Medical Records and Documentation

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1. Introduction

- Medical records are organised accounts of a patient's health history and care.
- Accurate documentation supports continuity, legal protection, and quality of care.

2. Components of a Record

- **Patient identification:** demographic and contact details.
- **History and examination:** presenting complaints, findings, and diagnoses.
- **Treatment and progress:** medications, procedures, and ongoing notes.

3. Documentation Formats

- The **SOAP** note records Subjective, Objective, Assessment, and Plan.
- Electronic health records store and share information digitally.

4. Principles of Good Documentation

- Entries must be accurate, legible, timely, and signed.
- Never alter records improperly; corrections should be clearly marked and dated.

5. Confidentiality and Access

- Records are private and access is restricted to authorised personnel.
- Patients generally have a right to see their own information.

6. Summary

- Records are essential clinical and legal documents.
- Clear, accurate, and confidential documentation underpins safe care.