

EMERGENCY DEPARTMENT CLINICAL ASSESSMENT AND DOCUMENTATION PROTOCOL

Protocol 4: Structured Assessment, Clinical Reasoning, Reassessment, and a Defensible Record of Care

DRAFT FOR CLINICAL, NURSING, HEALTH-INFORMATION, LEGAL, PRIVACY, AND PATIENT-SAFETY REVIEW

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Related policies	ED-PRO-001: ED Patient Journey; ED-PRO-002: Triage and Retriage; ED-PRO-003: Resuscitation and Initial Stabilization
Effective date	[To be inserted after approval]
Review date	[12 months after implementation, then every 2-3 years or sooner after major legal, information-system, or clinical-standard change]
Approved by	[Medical Executive / Nursing Executive / Health Information / Privacy / Clinical Governance / Hospital Board]
Applies to	All clinicians and staff who assess, treat, monitor, communicate about, document, scan, code, store, amend, disclose, or audit Emergency Department records
Supersedes	[Insert previous clinical-record or ED documentation policy, if applicable]

Important: This protocol defines the minimum process and content for clinical assessment and documentation. It does not replace professional judgment, condition-specific pathways, legal advice, or local privacy and records-retention requirements. Life-saving care must never be delayed to complete documentation; however, the record must be completed as soon as clinically possible and must accurately reconstruct the care provided.

Contents

1. Purpose
2. Scope
3. Core policy statements
4. Definitions
5. Roles and accountability
6. Documentation principles
7. Initiating the ED clinical record
8. Structured clinical assessment
9. Clinical reasoning and diagnostic uncertainty
10. Investigation and result ownership
11. Treatment and medication documentation
12. Monitoring and reassessment
13. Procedures, sedation, restraint, and intimate examinations
14. Consultation, escalation, and handover
15. Consent, capacity, communication, and safeguarding
16. Disposition documentation
17. Corrections, late entries, copy-forward, and abbreviations
18. Electronic systems, downtime, confidentiality, and access
19. Special circumstances
20. Completion, authentication, and record closure
21. Quality indicators and audit
22. Training and implementation
- Annex A. One-page assessment and documentation workflow
- Annex B. Minimum ED clinical-note dataset
- Annex C. Focused history and examination prompts
- Annex D. Clinical reasoning and reassessment template
- Annex E. Procedure-note minimum dataset
- Annex F. Consultation, escalation, and handover record
- Annex G. Correction and late-entry standard
- Annex H. Documentation audit tool
- Annex I. Local configuration and approved abbreviations
- Annex J. References and source tools

The record must answer five questions: What did the patient present with? What did staff find? What serious possibilities and risks were considered? What was done and how did the patient respond? Why was the final disposition safe and who owns the next action?

1. Purpose

To establish a consistent, clinically useful, timely, and legally defensible approach to assessment and documentation for every Emergency Department encounter.

To make clinical reasoning, treatment, response, risk, uncertainty, communication, and transfer of responsibility visible to the next clinician and auditable by the organization.

To support systematic emergency care and standardized data collection without turning documentation into a barrier to urgent treatment.

2. Scope

This protocol applies from the first clinical contact until the encounter is formally closed following discharge, admission, transfer, death, or departure before care is complete.

It applies to paper, electronic, hybrid, telehealth, ambulance-to-ED, observation, procedure, resuscitation, nursing, medical, allied-health, and consultation records created within or on behalf of the Emergency Department.

Condition-specific forms and checklists may add requirements but must not remove the minimum elements in this protocol.

3. Core policy statements

Clinical documentation is part of care. It shall support continuity, communication, patient safety, accountability, learning, and quality improvement.

Records shall be clear, accurate, relevant, objective, contemporaneous, legible, attributable, and sufficiently complete for another competent clinician to understand the patient’s condition, decisions, actions, response, and plan.

The urgency and complexity of the encounter determine the appropriate level of detail. High-risk, unstable, diagnostically uncertain, invasive, restrained, or transferred patients require more detailed documentation than uncomplicated low-risk encounters.

Life-saving care takes priority over writing. In emergencies, one team member should document in real time when possible; omitted details shall be entered as soon as practicable and identified honestly as a late entry when applicable.

Each entry shall identify the author and date and time. The system shall preserve the original record and audit trail when a correction or addendum is made.

Copy-forward, templates, voice recognition, and auto-population may assist documentation but do not transfer responsibility from the author. The clinician must verify that every retained statement is current, accurate, and applicable.

Abnormal results, persistent physiological abnormalities, important diagnostic uncertainty, pending actions, and barriers to care shall not be hidden by generic phrases such as “stable,” “reviewed,” or “continue management.”

Documentation shall never be falsified, backdated, deleted to conceal an error, or altered after an adverse event except through an approved transparent correction or addendum process.

