Background

Clear and accurate documentation is important as it provides a summary of the assessment, on-going care and education of the person with diabetes. It provides a method of communicating details about the care with other professionals as well as being a potential form of evidence if there is a legal case.¹

Documentation refers to all forms of documentation that has been recorded in a professional capacity. Accurate documentation and record keeping is a fundamental part of clinical practice as it demonstrates a clinicians accountability as well as providing a record of their professional practice.²

Effective documentation should be;² ¹

> clear, concise and accurate
> contemporaneous with the events recorded in chronological order
> complete
> comprehensive
> collaborative and person-centred
> confidential

Documentation can be made up of;²

> written and electronic health records including email and faxes
> audio and video tapes
> images such as photographs and diagrams
> observation charts and checklists
> communication books
> incident reports
> clinical anecdotal notes or personal reflections (eg held by clinicians personally)

Appropriate documentation promotes;²

> a high standard of care
> continuity of care
> improved communication
> an accurate description of the care provided
> goal setting and evaluation of care
> early detection of problems and changes in health status
> evidence of care provided

Documentation should be able to demonstrate;²

> a full report of the clinical assessment, the care provided and future care planning
> information related to the persons condition and any interventions/actions taken to achieve health outcomes
> evidence that the clinician has met their duty of care and has taken reasonable actions to provide the highest standard of care.
> a record of all communications with relevant health professionals.
Minimum standards for documenting diabetes education

The following minimum standards for documenting diabetes education have been developed to assist diabetes educators to produce high quality nursing notes that are consistent across health services. There are clinical and corporate risks if diabetes education documentation is not adequate.³

> Clinical risks: inadequate or incomplete documentation about the persons’ education impedes communication and also diminishes the specialist nursing role. This may lead to errors and/or delays in treatment which adversely affects the outcome for the person.

> Corporate risks: poor or inadequate documentation could affect outcomes of legal proceedings.

**Standard 1**

To maintain accurate and confidential records of clinical care including;⁴

> documenting the outcomes of the clinical assessment and ongoing care recommendations for each person

> providing the assessment and care plan information to the person

> ensuring that persons information is made available in a timely manner to all relevant health professionals

> safe and appropriate storage of private data.

**Standard 2**

Written education entries should be timely, objective, person centred and include;⁵

> a description of the material taught

> the method(s) used for teaching eg written, visual, verbal, auditory and any instructional tools that were used as part of the session

> information about the involvement of and interaction between the person and their family during the education process

> evaluation of the learning objectives eg evidence of the persons comprehension and learning, attainment of behavioural goals

> a documented education plan for follow up visits

> explanation of any referrals made.

**Standard 3**

Documentation provides evidence that the person’s needs were assessed and that the education plan was documented in collaboration with the person. It should demonstrate that education was tailored to the persons intellectual, social, psychological, spiritual, and cultural status.⁴

**Standard 4**

Documentation must fulfil legal requirements;

> consultations need to be written ‘defensively’ eg written in a way that explains the decisions that were made

> ensure that documentation gives an accurate account

> documentation should be a continuous narrative that describes how the educator has dealt with the various issues

> outcomes of the education should be documented.

**Standards 5**

Evidence that the clinician worked collaboratively with the referring practitioner, other members of the diabetes care team and the person to establish agreed clinical targets.⁴
Documenting the initial assessment

As a minimum the following information should be documented at an initial appointment:

- date and time of occurrence of service
- relevant history of the illness
- relevant physical examination, assessment findings and diagnosis
- treatment options and treatment given eg clinical observations results of treatment, and medication prescribed
- diagnostic and therapeutic orders/plan
- signature, surname and initials, and designation of the clinician.

Some aspects of the initial assessment can be documented using the CHSA Diabetes Assessment form or it can be documented in long hand in the case notes (see below for examples of headings that can be used in the notes). Note: If an assessment form is used it is still a requirement to make an entry in the case notes. The education delivered and the plan should be documented in the case notes.

Initial consult – case note entry

**Diabetes education assessment note**

- referral source and reason
- preferred name and age
- type of diabetes
- date of diagnosis
- current signs and symptoms/issues

**Concerns**

- persons understanding of purpose of the appointment
- how are they feeling about their diagnosis? Do they have concerns, questions?

**Diabetes management**

- management – prior and current (including diabetes medication)
- previous education

**Psychosocial**

- mental health
- social: Marital status, employment
- living arrangements
- independence level with ADLs
- cultural considerations
- social supports/significant others
- barriers to learning eg language, memory deficits, religion.

