Ensuring quality documentation practice – a review of allied health practice

Jo Brady[1]

1 Eastern Health, 5 Arnold Street, Box Hill, Victoria, 3128, Jo.Brady@easternhealth.org.au

Background
An acceptable standard of clinical documentation and information is the responsibility of all allied health professionals in any situation whereby services are provided. Clinical documentation serves multiple functions including a communication tool; a source of truth indicating accountability and medico-legal requirements are met; provision of data for education, quality improvement, research; and evidence for funding and resource management. Organisations need to ensure that high standards of documentation and management of health care records are consistent with common law and legislation, consider ethical principles and current best practice requirements, and remain focused on patient centred care.

An improvement project to redevelop and redefine the clinical documentation requirements for allied health professionals working in bed based, ambulatory and community services was developed. The purpose was to ensure standard documentation frameworks across allied health disciplines and programs of care (approx. 400 EFT allied health professionals). Allied health documentation requirements were defined for initial contact, assessment, review and discharge type interventions, and a set of mandatory criteria for each entry type was defined by each discipline. A key focus was on identifying and communicating risk, evidence based allied health diagnostic statements, and patient centred care.

Results
Following implementation of the revised documentation frameworks, audits were conducted with over 2600 medical record entries audited across allied health disciplines and programs. Results of the audits indicated the need for staff skill development in documentation of risk, patient consent for intervention, and of the patient's expectations and goals. Development of an agreed set of abbreviations was also required.

Discussion
This quality improvement activity provided opportunities for peer review of documentation and improvements in patient centred care. An unexpected outcome was the opportunity to review documentation practice across and between individual allied health disciplines, with a greater understanding of the principles of quality documentation as a result.