4. Definitions

Term	Operational definition
Clinical record	The complete paper or electronic account of the ED encounter, including triage, clinician notes, observation charts, orders, medication administration, results, procedures, consultations, handovers, disposition, and patient information provided.
Contemporaneous	Recorded at the time of care or as soon as practicable afterwards, with the actual entry time preserved.
Clinical reasoning	The documented interpretation of findings, formulation of the problem, dangerous diagnoses considered, working diagnosis or syndrome, uncertainty, and rationale for tests, treatment, observation, escalation, or disposition.
Problem representation	A concise synthesis of the patient’s key features, acuity, time course, and relevant risk factors.

Term	Operational definition
Reassessment	A repeat evaluation after an intervention, passage of time, test result, change in condition, movement, or handover, including response and next decision.
Addendum / late entry	A new, dated, timed, attributable entry added after the original note to supply omitted or subsequently available information without obscuring the original.
Correction	A transparent amendment that identifies the error and preserves the original content or audit trail according to the approved record system.
Result owner	The named clinician or team responsible for reviewing a test result, acting on it, informing the patient or receiving team as required, and documenting completion.
Authentication	The approved signature, initials, stamp, or secure electronic sign-off that identifies the author and confirms responsibility for the entry.
Minimum necessary access	Access to and disclosure of patient information limited to what is required for care, operations, law, or another authorized purpose under local policy.

5. Roles and accountability

Role	Minimum accountability
ED medical lead	Owns the clinical standard; approves note templates and terminology; ensures peer review, audit, feedback, and corrective action.
ED nursing lead	Ensures nursing assessment, observations, interventions, medication administration, escalation, and patient education are documented and integrated with the medical record.
Responsible clinician	Completes or supervises the clinical assessment; records reasoning, plan, reassessment, results, communication, and disposition; confirms pending-task ownership.
Triage clinician	Records arrival time, complaint, acuity, vital signs, immediate risks, interventions, and retriage in accordance with Protocol 2.
Resuscitation recorder	Creates a time-based account of rhythms, observations, interventions, medications, procedures, response, consultations, and outcome under Protocol 3.
Consulting clinician	Records advice, assessment, decisions, time, identity, and any conditions attached to acceptance, admission, procedure, or transfer.
All clinical staff	Document the care they personally provide; identify errors or gaps; escalate unsafe documentation systems; protect confidentiality; authenticate entries.
Health information / records staff	Maintain record integrity, indexing, scanning, retention, access controls, disclosure, amendment processes, and audit trails.

Role	Minimum accountability
Information technology	Maintains availability, security, time synchronization, role-based access, downtime procedures, backup, and recovery.
Clinical governance / privacy officer	Reviews incidents, access breaches, recurrent omissions, legal compliance, and improvement plans.
Hospital executive	Provides staffing, forms, technology, training, secure storage, and governance necessary to meet the standard.

6. Documentation principles

Principle	Operational meaning
Patient-centred	Use respectful, non-stigmatizing, precise language. Distinguish what the patient reports, what others report, and what staff directly observe.
Clinically useful	Prioritize information that changes risk, diagnosis, treatment, monitoring, or disposition. Avoid indiscriminate data dumps.
Structured but flexible	Use the approved ED form or electronic template while allowing narrative explanation of complexity, uncertainty, and exceptions.
Time anchored	Record actual times for clinically important events, not only the time the note was signed.
Objective	Record measurable findings and behaviour. When opinion is necessary, identify its clinical basis.
Traceable	Every order, intervention, result, consultation, handover, correction, and final decision must be attributable to a person and time.
Proportionate	The detail should match acuity, risk, complexity, invasiveness, uncertainty, and likelihood of deterioration.
Integrated	Nursing, medical, allied-health, procedure, medication, and monitoring records should tell one coherent story.
Secure	Use only approved systems and communication channels. Do not place patient-identifiable information in personal devices or unauthorized applications.
Closed-loop	Documentation of an order, referral, or test is incomplete until responsibility for review and action is clear.

A long note is not automatically a good note. The standard is a truthful, focused, time-linked account that enables safe continuation of care.

7. Initiating the ED clinical record

- Create an encounter and clinical record at first clinical contact. Registration or payment processes shall not delay triage or urgent care.
- Use at least two approved patient identifiers whenever available. For an unidentified patient, assign a unique temporary identifier and merge records only through the approved reconciliation process.

- Record arrival date and time, mode of arrival, source of referral, accompanying person, chief complaint, triage category, initial vital signs, allergies, infection precautions, and immediate interventions.
- Reconcile prehospital information, referral letters, medication lists, prior records, and collateral history. Label the source and reliability of information.
- Clearly mark allergies and high-risk alerts. “No known drug allergies” must mean that the patient or an appropriate source was asked; “unknown” shall be used when the history cannot be obtained.
- Use the designated trauma form when injury is the chief complaint and the designated medical emergency form for non-trauma presentations, where locally adopted.
- If documentation begins on paper during system downtime or resuscitation, label every page with patient identifiers and encounter details and incorporate it into the permanent record promptly.

