Clinical Documentation Improvement and patient safety

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Two years ago I spoke at this Conference about the advantages of a concurrent clinical documentation improvement process as a way forward to ensure accurate and complete Coding of hospital episodes that ensures hospital data is a true reflection of hospital activity which then provides for appropriate reimbursement of an episode in an Activity Based Funding (ABF) environment. Whilst these issues are still important and relevant to a clinical documentation improvement program today the principles of concurrent clinical documentation improvement are now being embraced as a necessity to improve patient quality and safety outcomes.

The recent release of the revised Australian Safety and Quality Health Standards has included a new Standard, number six, Communicating for Safety. The standard previously titled Clinical Handover was removed and this new Standard – Communicating for Safety included. This suggests quite a shift in thinking. We are no longer just talking about a process that occurs at the end of a shift to transfer care from one Clinician to another but an expansion of the Standard to reflect clinical communications in a much broader sense which supports the significance of good communications throughout the delivery of care process. The Australian Commission of Safety and Quality in Health Care (The Commission) acknowledge that communication failures, and inadequate or poor documentation of clinical information result in errors, misdiagnosis, inappropriate treatment and poor care outcomes.

Hospital leaders are now required to set up and maintain effective communication systems and processes to ensure safety and they are to support initiatives to improve documentation in the medical record as a requirement of Standard 6 but it is not only Standard 6 that points to the need for strong clinical documentation programs – each of the Standards point to the need for good documentation in the medical record.

This year also saw the introduction of a funding model which included penalties for designated Hospital Acquired Complications (HACs). This also highlights the priority of patient safety.

A trained Clinical Documentation Specialist (CDS) can improve clinical documentation through clinician engagement and education, can analyse documentation in real time to ensure the correct principal and additional diagnoses have been documented and in a manner which can be translated into coded data, can monitor the health record for clarity and quality of clinical documentation with the aim of improving patient outcomes and has the ability and opportunity to monitor the level of compliance to the NSQHS standards during review of the health record.

Clinical Documentation Specialists are in a unique position to positively change patient outcomes by recognising when poor documentation is posing a threat to

patient safety and quality of care. When analysing medical documentation with a clinical eye the CDS is looking for what is not there. A CDS is a valuable member of the clinical team who can ensure the clinical documentation meets all required Standards in addition to assisting Clinicians to always ensure documentation is complete and accurate.

The need for Clinical Documentation Specialists and concurrent CDI programs continues to grow.