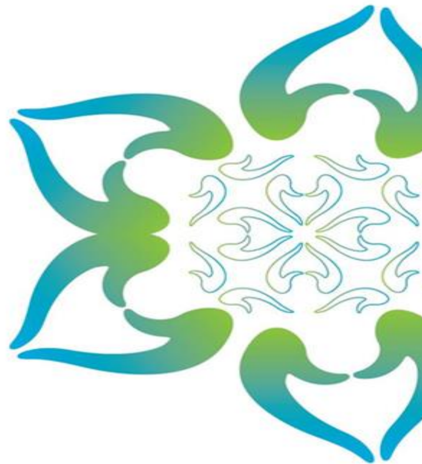
GOOD DOCUMENTATION PRACTICE POLICY



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Purpose

Documentation of medical information by all healthcare professionals is an integral part of their daily practice. With the increase in the number of complaints and lawsuits against healthcare professionals, it is essential that healthcare professionals maintain good documentation skills. This policy sets the minimum requirements for good documentation practice within the Kingdom of Bahrain.

Policy Statement

The National Health Regulatory Authority (NHRA) is the authority responsible for the investigation of professional negligence and misconduct. On many occasions, through the initial investigation process, healthcare professionals fail themselves with the poor documentation of events that take place during the management of their patients. This policy is set as a national policy for proper documentation. Violations of this policy may lead to professional disciplinary procedures being imitated.

Scope

All health care professionals

Definitions:

Archiving: A process of protection of records from the ability to be further altered or deleted and storage under the control of dedicated data management personnel throughout the required period of retention as per the laws of the Kingdom.

Audit trail: A process that detects additions, deletions, or alterations of information in a medical record without obscuring or over-writing the original record.

Backup: a process whereby a copy of the electronic medical records is created as an alternative in case the original data or system is lost or becomes unusable.

Data Integrity: The extent to which all data are complete, consistent, and accurate throughout. It applies to paper and electronic records

Discharge Instructions: Any form of documentation given to patient/legal guardian upon discharge from the healthcare facility for the purpose of facilitating safe and appropriate continuity of care

Healthcare Facility: A licensed healthcare facility including hospitals, centers, clinics, units, and ambulance services

Hand-off: Information transfer from one professional to another such as between nurses and physicians at change of shift, hand-off to admitting team, hand-off between physicians and nurses, or hand-off between ambulance nurse/paramedic to receiving team

Healthcare professionals: All licensed health care professionals including doctors, dentists, nurses, pharmacists, and allied health professionals.

Medical record: A record initiated for every patient who attends at a healthcare facility for consultation, treatment, or follow up and holds a unique identifier for each patient. These records may be paper or electronic records.

Verified/ checked by: A note which signifies a responsible person has checked the activity by witnessing the steps being performed.

Benefits of documentation:

1. Create a legal document
2. Protects healthcare professionals from liability in a malpractice/negligence investigation
3. Comply with laws and resolutions of the Kingdom
4. Keep track and prove activity
5. Health information sharing
6. Inform others within the same team, from other teams/specialty, or other professions
7. Instruct others
8. Create a historical record
9. Provide a comprehensive patient medical history
10. Improve quality of care
11. Reduce cost

Types of medical records:

Healthcare facilities may implement one type of medical record, either paper medical records or electronic ones.

Paper Medical Records:

All documentation within paper medical record must be:

1. **Permanent:**

   1.1 All entries done within the medical record must be with a permanent indelible ink. No pencils or erasable ink should be used.

   1.2 If an error occurs, a single line should be made through the entry with the stamp, signature and date of correction being made beside the correction.