8. Structured clinical assessment

8.1 Immediate danger and acuity

- Record whether the patient is stable, unstable, or at risk of deterioration and the findings supporting that judgment.
- For a critically ill or injured patient, record the primary survey, interventions, and response before a full history. Do not create false completeness by documenting examinations that could not safely be performed.
- Record the source and time of vital signs used in decision-making. Repeat or verify implausible, incomplete, or discordant measurements.

8.2 History

- Document the presenting symptom or event, onset, chronology, severity, progression, precipitating and relieving factors, associated symptoms, and treatment already attempted.
- Capture relevant negatives that materially reduce or alter risk; avoid exhaustive templated negatives that were not actually assessed.
- Record relevant medical, surgical, obstetric, psychiatric, medication, allergy, immunization, substance, exposure, travel, social, functional, and family history according to the presentation.
- Document baseline cognition, mobility, function, frailty, supports, and living circumstances when these affect treatment or safe disposition.
- Identify the historian and any limitation: language, hearing, cognition, intoxication, distress, developmental stage, unconsciousness, conflicting accounts, or unavailable records.
- For injury, document mechanism, timing, protective equipment, energy transfer, anticoagulants, tetanus status, and safeguarding concerns as relevant.

8.3 Examination

- Record general appearance, distress, mental status, perfusion, work of breathing, mobility, hydration, pain, and other clinically meaningful observations.
- Document a focused examination appropriate to the presentation and differential diagnosis. Record positive and important negative findings.
- For neurological assessment, identify the scale used and its components where clinically important; do not rely only on a total score when components or confounders matter.
- Document serial vital signs and examination findings when the condition is dynamic.
- Record why an important examination was deferred, refused, not possible, or not clinically indicated.
- When photographs, diagrams, body maps, wound measurements, or device data form part of the record, obtain and store them under approved consent, privacy, and evidentiary procedures.

Assessment component	Minimum record
Initial clinical state	Acuity, appearance, ABCDE concerns, pain, vital signs, infection risk, immediate action.
Focused history	Presenting problem and time course; relevant risks, medications, allergies, comorbidity, baseline function, source and limitations.
Focused examination	Relevant positives and negatives, objective findings, severity, laterality, anatomical site, and serial changes.
Problem list	Immediate threats, active symptoms, physiological abnormalities, injuries, comorbidities affecting care, social or safeguarding risks.
Patient priorities	Key concern, expectations, preferences, values, and constraints relevant to emergency treatment or disposition.

9. Clinical reasoning and diagnostic uncertainty

- Write a concise problem representation that integrates acuity, key symptoms, time course, findings, and risk factors.
- Identify immediate threats and time-critical diagnoses considered. Document why they remain possible, are less likely, or have been reasonably excluded.
- State the working diagnosis, syndrome, or unresolved problem. Do not force diagnostic certainty when the evidence supports only a provisional assessment.
- List a prioritized differential diagnosis when uncertainty is clinically important. A long unranked list does not demonstrate reasoning.
- Explain major decisions that may not be obvious from the record, including why a test, treatment, consultation, observation period, admission, transfer, or discharge was chosen or deferred.
- Document decision rules, scores, or pathways only when actually applied; include the result and the clinical interpretation rather than naming the tool alone.
- When departing from an approved pathway, record the patient-specific reason and any senior discussion.
- At disposition, update the assessment to reflect what changed after treatment, observation, and results.

Diagnostic uncertainty is not a documentation failure. Unacknowledged uncertainty is. State what is known, what remains possible, and what safety mechanism addresses the residual risk.

10. Investigation and result ownership

- Every investigation shall have a clinical question or rationale evident from the note or order.
- Record the date and time of time-critical tests, specimens, ECGs, imaging, point-of-care studies, and repeat measurements.
- Identify who will review each result and by when. The ordering clinician retains responsibility unless responsibility is explicitly transferred and accepted.
- Document clinically important results, interpretation, action, and communication. “Labs reviewed” is insufficient when abnormalities affect care.
- Record critical-result notification, including the result, caller, recipient, read-back where required, time, and action taken.
- Reconcile conflicting, unexpected, contaminated, haemolysed, technically limited, or implausible results; document repeat testing or clinical acceptance.

- Before disposition, confirm that required results have been reviewed or that a documented follow-up system exists for results legitimately pending.
- For discharged patients with pending results, record the responsible clinician or service, contact method, expected timeframe, patient instructions, and escalation if the patient cannot be reached.
- For transfer or admission, identify pending results and required actions in the handover and transfer documentation.

Result state	Required documentation
Normal and relevant	Result or concise summary; why it supports the plan when clinically important.
Abnormal	Value or finding; interpretation; action; reassessment; communication.
Critical	Direct notification, read-back if required, exact time, recipient, immediate response.
Pending at disposition	Test, expected availability, named owner, communication plan, patient/receiving-team instruction.
Unavailable / delayed	Reason, risk assessment, interim management, escalation, alternative plan.
Technically limited / uncertain	Limitation, clinical implication, repeat or alternative test, senior review if needed.

