Documentation and Record-Keeping

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1. Introduction

- Clinical documentation is the accurate recording of patient care, observations, and decisions.
- Good records support safe care, communication, and legal protection.

2. Principles of Good Records

- **Accurate:** factual, objective, and free of unsupported opinion.
- **Timely:** completed as soon as possible after the event.
- Legible, signed, and dated, with no falsification or unexplained gaps.

3. What to Record

- Assessments, vital signs, treatments, and medications given.
- Patient responses, consent, and communication with the team and family.
- Incidents, risks, and any deviation from the care plan.

4. Legal and Ethical Aspects

- **Confidentiality:** records must be stored securely and shared only as permitted.
- Records are legal documents that can be used as evidence.
- Patients generally have a right to access their own records.

5. Systems and Standards

- Electronic health records improve accessibility and reduce duplication.
- Standard formats, such as SOAP notes, aid consistency.
- Audits and policies ensure compliance and quality of records.