Course Information Sheet

Documenting in a Care Environment

Course Code	AOC17030	**Course Series**	Information Management
Learning Pathway	Developing		
Course Description	Effective documentation is essential in the delivery of quality care and support. We look at the principles of effective documentation and how to apply them. This course identifies and describes the various types of written and computer-based documentation found in the care environment. The importance of good documentation and the problems associated with poor documentation are discussed. Specific methods that care staff should use to produce effective documentation are outlined and demonstrated – the PIE tool for care workers and the SBARR method for RN's.		
Subjects covered include	Admission Documentation – Care Plan – Comprehensive Assessment – Charts – Continuity Documentation – Reporting Documentation – Feedback & Complaints – Person-Centred Care – PIE tool Organisational Policies & Procedures		
Target Audience	All Staff		

Learning Outcomes

After viewing this course, participants should be able to:

- Recognise the purpose and legal requirements of accurate documentation
- Identify types of documentation found in the care environment
- Recognise problems caused by poor documentation
- Describe key principles of effective documentation and how to apply them

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Think About

- The purpose of documentation in care is to facilitate the flow of information to ensure consistency, continuity, quality and safety in the care provided.

- All documentation created and used should be considered a legal document and should therefore be treated appropriately.

Subject Matter Expert

Linda Starr is a general and psychiatric qualified nurse, lawyer and Associate Professor in the School of Nursing and Midwifery. Her research interests have been in health law, criminal law, profiling and offender behaviour, forensic practice, forensic nursing, and elder abuse investigation.

Linda has been nursing since 1971 and was admitted to the Supreme Court as a solicitor in 1996, completing a Masters in Law in 1998. Linda is currently enrolled in a PhD program, researching the links between reporting elder abuse and the successful investigation and prosecution of offenders by police. Linda is a member of a team of academics from Flinders University and Johns Hopkins University (USA), developing a co-badged online continuing education program on forensic health for medical officers, paramedics, nurses and midwives.

Key Definitions

Admission Documents	Information collected during admission, including personal details, medical history and care needs.
Care Plan	This information is gathered from admission documentation and comprehensive assessment and includes the resident's current needs, goals and preferences. It needs to be continually updated so it is always current, and it needs to be person centred.
Charts	These are monitoring records and can include: • observations • food and fluid intake • bowel monitoring • personal hygiene • repositioning • behaviour • medications • weight • wound monitoring • pain monitoring

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Comprehensive Assessment	This is a thorough assessment of a person's health and general condition.
Confidentiality	This is the right of an individual to have personal, identifiable medical information kept private.
Consistency	Defined as acting or doing something the same way over time, especially to act as fair or accurate.
Continuity of care	Is concerned with quality of care over time. This is the process by which the person and their health care team are cooperatively involved in ongoing health care management.[1]
Continuity Documentation	Includes progress notes and may be referred to as 'daily records', 'care records' or 'care logs'. They record exceptions to the normal care of a resident.
Documentation	This is material that provides official information or evidence that serves as a record.
Duty of Care	Defined as a moral or legal obligation to ensure the safety or well-being of others.
Pre-admission Documents	Information collected prior to admission.
Quality of care	The extent to which health care services provided to individuals and patient populations improve desired health outcomes.[2]
Reporting Documentation	This is generally an incident report and records incidents.
Risk Assessment Forms	These forms assess risk and are assessments such as the risk of developing pressure injuries, falls or malnutrition.
Safety	Patient safety is the prevention of errors and adverse effects to patients associated with health care. [3]

Resources to Support Your Learning

Aged Care Funding Instrument (ACFI) Reports
https://agedcare.health.gov.au/tools-and-resources/aged-care-funding-instrument-acfi-reports

1 https://www.aafp.org/about/policies/all/definition-care.html

2 https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/

3 http://www.euro.who.int/en/health-topics/Health-systems/patient-safety

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Code of Professional Conduct for Nurses in Australia
https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

The NSW Nurses' Association. Guidelines on Documentation and Electronic Documentation
http://www.nswnma.asn.au/wp-content/uploads/2013/07/Guidelines-on-Electronic-Documentation-and-Documentation.pdf

Active Learning Hours

This course and the accompanying assessment may require up to three hours of active learning. It is the learner's responsibility to calculate how many hours of active learning have taken place. The course viewed must be relevant to the care worker or nurse's context of practice for it to be considered continuing professional development. Certificates are available from your coordinator.