11. Treatment and medication documentation

- Record treatment indication, date and time, dose, route, rate where relevant, authorizing clinician, administering clinician, and patient response according to local medication policy.
- Document allergy status, weight where dose-dependent, important contraindications, renal or hepatic considerations, pregnancy or lactation considerations, and deviations from usual dosing when relevant.
- Record oxygen device and flow or concentration, fluids and blood products, immobilization, wound care, devices, non-pharmacological treatment, and patient refusal.
- When a medication is withheld, delayed, unavailable, refused, or omitted, record the reason, risk mitigation, and escalation where clinically important.
- For high-alert medications, infusions, sedation, blood, insulin, anticoagulation, vasoactive drugs, and paediatric dosing, document required independent checks under local policy.
- Record adverse reactions, medication errors, near misses, disclosure, treatment, and required incident reporting without inserting blame or speculation into the clinical record.
- Medication reconciliation at disposition shall identify medicines started, stopped, changed, continued, or temporarily held, and the reason.

12. Monitoring and reassessment

- Document a reassessment after every significant treatment, procedure, analgesic or sedative intervention, fluid or blood bolus, abnormal result, clinical change, escalation, and before disposition.
- The reassessment shall address symptoms, vital signs, examination, pain, mental status, response, adverse effects, unresolved abnormalities, and the next decision as relevant.
- Frequency shall match clinical risk. An unstable patient requires continuous or very frequent assessment; a waiting or observed patient requires scheduled and event-triggered reassessment.

- Persistent abnormal vital signs must be acknowledged and explained, treated, escalated, or explicitly accepted by the responsible senior clinician before discharge or movement to a lower-acuity area.
- Record changes in diagnosis and plan over time. Do not leave an earlier, superseded assessment as the only visible formulation.
- If a patient cannot be reassessed because they left, refused, could not be located, or were moved unexpectedly, record the circumstances and actions taken.

Reassessment trigger	Minimum content
After treatment or procedure	Time; symptoms; vital signs; examination; response; complication; next action.
After diagnostic result	Result; interpretation; change or confirmation of plan; communication.
Clinical deterioration	New ABCDE findings; activation/escalation; treatment; response; senior involvement.
Observation period	Serial trend; oral intake, mobility, function, pain, cognition, or disease-specific endpoints as relevant.
Before discharge / admission / transfer	Current state, latest vital signs, unresolved risks, completed and pending actions, destination and ownership.

13. Procedures, sedation, restraint, and intimate examinations

- Use an approved procedure note or document indication, consent or emergency basis, site and side, time-out, personnel, preparation, anaesthesia or sedation, technique, equipment, findings, specimens, complications, success, aftercare, and reassessment.
- Document pre-procedure risk assessment, monitoring, medication, airway readiness, recovery, discharge criteria, and responsible escort for procedural sedation under the separate sedation policy.
- For restraint or emergency behavioural medication, document the immediate risk, alternatives attempted or impracticable, authorization, type and duration, observations, physical needs, injuries, reassessment, release criteria, and legal basis.
- For intimate or sensitive examinations, record consent, indication, chaperone offered and accepted or declined, chaperone identity, persons present, findings, and any reason an emergency exception applied.
- For forensic or assault-related care, use objective language, preserve chain of custody, record patient words accurately where material, and follow safeguarding and evidence policies.
- For invasive devices, record type, size, site, depth or external marking where relevant, confirmation method, fixation, complications, and removal or transfer status.

14. Consultation, escalation, and handover

- Record the reason for consultation or escalation, date and time requested, person or service contacted, response time, information communicated, advice, decisions, and unresolved disagreement.
- When a consultant or senior clinician reviews the patient, the record should distinguish direct bedside assessment from telephone advice.
- If advice is not followed, document the patient-specific reason and subsequent escalation. If the consultant declines or delays review, document the clinical risk and escalation pathway.
- Admission or transfer acceptance shall include the accepting clinician or service, date and time, destination, conditions attached to acceptance, and actions required before movement.
- Use an approved structured handover. Record current status, key history, working diagnosis, treatment, response, pending results, risks, treatment limitations, and required next actions.

- A referral entry does not transfer responsibility. Responsibility changes only when the receiving clinician or service has accepted and the handover is complete under local policy.

15. Consent, capacity, communication, and safeguarding

- Document the information given, material benefits and risks, alternatives, questions, patient decision, and consent for significant procedures or choices according to local law and policy.
- When capacity is in question, record the decision in question, impairment, assessment of understanding, retention, use or weighing, communication, reversible causes, support provided, and conclusion.
- For emergency treatment without consent, record why delay threatened life or serious harm, why the patient could not decide, what was done in the patient's interests, and efforts to involve a substitute decision-maker.
- Document interpreter identity or service and language used. Record communication aids and reasonable adjustments for hearing, vision, literacy, cognition, disability, or developmental needs.
- Record important discussions with the patient, family, caregiver, proxy, police, ambulance, social services, or other agencies, including identity, relationship, information exchanged, and decisions.
- Document safeguarding concerns objectively, including observations, disclosures, immediate risk, persons notified, advice received, safety plan, and limits on information sharing.
- When a patient refuses examination, investigation, treatment, admission, or transfer, document capacity, information and risks explained, alternatives offered, patient reasons where provided, senior discussion, and safety-net plan.