   1.3 Scribbling with a pen and the use of white out or white cover is strictly prohibited.

   1.4 Correct information should then be entered, signed, stamped, and dated

   1.5 All corrections must be justified (the reason for correction must be stated within the medical record)

   1.6 Procedures verified and checked by others must be clearly documented in the medical record

2. **Legible:**

   All handwritten entries must be legible holding the date, time, signature, and name of person entering the information

3. **Accurate:**

   The data entered must be correct, truthful, valid, and reliable. The following should also be ensured:

   3.1 Perform calculations at least twice
   3.2 Calculations must be verified by a second person
   3.3 Write results in units specified
   3.4 Ensure correct spelling of product names
   3.5 Double check serial number and codes
   3.6 Double check blood products prior to administration

4. **Prompt:**

   4.1 Ensure all information is recorded within a maximum of 8 hours from the time the patient is seen.
   4.2 Document actions immediately after performing them
   4.3 Never pre-date or post-date documentations

5. **Clear:**

   5.1 All documentation must be clear and understood be anyone who reads them
   5.2 Areas which are not applicable, or N/A must be documented
   5.3 Use abbreviations approved by the healthcare facility only

6. **Consistent:**

   6.1 All abbreviations must comply with facility list of approved and prohibited list of abbreviations
   6.2 Specify time as am or pm or use 24 hours
   6.3 Unify date of entry as per facility policies (day/month/year or month/day/year)

7. **Complete:**

7.1 Do not leave any blank spaces, pages, or portions of pages

7.2 N/A should only be used when it is very clear that the portion of a document, form, or record does not apply

7.3 For tables which are not applicable, draw a line "/" through the table, sign, stamp, and date.

8. **Direct:**

8.1 Information should be recorded immediately onto the proper form/area

8.2 No scrap paper and no sticky notes are to be used

9. **Truthful:**

9.1 Your stamp and signature on the document mean the information is true

9.2 Only report factual information

9.3 Never falsify information in the medical record, reports issued, or sick leaves

Electronic Medical Records:

Electronic medical records must ensure the following:

1. **Records are permanent:**

1.1 All entries within the electronic system must be permanent without the possibility of being deleted from the system

1.2 The system should mandate completion of certain medical information as specified within this guideline.

1.3 System should identify user by name and position

1.4 System should specify date and time of entry

1.5 Amendments may be permitted and must show as separate from the initial entry done. The system should not permit direct changes to initial entry done. This amendment must specify name of person making the changes, date and time of the amendment.

1.6 All amendments must be justified (the reason for amendment must be stated within the medical record)

1.7 The system must clearly show procedures verified and checked by healthcare providers.

2. Accurate:

The data entered are correct, truthful, valid, and reliable.

The system should ensure the following:

2.1 System should alert for wrong dose compared to age

2.2 System should require confirmation if higher dose than normal is being prescribed

2.3 System should alert for drug interactions

2.4 System should alert to patient allergy if prescribed medication poses a risk to the patient

2.5 System should specify units of results

2.6 System should allow for confirmation of blood and blood products

3. Prompt:

2.7 The system should prompt healthcare professionals to complete medical records at the same time.

2.8 Mandatory fields must be identified which cannot be bypassed by the healthcare professional.

2.9 The system should not save a visit or documentation except if all mandatory fields are complete.

2.10 The system should reflect late entry clearly by name of person making the late entry, time, and date of the entry.

4. Clear:

a. All documentation must be clear and understood be anyone who reads them
b. Areas which are not applicable, or N/A must be documented
c. Only abbreviations approved by the healthcare facility should be permitted within the system

5. **Consistent:**
    a. All abbreviations must comply with facility list of approved and prohibited list of abbreviations
    b. The system should specify time as am or pm or use 24 hours
    c. Unify date entry as per facility policies (day/month/year or month/day/year)

6. **Truthful:**
    6.1 Only report factual information
    6.2 Never falsify information in the medical record, reports issued, or sick leaves
    6.3 Never delete medical records or change original entries

Healthcare professional's responsibilities:

All healthcare professionals must ensure the following:

1. Completion of medical records within a maximum of 8 hours from the time of seeing the patient.
2. Entry of all relevant information in the medical record for all patient visits including:
    2.1 Presenting complaint
    2.2 History
    2.3 Allergies
    2.4 Past medical/surgical history
    2.5 Vital signs
    2.6 Examination
    2.7 Clinical Impression/ Differential diagnosis
    2.8 Management plan:
        2.8.1 Treatment
        2.8.2 Consultation requested if any and may include:
            2.8.2.1 Consultation of senior staff/consultant: In such cases the following should be documented:

