TITLE: Dispelling bad documentation habits in clinicians early

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Due to an intern's omission to make proper recordings of a patient's treatment, a Coroners Inquest conducted in August 2005, identified as a useful tool the 'mentoring of junior staff and an audit of written charts'.

As litigation statistics increase in Australia, doctors are now more reliant than ever on referring to the clinical record to recall past events along with the necessity to prove continuum of care. Redcliffe Hospital is improving processes by providing *interns* with intensive best practice *documentation* guidelines to support them throughout their careers.

Increasingly medical colleges are including *documentation* standards into their frameworks complementing the Australian Council of Healthcare Standards mandatory criteria 1.1.8 for the health record to 'ensure comprehensive and accurate information is recorded and used in care delivery'.

Health Information Management Services in conjunction with the Medical Education Unit and interested parties compiled a case study to present at Intern Orientation. The case study and sample clinical record assisted in the education of expected standards for the doctor to complete the first notation in the clinical record following the simulated patient's admission.

The clinical records were then audited against an audit tool with results reported to the interns at a debrief session on the last day of orientation. It was during this session that interns were also advised that the Health Information Management Service would be supporting them during their internship by auditing their notations throughout the year and providing results at their first mid term interview and every end of term interview.

A cumulative report is provided as evidence at each interview displaying the records and episodes audited to obtain their results against the set criteria. Results are benchmarked against their group results achieved at orientation and the most up to date hospital wide audit results.

To date results show that the intern's results equal the hospital wide statistics. It is envisaged that by the end of the year interns will achieve an outcome of > 90-100% compliance in all criteria, demonstrating that auditing and education has improved the basis for which documentation is in encapsulated in their everyday practices.