16. Disposition documentation

Disposition	Minimum documentation
Discharge	Final or working diagnosis; relevant uncertainty; clinical course and response; latest vital signs; significant results; medicines; written and verbal instructions; specific warning signs; follow-up; pending-result owner; capacity and transport/support where relevant; departure time.
Admission	Reason and level of care; accepting clinician/service; current status; treatment and monitoring while awaiting bed; latest vital signs; pending actions/results; handover; movement time.
Interfacility / overseas transfer	Reason and urgency; unavailable local service; stabilization; risks and benefits; patient/family discussion; accepting clinician/facility; transport and escort; equipment, oxygen, drugs and documents; pending results; departure and handover times.
Observation	Clinical question or endpoint; monitoring plan; reassessment frequency; permitted treatment; escalation criteria; responsible clinician; review deadline.
Left before completion	Last known condition and acuity; stage of care; attempts to locate/contact; risks; advice; notifications; clinician review where high risk.
Left against advice / refused recommended care	Capacity; recommendation; material risks; alternatives; treatment accepted; safety net; follow-up; witnesses; departure state and time.
Death	Circumstances and time; resuscitation or treatment limitation; pronouncement; notifications; family communication; belongings; forensic, coroner, police, donation, and mortuary actions as applicable.

“Discharged well” or “admit under medicine” is not a disposition record. The note must show current clinical state, rationale, unresolved risk, next responsibility, and what the patient or receiving team was told.

17. Corrections, late entries, copy-forward, and abbreviations

- Correct an error as soon as identified using the approved method. Preserve the original entry and audit trail; identify the reason, date, time, and author of the correction.
- On paper, draw a single line through incorrect text so it remains readable, write the correction, and add date, time, and initials. Do not erase, obscure, use correction fluid, or remove pages.
- Label a delayed entry “Late entry” or “Addendum,” state the date and time of the event being described and the actual date and time entered, and explain the source when not based on direct memory.
- Do not backdate, pre-chart, or alter the record to make care appear more timely or complete than it was.
- Copy-forward or cloned text shall be reviewed line by line. Remove obsolete findings, outdated plans, incorrect patient details, contradictory statements, and examinations not personally performed.
- Auto-populated data such as vital signs, medication lists, and results must be checked for encounter relevance and timing.
- Use only locally approved abbreviations and symbols. Avoid ambiguous dose, route, frequency, laterality, and decimal notation. Never use an abbreviation when misunderstanding could cause harm.
- Voice-recognition text must be reviewed before authentication, especially medication names, doses, anatomical sites, negations, and numerical values.

18. Electronic systems, downtime, confidentiality, and access

- Use individual credentials; never share passwords, smart cards, signatures, or electronic tokens.
- Access records only for an authorized purpose. Curiosity access, celebrity access, and access to family, colleagues, or one’s own record outside the approved process are prohibited.
- Keep screens, printouts, labels, whiteboards, photographs, and verbal handovers protected from unauthorized viewing or hearing.
- Use only approved systems for clinical messaging, images, teleconsultation, and transfer of records. Apply local policy to personal devices and delete any transient authorized copy securely.
- The electronic record shall use synchronized clocks, role-based access, audit logs, data backup, and secure recovery. Unsafe interface, order, result, or identity errors must be reported promptly.
- During downtime, use numbered approved forms, label every page, maintain a manual tracking list, document orders and results, and reconcile all paper records into the permanent record after restoration.
- Duplicate encounters and temporary identifiers shall be reconciled by authorized staff. Clinical teams must be notified when relevant records are merged or corrected.
- Disclosure to police, employers, insurers, media, relatives, or other third parties must follow consent, law, and local privacy policy. Document the basis and content of material disclosures.

19. Special circumstances

Circumstance	Additional documentation
Unidentified / unconscious patient	Temporary identifier; distinguishing features; source of belongings/history; attempts to identify; identity reconciliation; consent basis.

