultant, specialty)

consultant, specialty)
- Print name
- Signature
- Designation

Remember

- Black ball point pen only.
- No liquid paper
- Single line to cross out mistakes – they still need to be legible. They are to be signed and dated, and can be notated with an explanation eg: “written in error”.

Each admission

Each patient admission must contain documented evidence of the following:

- Time of admission,
- Reason for admission,
- Summary of current conditions/problems
- Relevant legal information (mental capacity, advance decision to refuse treatment, Power of Attorney, organ donation),
- Alerts (risks and warnings

and adverse reactions (allergies) centralised on the Alerts and Adverse Reactions form in the front of all clinical records

- Social (lifestyle, social and personal circumstances, services and carers),
- Patient’s concerns, wishes, expectations
- Relevant risk assessment,
- Care Plan

When to document

- Minimum of 1 entry every 24 hours
- Significant event occurs
- Decisions
- Test or investigation ordered & results
- Plan for care
- The patient’s condition improves or deteriorates

Alerts & Adverse Reactions

Step 1. IDENTIFY
Clinical staff are responsible to identify and review all Alerts and Adverse Reactions for every hospital presentation. Central sources to be maintained and referred to are: HBCIS, and Adverse Reactions Form at the front of the Clinical Record.

Step 2. DOCUMENT
Clinical Staff are to update the Alerts and Adverse Reactions Form – adding new Alerts and Adverse Reaction information or end dating any irrelevant information, date, sign and print your name.

Step 3. ADVISE
Advise your local Administration Officer so they are able to update any relevant electronic information systems as soon as possible.
• Any consultations
• Observations
• Decision makers/family members/others are consulted in relation to the care and treatment

Patient Identification
• A patient identification label is to be placed on the top right hand corner of each page of each form in the clinical record. Back and front.
• If identification labels are unavailable, the patient’s name, date of birth, gender and UR number are to be written in the top right hand corner of page of each form or ask the administration officer in your area to print some.
• Ensure you are documenting in the correct clinical record by checking front cover.

Discharge Documentation – within 48 hours
Required for admitted patients on discharge. Discharge documentation includes:
• Enterprise Discharge Summary (EDS)*
• Patient Admission Form (Red sheet)
• Emergency Department Information System (EDIS) documentation
• Community Integrated Mental Health Application (CIMHA) – Consumer End of Care/Discharge Summary
• Discharge Notation in the Progress Notes

EDS can be accessed via a desktop icon, found on all computers. This is used across all Queensland Hospital & Health Services and users can view summaries from all facilities.

It has the ability to send summaries electronically, and a copy is retained in the clinical record. Pre-populated with information from feeder systems (eg pathology, ELMS)

Completion required within 48 hours. It is then available to the patient through My Health Record.

General guidelines for completion:
• It is the responsibility of the treating team on discharge to complete discharge documentation. The discharge documentation should adequately describe the entire episode including acute and subacute episodes (episode of care changes).
• If an inpatient is transferred to Hospital in the Home (HITH) the discharge summary is to be commenced by transferring unit. HITH medical officers are responsible for finalising and distributing the discharge summary when the patient has been discharged from HITH.
• Summaries completed for patients awaiting nursing home placement must include information regarding the acute episode and the time period in which the patient is awaiting nursing home placement. They must be finalised prior to patient discharge.
• Discharge Summaries are completed for deceased patients.
• Admissions to the Emergency Department require Emergency Department Information System (EDIS) documentation.
• Nursing staff are required to document a final entry on discharge in the progress notes.
• Health Practitioners contribute to EDS

When completing Discharge Summaries:
• Be clear about what the clinical diagnosis is.
• A procedure is not a principal diagnosis, document the condition that necessitated the procedure
• Document any additional diagnoses that are currently being monitored or treated in the ‘Other Active Problems’ section – this is not medical history
• Document any ongoing treatment plans to continue post-discharge
• Document any procedures performed
• Include medication: current, changed, ceased
• Must reflect/confirm what is in the progress note