

Effective Health Record Management in Healthcare



Reading time:
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If it's not written down, it didn't happen. Health records are essential for the safe and consistent delivery of patient care, as well as scientific evaluation of the patient profile. They help in analysing the treatment results, and to plan treatment protocols. They also facilitates your hospital colleagues a seamless, safe and consistent continuity of care.

How poor records can impact patient care?

- Errors of treatment /medication errors.
- Inaccurate care may be given due to poor notation & or communication.
- Inaccurate care may be give if important vital signs observations not recorded (for example. blood pressure or important information not passed on)
- Can contribute to inaccurate quality and care information
- Can result in poor patient care by other healthcare team members
- Can lead to punitive actions by your regulator
- Raise concerns with your employer/ supervisor
- Put you at medico legal risk.

As stated by the [Australian Commission on Safety & Quality in Healthcare](#) (2021):

"Documentation is an essential component of effective healthcare communication. Given the complexity of healthcare and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians. Good documentation contributes to better patient outcomes by enabling information exchange and continuity of care by all members of the healthcare team."

MIPS medico-legal perspective

- Records are vital in determining strength & weaknesses of cases.
- Records are sought by patient/solicitor to gauge claim potential.
- Records are important to investigation/defence of all civil cases, Coroner's Court inquests, professional issues, Medicare & Board matters.
- In all cases your records will be required and closely analysed.

Key advice

- Management of health records is very important whether in public or private practice, no matter at what level or craft group
- Familiarise yourself with the general requirements
- Follow a set routine in your practice
- Know hospital protocols, policies & procedures
- Ensure easy access & reference to medical history
- Be prepared & be careful – there may be medico –legal and/or professional consequences
- Consult your MDO or hospital supervisor for assistance

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