**Relevant medical and surgical history**

- include relevant history including mental health, family history of cardiovascular and / or early death (<60 years).
- allergies/alerts
- hearing or visual deficits

**Diabetes complications/cycle of care**

- micro – retinopathy, nephropathy, neuropathy
- macro – CHD, CVA, PAD
- oral health and sexual health
**Medications**
- include over the counter and complementary medications

**Anthropometry**
- weight, height, BMI
- pathology tests eg HbA1c/ lipids/eGFR/AER/Liver function
- BP

**Foot assessment (see separate CHSA Diabetes Foot Assessment form)**
- circulation and sensation
- self care and footwear

**Lifestyle**
- smoking
- alcohol
- nutrition
- physical activity/exercise
- stress
- driving

**Self-care assessment and education planning (based on risk factors and current need)**
- pathophysiology of type 1/type 2/steroid induced
- management requirements
- oral hypoglycaemic agents profile
- insulin profile
- healthy eating principles/carbohydrate intake
- importance of regular activity
- commencement /update of blood glucose monitoring
- commencement/update of insulin/check technique
- hypoglycaemia ] Hypo Action Plan
- unconscious hypoglycaemia ] “ “ “
- hyperglycaemia ] Hyper Action Plan
- ketones/DKA ] “ “ “
- sick day management ] Sick Day Action Plan
- complications of diabetes (micro and macro)
- health checks (cycle of care)
- coping skills
- rights and responsibilities
- decision making/behaviour change
- driving
- ambulance cover
- medic Alert
- travel

**Education provided**
Once an education plan is agreed and priorities agreed with the person use this heading for documenting what was covered at this particular session.
Referrals
What referrals did you provide (to allied health) or recommend at this appointment?

Resources provided
What written or other resources did you provide at this appointment?

Goals
S = Specific
M = Measurable
A = Achievable
R = Realistic
T = Time framed

Education plan
To be used to document what is planned for subsequent appointments.

Subsequent visit
The method used to document education will vary depending on the preferences of the practitioner. However, it is useful to use headings and try to avoid writing in narrative sentences.

Narrative charting refers to documentation that follows a chronological framework rather than grouping the information into categories. It can result in a lot of writing, can be time consuming and repetitive. This method of writing case notes is still commonly used but more nurses are now turning to problem oriented approaches, clinical pathways or focus charting.6

A problem orientated approach to documentation encourages nurses to think critically and an example is the SOAP framework. This framework includes subjective and objective assessment data, plan of care, interventions, evaluation and reflection. One limitation of the SOAP format is that it does not work as well for multiple problems. A New Zealand group trialled a focus charting approach as they found the SOAP format was not meeting the needs of nurses. In their focus charting they used headings assessment, implementation and evaluation (AIE).6

Some diabetes services use standard stickers as a way of documenting some aspects of their education. It is important that stickers are only used as a guide and that individualised information relevant to the person’s circumstances are added.

Guiding principles;
> document any amendments to education plan
> document education given
> document plan for next appointment including client goals
> complete any outstanding assessment areas.
Review tool

The review tool can be used at any time to document the persons understanding, knowledge and self-management skills.

**Evaluation of plan**

- coping skills
- client concerns
- attended referrals
- techniques assessed
- knowledge assessed
- behaviour changes assessed

**Pregnancy**

Under development.

**Communicating with the referring doctor**

It is important to communicate with the referring doctor after your initial appointment to communicate the education plan and potential education completion date. Consider additional communication if circumstances change or there are concerns. Always communicate when the person discharged from your care. The CHSA template can be used to format a concise letter to the general practitioner.

**Acknowledgements**

We would like to thank and acknowledge the SA Health Diabetes Nurse Leaders Group for sharing their documentation resources for the purpose of developing this documentation guide and tools. We would also like to thank and acknowledge the South East Diabetes Educators Network for allowing us to adapt their assessment form so that it can be used by all Country Health Diabetes Educators.

**References**


2. WHO-SEARO coding workshop, 2007, Guidelines for medical record and clinical documentation, September,


4. Australian Diabetes Educators Association, 2008, National core competencies for credentialled diabetes educators, Australian Diabetes Educators Association, Canberra

5. College and Association of Registered Nurses of Alberta, 2006, Documentation Guidelines for Registered Nurses, College and Association of Registered Nurses of Alberta, Alberta