Topic 2.15. Working with Medical Documentation/ Тема 2.15. Работа с медицинской документацией

Medical documentation is a cornerstone of healthcare delivery. It serves as a legal record of patient care, supports clinical decision-making, ensures continuity of treatment, and facilitates communication among healthcare professionals. For medical staff, translators, administrators, and other specialists working in healthcare, the ability to understand, complete, and discuss medical documents in English is a vital professional skill. This lecture covers the main types of medical documents, their key components, standard formats, essential terminology, and best practices for accurate and safe documentation.

Main Types of Medical Documents

Different documents serve different purposes in the patient journey. Knowing the type helps professionals locate the right information and use the correct language when discussing it.

- **Medical history (anamnesis)** — a structured record of the patient's past and present health. It includes chief complaint, history of present illness (HPI), past medical history (PMH), family history, social history, and review of systems (ROS).
- **Physical examination record** — the clinician's findings from the physical assessment: general appearance, vital signs, and system-by-system observations (e.g., cardiovascular, respiratory).
- **Progress notes** — regular updates on the patient's condition and treatment response. Common formats include SOAP (Subjective, Objective, Assessment, Plan) and DAR (Data, Action, Response).
- **Discharge summary** — a concise overview at the end of an inpatient stay: reason for admission, key diagnoses, procedures performed, treatments given, current status, and follow-up instructions.
- **Referral letter** — a formal request to another specialist or facility, including background information, reason for referral, and specific questions or goals.
- **Laboratory and imaging reports** — results of tests with reference ranges and the radiologist's or lab specialist's interpretation.
- **Consent forms** — documentation of the patient's informed agreement to a procedure, including explanation of risks, benefits, and alternatives.
- **Medication list and prescription** — current medications, doses, frequency, route, and any allergies or adverse reactions.
- **Nursing documentation** — vital signs charts, intake/output records, wound assessments, pain scores, and nursing interventions.

Core Components of a Patient Record

A complete patient record typically contains the following elements:

1. **Patient identification data** — full name, date of birth, gender, unique medical record number, contact information.
2. **Chief complaint (CC)** — the main reason the patient sought care, in their own words if possible. Example: "chest pain for 2 hours".
3. **History of present illness (HPI)** — a chronological description of the problem: onset, location, duration, character, aggravating/relieving factors, radiation, timing, severity (OLDCART mnemonic).

4. **Past medical history (PMH)** — previous illnesses, surgeries, hospitalisations, chronic conditions.
5. **Medications and allergies** — current drugs with doses and frequencies; known allergies and the type of reaction.
6. **Family and social history** — hereditary conditions in close relatives; lifestyle factors such as smoking, alcohol, occupation, living situation.
7. **Review of systems (ROS)** — a systematic check of symptoms across body systems to identify additional issues.
8. **Physical examination findings** — objective measurements and observations.
9. **Diagnostic results** — lab values, imaging descriptions, pathology reports.
10. **Assessment and diagnosis** — the clinician's interpretation and formal diagnosis codes (ICD-10).
11. **Plan** — treatment steps, follow-up, referrals, patient education.

Standard Documentation Formats

Using standardised structures improves clarity and reduces errors. Two widely used formats are:

SOAP Notes

- **Subjective (S)** — what the patient tells you: symptoms, concerns, changes in condition. *Example:* "Patient reports increased shortness of breath over the last 24 hours and difficulty sleeping lying flat."
- **Objective (O)** — measurable data: vital signs, physical exam, test results. *Example:* "BP 160/95 mmHg, HR 98 bpm, SpO_2 93% on room air; bilateral crackles on lung auscultation."
- **Assessment (A)** — clinical interpretation: possible diagnoses, differential diagnosis, severity.
  Example: "Worsening heart failure; consider fluid overload."
- **Plan (P)** — next steps: medications, tests, consultations, patient instructions. *Example:* "Increase diuretic dose; order chest X-ray and BNP test; schedule cardiology follow-up in 3 days."

DAR Notes

- **Data (D)** — facts and observations (both subjective and objective).
- **Action (A)** — interventions performed or planned.
- **Response (R)** — patient's reaction to the intervention and changes in status.

These formats are common in both hospital and polyclinic settings and are often used in electronic health records (EHR).

Essential Terminology for Describing Findings

Precise language is critical for accurate documentation. Below are key terms and how they are used in context.

Term	Meaning / Usage Context
Acute	A sudden, severe condition with rapid onset (e.g., acute chest pain).
Chronic	Long-standing condition lasting months or years (e.g., chronic kidney disease).
Exacerbation	Worsening of a chronic condition (e.g., exacerbation of asthma).
Remission	Period when symptoms are reduced or absent (e.g., in cancer or autoimmune disease).
Stable	No significant change in condition over time.
Deteriorating	Condition getting worse; requires closer monitoring or intervention.
Afebrile	Without fever; normal body temperature.
Febrile	With fever; elevated body temperature.
Normotensive	Normal blood pressure.
Hypertensive	Elevated blood pressure.
Tachycardia	Heart rate above normal range (>100 bpm in adults).
Bradycardia	Heart rate below normal range (<60 bpm in adults).
Dyspnoea	Shortness of breath; difficulty breathing.
Oedema	Swelling due to fluid accumulation in tissues.
Haemoptysis	Coughing up blood.
Malaise	General feeling of discomfort or illness.

When documenting, always use exact measurements and avoid vague terms like “a bit high” or “slightly worse”. Instead, write: “BP increased from 130/85 to 155/95 mmHg” or “Pain score rose from 3/10 to 7/10”.

Best Practices for Accurate and Safe Documentation

Good documentation protects patients, clinicians, and institutions. Key principles include:

- **Timeliness** — record observations and actions as soon as possible after they occur. Delayed entries increase the risk of omissions and inaccuracies.
- **Clarity and precision** — use standard terms and avoid abbreviations that are not universally accepted. Many institutions ban ambiguous abbreviations (e.g., “U” for unit, “QD” for daily) to prevent errors.
- **Objectivity** — state facts and observations rather than assumptions or judgements. Instead of “the patient is lazy”, write “the patient declined to participate in physiotherapy session”.
- **Completeness** — include all relevant data: what was done, when, by whom, and the patient’s response.

- **Legibility and structure** — in paper records, handwriting must be clear. In EHR, use templates and headings to organise information logically.
- **Confidentiality and security** — protect patient data in line with regulations (e.g., GDPR, HIPAA). Do not share records with unauthorised persons or via insecure channels.
- **Corrections** — if a mistake is found, do not erase or obliterate the original entry. Draw a single line through the error, write "error", initial and date it, then add the correct information nearby. In EHR, follow the system's audit trail rules.
- **Signatures and credentials** — every entry must be signed with the author's name, role, and date/time. This ensures accountability and traceability.

Communicating About Medical Documents in English

In multilingual or international settings, healthcare professionals often need to explain, request, or clarify information from medical records. Useful phrases include:

- Requesting information:
  "Could you please check the patient's last blood test results in the EHR?"
  "I need to see the discharge summary from the previous admission."
- Clarifying findings:
  "The note says 'mild dyspnoea on exertion' — does that mean the patient gets short of breath when walking?"
  "Can you confirm the exact dose and frequency for this medication?"
- Reporting changes:
  "Over the last 12 hours, the patient's temperature has risen from 37.2°C to 38.8°C."
  "There's new oedema in the lower limbs; I've recorded it in the nursing notes."
- Discussing the plan:
  "The consultant recommends a CT scan to rule out pulmonary embolism."
  "We'll schedule a follow-up appointment in two weeks and repeat the blood tests."