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What Constitutes Timely Documentation?

Clinical Documentation and Record Keeping Guidelines, Release Date September 2011

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When it comes to preparing clinical documentation, there is no "one-size-fits-all" rule as to what time frame is required in every situation. Ideally, charting should be contemporaneous with the events described. Generally speaking, clinical observations and/or data and records of a treatment should be recorded concurrently with or as soon after the assessment/treatment as possible. As a matter of common sense, the longer the delay in making such records, the less reliable they will be. Some delay in writing up a clinical opinion interpreting those observations and data would not necessarily affect the reliability of the interpretation, provided that the underlying observations and data were recorded contemporaneously and accurately. Even so, delays should not be excessive. It is difficult to imagine a situation in which a delay of months would be acceptable. The degree of urgency for completion of the records could vary depending on the circumstances, and is a matter of professional judgment. The factors to be considered would include the patient's circumstances, the nature of the assessment/treatment provided, the role that SLP/Audiology services play in the overall context of the patient's care, and the turnaround time requested or expected by the referring source.

It is important to be mindful that one of the key purposes of clinical documentation is communication with other health care providers. To be useful, clinical records have to be available when other members of the health care team need them in order to diagnose, treat or monitor a patient's status. If the records are not available to future health care providers when needed, and this lack of communication compromises the patient's future care, liability can be – and has been – imposed by courts. Professional disciplinary consequences can also follow.

Another consideration from a legal perspective is that if a matter ends up in litigation, the health records are important evidence of what did or did not take place. By the time an action gets to trial, years will have passed, and the health professional, who may have seen hundreds of other patients since then, very often has little independent recollection of the events. On the other hand, patients who become plaintiffs tend to have much clearer memories of their encounters with health care providers, particularly if something went awry. In such a case, the records may be the health professional's only way to establish what happened. Health records' value as evidence diminishes if they were prepared so long after the event that their reliability may be questioned, in which case there would be little to counteract the plaintiff's version of events. In some cases, late records can also appear to be self-serving and lacking in credibility, and may be disbelieved by a court altogether.