Circumstance	Additional documentation
Child or adolescent	Weight; developmental status; caregiver and legal authority; immunization where relevant; safeguarding; assent; medication calculations; family communication.
Pregnancy / postpartum	Gestation or postpartum interval; obstetric history; fetal status where applicable; Rh status when relevant; obstetric consultation; maternal and fetal disposition.
Older or frail adult	Baseline cognition, function, mobility, frailty, supports, falls risk, medicines, goals of care, delirium screen where relevant, safe transport and home plan.
Mental-health / behavioural emergency	Behaviour and risk; medical causes considered; capacity; suicide/self-harm/violence risk; observation level; search and belongings; restraint; psychiatric consultation; safe disposition.
Intoxication / poisoning	Substance, dose, route, time, co-ingestants, source reliability, toxidrome, poison-centre advice, serial mental state, capacity, antidote and observation endpoints.
Trauma / violence / sexual assault	Mechanism; body map; injuries; patient words where relevant; safeguarding; evidence handling; police involvement; consent; prophylaxis and follow-up.
Communicable disease / isolation	Symptoms and exposure; precautions; notifications; testing; PPE or decontamination issues; contacts and transfer precautions.
Teleconsultation	Participants and locations; technology used; consent; limitations of remote assessment; information reviewed; advice; responsibility and follow-up.
Resource limitation / unavailable service	Missing resource; clinical effect; persons escalated to; alternatives; transfer decision; interim mitigation; patient/family communication.
Disaster / mass casualty	Disaster identifier and triage tag; abbreviated minimum record; interventions; movement; reunification and later record reconciliation under the incident plan.

20. Completion, authentication, and record closure

- Complete and authenticate entries as soon as possible. The hospital shall define maximum local completion times and an escalation process for unsigned or incomplete records.
- Before closing the encounter, confirm patient identity, final disposition, diagnoses or problems, procedures, medications, allergies, results, pending tasks, referrals, instructions, and departure time.
- The senior or responsible clinician shall review and co-sign trainee, student, or delegated documentation where required by law, credentialing, supervision policy, or clinical risk.
- Co-signature means the reviewer accepts the documented level of supervision and must not be used as a routine substitute for actual review.
- Paper components, ambulance forms, ECGs, monitor strips, consent forms, referral letters, and external reports shall be scanned or filed under the correct encounter with legible identifiers.
- An incomplete record that creates immediate patient risk shall be escalated before the clinician leaves duty. Administrative completion does not replace direct handover of urgent information.

21. Quality indicators and audit

Indicator	Suggested measure
Patient identification	Percentage of records with two identifiers or approved temporary identification.
Timeliness	Percentage with time-stamped initial clinician assessment and authenticated final note within locally approved targets.
Core assessment	Percentage documenting complaint, relevant history, allergies, vital signs, examination, assessment, and plan.
Clinical reasoning	Percentage of selected high-risk cases documenting working diagnosis/syndrome, time-critical diagnoses considered, and disposition rationale.
Reassessment	Percentage of treated or observed patients with documented response and pre-disposition reassessment.
Result ownership	Percentage of pending results with named owner and communication plan; rate of unacknowledged critical results.
Medication safety	Percentage of dose-dependent paediatric or high-alert medication records containing weight/checks required by policy.
Consultation / transfer	Percentage with named accepting clinician, time, structured handover, and current clinical status.
Discharge safety	Percentage with diagnosis, instructions, warning signs, follow-up, medication changes, and latest vital signs.
Record integrity	Rate of unsigned notes, duplicate records, unauthorized access, inappropriate copy-forward, missing scanned documents, and improper amendments.
Equity and respect	Rate of stigmatizing language or missing interpreter/communication-support documentation in sampled cases.
Learning	Documentation-related incidents reviewed with actions, feedback, and re-audit.

Audit design: Use a balanced sample of adult, paediatric, trauma, mental-health, discharge, admission, transfer, left-before-completion, and high-acuity encounters. Measure record quality alongside clinical outcomes and system constraints; do not use documentation metrics punitively when unsafe workload or technology is the primary cause.

22. Training and implementation

- Adopt or adapt the WHO Emergency Unit Standardized Clinical Forms for medical and trauma cases, or ensure the local electronic template contains equivalent core elements.
- Map current paper and electronic workflows, remove duplicate entry where safe, and test forms with frontline staff before rollout.
- Train all staff in structured assessment, clinical reasoning, reassessment, result ownership, corrections, confidentiality, downtime, and approved abbreviations.
- Use case-based training to address high-risk documentation: chest pain, sepsis, trauma, child, pregnancy, self-harm, restraint, sedation, transfer, pending results, and refusal of care.

- Provide protected feedback using peer review, real cases, and periodic audit. Focus on improving care rather than increasing note length.
- Ensure sufficient computers, forms, printers, scanners, secure storage, clocks, labels, and technical support are available at all times.
- Pilot the protocol, review defects at 30, 60, and 90 days, amend forms and workflow, then approve the final version.

