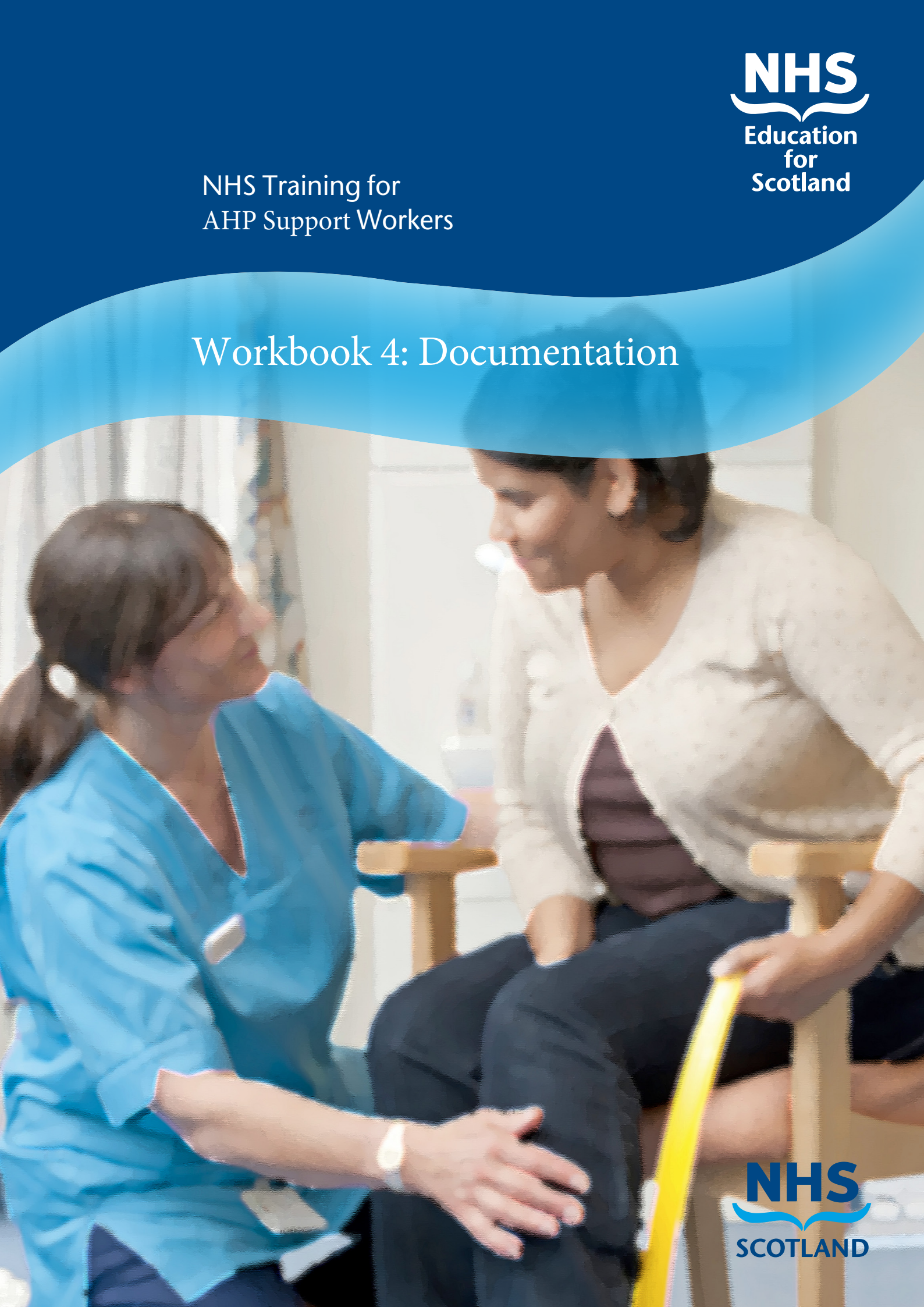
NHS Education for Scotland

NHS Training for
AHP Support Workers

Workbook 4: Documentation



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Contents

4.1 Aim

The aim of this workbook is to introduce the Healthcare Support Worker (HCSW) to documentation processes and to record patient information appropriately.

