Avant
By doctors for doctors

Documentation *essentials*

Detailed patient records are essential for the efficient and safe ongoing care of patients. There are also ethical and legal factors to consider when you are creating, maintaining, storing and using medical records.

Note: This content is a brief summary of the key issues on this topic. Further insights and information can be found on the Avant Learning Centre or by seeking medico-legal advice.

What are medical records?

The term 'medical record' refers to many types of health data and includes a patient's progress notes (handwritten or electronic), referral letters, specialist letters, hospital discharge summaries, pathology and radiology images and reports, other test results, videos, photographs, medical assessments for external authorities, medical certificates and applications for disability certificates and medico-legal reports.

What should you document?

Medical records are more than notes to assist your memory. Good records are essential for patient care and can also assist in the defence of a claim or complaint against you.

Generally, records need to contain enough information to allow another practitioner to identify the patient and continue their care. They should be clear, contemporaneous and, if handwritten, legible.

The records should include:

- Details of any physical examination and include what was checked for and not found.
- Tests requested and findings even if negative.
- Any clinical images/photographs you take.
- Any clinical decision making, including the reasons behind your decisions and any discussion with a colleague about this, including any difference of opinion, any further escalation and the impact on the final decision.
- Ongoing management plan.

See Avant's factsheet Avant - Medical records - the essentials.

What not to include

Ensure your medical records show respect for your patients and colleagues. Assume your records will be seen by the patient at some stage, so do not include derogatory or demeaning remarks about the patient, their family or your colleagues treating the patient.

Avoid using subjective or defensive language especially as that may be unclear.

Any discussion with or advice from your hospital's medico legal team or professional indemnity insurer, even though it's about a patient, does not form part of the patient's treatment and should not be documented in their medical record. You can document the steps or plan you take based on that discussion in the medical record.

Checklist

- Ensure records are written contemporaneously as possible
- Include details of verbal discussions about risks, complications and treatment options
- Document clinical reasoning and any differential diagnosis including negative findings
- Have a system in place to follow-up on test results and recall patients as needed
- Ensure records contain enough information to allow another doctor to understand what has occurred and to be able to take over the care of the patient, without the ability to discuss it with you.

Want more?

Visit the Avant Learning Centre – avant.org.au/avant-learning-centre, for resources including webinars, eLearning courses, case studies, articles and checklists.

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