Annex A. One-page assessment and documentation workflow

Step	Required record
1. Identify and time-anchor	Confirm identifiers; arrival and assessment times; source of information; triage category; immediate danger.
2. Stabilize first	Record ABCDE threats, interventions, and response. Do not delay life-saving care for a complete note.
3. Build the clinical picture	Focused history, examination, vital-sign trends, baseline function, patient priorities, limitations.
4. Show the reasoning	Problem representation; immediate threats; prioritized differential; working diagnosis or syndrome; uncertainty.
5. Make the plan explicit	Tests and clinical questions; treatment; monitoring; consultation; reassessment time or endpoint.
6. Close every loop	Review results; document interpretation and action; identify pending-result owner; record response.
7. Reassess	Symptoms, observations, examination, pain, adverse effects, new risk, revised diagnosis and plan.
8. Transfer responsibility safely	Discharge, admission, observation, procedure, or transfer rationale; instructions; handover; accepting person; departure time.
9. Authenticate and protect	Sign/date/time; correct transparently; secure paper and electronic information; report system defects.
Document the patient's journey, not merely a snapshot. The note should make changes over time and responsibility at each transition visible.	

Annex B. Minimum ED clinical-note dataset

Domain	Minimum content
Identity and timing	Two identifiers or temporary ID; encounter number; date; arrival, assessment, important intervention, disposition, departure times.
Presentation	Chief complaint/event; source; onset/course; triage category; mode of arrival; referral and prehospital care.
Safety alerts	Allergies; infection precautions; anticoagulants; pregnancy; treatment limitations; safeguarding; fall/violence risk as relevant.

Domain	Minimum content
Initial status	General appearance; ABCDE; vital signs; pain; mental status; glucose/weight when relevant.
History	Focused symptom history; relevant conditions, operations, medicines, allergies, exposures, substance use, social/function, baseline and source limitations.
Examination	Focused positives and relevant negatives; laterality/site/severity; serial findings; deferred/refused elements.
Assessment	Problem representation; immediate threats; working diagnosis/syndrome; prioritized differential; uncertainty and risk.
Plan	Investigations with questions; treatment; monitoring; reassessment; consultation; anticipated disposition.
Results	Important results; interpretation; action; critical notifications; pending-result owner.
Clinical course	Interventions; medication; procedures; serial observations; response; complications; changes in diagnosis or plan.
Communication	Patient/family/interpreter; consent/capacity; consultant advice; safeguarding; refusal; information and shared decisions.
Disposition	Current status and latest vital signs; rationale; diagnosis; medicines; instructions; warning signs; follow-up; receiving clinician; handover; departure.
Authentication	Author name, role, signature/e-authentication, date and time; supervisor/co-signature where required.

Annex C. Focused history and examination prompts

Use selectively. These prompts support memory; they are not a requirement to document every item for every patient and must not create false negatives.

Prompt	Possible use
SAMPLE	Symptoms/signs; Allergies; Medications; Past history/pregnancy; Last oral intake; Events/exposures.
OPQRST	Onset; Provocation/palliation; Quality; Region/radiation; Severity; Time course.
Danger screen	Airway, breathing, circulation/bleeding, disability/glucose, exposure/temperature; time-critical syndrome features.
Medication risk	Anticoagulants/antiplatelets; insulin; opioids/sedatives; steroids/immunosuppression; renal-toxic medicines; allergies.
Baseline and capacity	Cognition, mobility, function, communication, frailty, supports, living arrangement, decision-making ability.

Prompt	Possible use
Context and safety	Pregnancy; child or dependent adult; abuse/neglect; self-harm; intoxication; occupational/environmental exposure; infection risk.
Focused examination	General state; vital signs; system-specific positives and important negatives; perfusion; function; serial change.

Annex D. Clinical reasoning and reassessment template

Field	Prompt
Problem representation	[Age/context] with [acuity] [main syndrome] for [time course], associated with [key positives], with [key risks] and [important negatives].
Immediate threats considered	[Threat] - evidence for/against - action or exclusion strategy.
Working diagnosis / syndrome	[Provisional diagnosis or unresolved syndrome].
Prioritized differential	1. [Most likely or most dangerous] 2. [...] 3. [...]
Plan and rationale	Tests: [question]. Treatment: [goal]. Monitoring: [variables/frequency]. Consultation: [reason].
Reassessment	Time: ____ . Symptoms: ____ . Vital signs: ____ . Examination: ____ . Response/adverse effects: ____ .
Revised assessment	[Improved/unchanged/deteriorated]; diagnosis/uncertainty updated because ____ .
Disposition logic	[Discharge/admit/observe/transfer] because ____ ; unresolved risk addressed by ____ ; next responsibility is ____ .

Annex E. Procedure-note minimum dataset

Phase	Required elements
Before	Indication; alternatives; consent/emergency basis; site/side; allergies; anticoagulation; relevant tests; time-out; monitoring; personnel; equipment.
Analgesia / anaesthesia / sedation	Agent, dose, route, time, pre-assessment, monitoring, airway plan, independent checks, response.
Technique	Preparation; asepsis; positioning; landmark or image guidance; device/size; steps; number of attempts; specimens.
Findings and outcome	Findings; success or failure; confirmation method; blood loss; complications; corrective action.
Aftercare	Post-procedure observations; pain; device securement; restrictions; repeat imaging/tests; instructions; removal/review plan; responsible clinician.

Phase	Required elements
Authentication	Operator; supervisor; assistants/chaperone; date and event time; entry time; signatures.