4.2 Learning Outcomes

By the end of this workbook you will be able to:

- Give evidence that you have read and understood documentation guidelines and how this relates to your role.
- Find patients details and record in the appropriate patient record.
- Extract relevant information from medical records.
- Record all relevant information in the patient records as per local guidelines.
- Identify and understand unfamiliar abbreviations in the patient record.
- Maintain AHP professional standards in record keeping.

4.3 Documentation and Ward Meetings

As a support worker one of your duties will be to gather information with relevant AHPs and record it in the patient record. In this workbook we describe the "patient record"; this can refer to the AHP record for your particular discipline, medical record or the multidisciplinary health record. It varies from area to area.

Referral is the term used when there is a request for assessment and possible interventions from a service. This can occur verbally or in writing depending on local referral procedures. Doctors, Nurses or other health and social care professionals may all refer patients for assessment. Alternatively, patients or their carers may refer.

You need to know how referrals are made and processed in your area. You also need to know how to understand your role in ensuring that they are dealt with effectively and efficiently.

 Activity

Find out and write down here how referrals are dealt with in your area. Describe what your role may be in the referral process. You may wish to refer to local guidelines for referrals.

Look at some recently completed referral forms. Provide examples of reasons for referral to AHPs, diagnosis and any risk factors for the patients concerned.

4.4 Completing Documentation in the Patient Record

The therapist may ask you to gather information and record it in the patient record. Different information will be required depending on where you work. You need to ensure that you understand what is required of you through discussion with the therapist and with reference to local documentation guidelines.

Describe the kind of information you need to collect and record in the patient record. Give some examples of what you would record in the patient record.

Within your workplace, who is likely to refer patients to your services? List the people who would do so.

Completing Patient Details

To ensure that the record and the referral are correct for each patient, it is vital that the correct details are assigned for every patient and are recorded on the patient's record:

Full name on every page of the record
Date of birth (DOB on every page of the record)
Community Health Index (CHI) number: this is the unique health service number for every patient and is important in identification (on every page of the record)
The current address of the patient
Responsible medical officer
GP contact details
Any other professional involved
Patient advocacy contact
Contact person: next of kin (NOK) or carer and their relationship to the patient

 Activity

Where would you find the above information? What would you do if some of the information could not be easily found?

Ask your supervisor to provide you with a sample of AHP documentation that you would find in the patient record.

Look at 2 patient records and record below examples of good and poor AHP documentation.

Record 1

Record 2

What other information might you need to collect? List anything else that might be important.

What difficulties might there in obtaining or sharing information? What options do you have to obtain / share the information?

Show your supervisor an example of documentation you have recorded in the patient record. Discuss and record your learning from this activity. Give examples of any agreed changes you will make to your documentation practice.

Ongoing Records

To comply with the legal standards, it is important that every page of the patient's record are completed to include:

Patient's name
DOB / CHI
Ward or address
Page number
Date and time of patient contact in margin of each entry
Abbreviations must be written in full the first time used on each page
Signature
Job title
Records complete in a timely manner

4.5 Contributing to Patient Reviews

You may be asked to represent AHP staff at patient reviews. Your role will be to:

Gather and share information about the progress of the patient
Liaise with other staff about the care and progress of the patient
Feedback your attendance, actions and outcomes to your supervisor

 Activity

Give an example of when you have contributed to a patient review. What went well? What could have been better? Anything you would do differently next time? How did you record the outcome of the meeting?

4.6 Documentation Workbook Completion

Your mentor / supervisor will sign your portfolio to indicate that you have completed this workbook successfully.

Objective	**Supervisors Signature**	**Date**
Evidence documentation guidelines have been understood and how relates to role		
Find patient details and accurately record in the patient record		
Extract relevant information from the patient record		
Record relevant information in the patient record		
Identify and understand unfamiliar Abbreviations		
Contribute relevant information to patient review meetings		

Support worker (name)	
Support workers signature	
Supervisor (name)	
Supervisors signature	
Date	

4.7 Documentation Reflection

Suggested KSF Dimensions: C1, C5 and IK1

This form should be placed in the appropriate section of your portfolio.

What did you learn from this module?
How has this influenced your work?
Date module completed

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