2.8.2.1.1 The name of the staff consulted, their position

2.8.2.1.2 The decision of consulted staff regarding the case

2.8.2.1.3 Their patient assessment if any

2.8.2.1.4 Their attendance to the patient

2.8.2.1.5 Their instruction

2.8.2.2 Consultation with other specialties/entities; this should include:

2.8.2.2.1 Service consulted

2.8.2.2.2 Name of person informed about the consultation, and their position

2.8.2.2.3 Refusal to come and see the patient (if applicable)

2.8.2.2.4 No phone consultations should be accepted for other specialties

2.8.2.2.5 Consultation of other entities such as for example the police, or child protection services

2.8.3 Investigations requested (laboratory tests/ radiological images) and results once obtained

2.9 Re-evaluation of patients and their response to treatment

2.10 Plan of care including:

2.10.1 Exit Medications (amount, frequency, and dose)

2.10.2 Patient and family education

2.10.3 Appointment given

2.11 Discharge Instructions:

2.11.1 Clear instructions should be given to patients upon discharge

2.11.2 A copy of the instructions given must be retained in the medical record and signed by the patient to acknowledge receipt of the instructions

2.12 Patient non-compliance

2.13 Refusal of medical care

2.14 Patients leaving against medical advice (AMA) including:

2.14.1 Details of information given to patient/legal guardian including risks, alternatives, and consequences of leaving AMA

2.14.2 Patient competence to refuse treatment

2.14.3 Patient's understanding of information presented

2.14.4 Instruction to return to facility if the patient's condition worsens or he/she changes his/her mind

2.14.5 The process must be witnessed by another healthcare professional. The name of the witness should be clearly stated and their position

3. Details of discussions with patients/legal guardian and family in complicated/High risk patient including:
   3.1 Details given to patients/legal guardian including alternative options of treatment, as well as the risks and benefits of the intervention being offered
   3.2 Names of witnesses
   3.3 Signature of patient/legal guardian
4. Document hand-off of patients
5. Document informed consent process and information provided
6. Entry of accurate and truthful information only
7. Use only approved abbreviations by the facility
8. Make changes when required as per this guideline only

Responsibilities of healthcare facilities:

Healthcare facilities have the following responsibilities:

1. Train all healthcare professionals about data integrity and policies regarding completion of medical records
2. Data integrity has to be ensured at all times
3. Always ensure security and confidentiality of information contained within medical records
4. Perform Audit trails regularly to ensure compliance with completion of medical records and the quality of information documented
5. Ensure systems are in place to prevent and detect data changes
6. Establish disciplinary processes for violations of documentation policies
7. Establish a backup system for all medical records
8. Ensure discharge summaries are given to all patients upon discharge

9. Establish an archiving system for medical records as per the laws of the kingdom
    9.1. Archive paper medical records within the facility for a minimum of 5 years from the last date of the patient's visit
    9.2. Archive paper medical records for another 10 years from the last date of a patient's visit
    9.3. In cases of lawsuits of disputes, records should be maintained until the dispute of over.
    9.4. Electronic record must be archived permanently
10. Healthcare facilities must establish a framework for the development and delivery of suitable education on documentation and management of health care records. All health care personnel who document or manage health care records must be provided with appropriate orientation and ongoing education on the documentation and management of health care records. The content and delivery of education programs should be informed by health care record audits. The results of such audits should be used to target problem areas relating to particular health care personnel groups or facets of documentation and management. Specific education must be conducted for the introduction of any new complex health care record forms and for changes in documentation models.

General rules:

In cases of dispute or medical negligence or misconduct, decisions will be made based on medical record entries only. Claims that additional actions have been taken without being documented in the medical record will not be considered.

Legally, any information not documented in the medical record has not been done

References:

1. 26th Annual ASQ Audit Conference Blueprint for a Successful Audit
2. Good Documentation Practice (GDP) Guideline, Innovation, Quality, and Global Reach Feb 2018
3. WHO: Guidance on Good Data and Record Management Practice