Annex F. Consultation, escalation, and handover record

Domain	Document
Request	Date/time; service/person; reason and urgency; requester.
Information transmitted	Identity; situation; relevant background; assessment; treatment/response; explicit question or request.
Response	Time answered/attended; telephone versus bedside; advice; tests/treatment; review plan; acceptance or refusal.
Escalation	Delay, disagreement, unavailable service, or unresolved risk; senior persons contacted; interim mitigation.
Transfer of responsibility	Accepting clinician/service; destination; conditions; current state; pending tasks/results; handover time; person receiving.
Patient communication	What patient/family was told; preferences; consent; transport and expected next steps.

Annex G. Correction and late-entry standard

Situation	Approved approach	Prohibited approach
Paper error	Single line through error; correction remains legible; initial/date/time; explanation if material.	Erasing, correction fluid, obliteration, removal or replacement of page.
Electronic error	Use correction/addendum function; identify inaccurate element, correction, reason, author and time; preserve audit trail.	Deleting or overwriting to conceal the original; altering another author's entry without approved process.
Late entry	Label clearly; state event date/time and actual entry date/time; identify source and reason if material.	Backdating or implying the entry was contemporaneous.
Post-event clarification	Factual addendum based on records or clear recollection; distinguish new interpretation from facts known at the time.	Coordinated rewriting, speculation, blame, or altering records after complaint/adverse event.
Wrong-patient entry	Stop use; notify records/privacy and clinical team immediately; correct through approved identity and amendment process.	Copying content into the right chart and silently deleting the wrong entry.

Annex H. Documentation audit tool

Audit domain	Pass criteria
Identity and time	Two identifiers; arrival/assessment/disposition times; author and role.
Assessment	Complaint; relevant history; allergies; vital signs; examination; severity.
Reasoning	Working diagnosis/syndrome; dangerous diagnoses; differential/uncertainty; rationale.
Plan	Tests, treatment, monitoring, reassessment, consultation.
Results	Important results, interpretation/action, critical notification, pending owner.
Course	Medication/procedures; serial observations; response and complications.
Communication	Consent/capacity, interpreter, patient/family, consultant, safeguarding/refusal.
Disposition	Latest status/vitals; rationale; diagnosis; medicines; instructions; warning signs; follow-up/handover.
Integrity	Clear, relevant, legible; no unsafe copy-forward; approved abbreviations; transparent corrections; authenticated.
Overall	Would a new clinician understand what happened, current risk, and what must happen next?

Suggested scoring: Met / Partly met / Not met / Not applicable. A single serious omission involving identity, critical result, deterioration, medication, consent, pending action, or transfer of responsibility should trigger case review even when the overall score is high.

Annex I. Local configuration and approved abbreviations

Local item	Decision / reference
Approved ED form / EHR template	[Name, version, owner]
Trauma form	[Name, version]
Medical emergency form	[Name, version]
Observation chart	[Name, review frequency]
Maximum note completion target	[Insert by acuity and role]
Co-signature requirements	[Trainees, students, delegated notes, procedures]
Pending-result process	[Owner, queue, escalation, patient contact]
Critical-result policy	[Notification, read-back, time standard]
Downtime record location	[Forms, log, reconciliation lead]

Local item	Decision / reference
Privacy / disclosure policy	[Local law and policy]
Retention period	[Insert jurisdictional requirement]
Approved secure messaging / image system	[Insert]
Incident reporting system	[Insert]
Approved abbreviations list	[Attach or link]
Prohibited abbreviations	[Attach or list]
Audit owner and frequency	[Insert]

Annex J. References and source tools

1. World Health Organization. Emergency Care Toolkit. [Source](#)
2. World Health Organization. Standardized Clinical Forms for medical and trauma emergency-unit cases. [Source](#)
3. World Health Organization. Medical Emergency Checklist and Trauma Care Checklist. [Source](#)
4. World Health Organization. WHO Data Set for Emergency Care (DSEC), 2026. [Source](#)
5. World Health Organization. Emergency Care System Framework. [Source](#)
6. General Medical Council. Good medical practice 2024, including standards for clear, accurate, contemporaneous and legible records. [Source](#)
7. Royal College of Emergency Medicine. Patient Care in the Emergency Department. [Source](#)
8. Royal College of Emergency Medicine. Clinical Information Systems. [Source](#)
9. Royal College of Emergency Medicine. Providing Patient Information in the Emergency Department. [Source](#)

Local documents to insert before approval: health-record law and retention schedule; privacy/confidentiality policy; EHR and downtime procedure; approved abbreviations; medication documentation policy; consent and capacity policy; safeguarding policy; chaperone policy; restraint and behavioural emergency policy; procedural sedation policy; critical-result policy; incident reporting; discharge, transfer, death, and left-before-completion procedures; supervision and co-signature rules.

Local approval and sign-off

Role	Name	Signature	Date
Emergency Department Medical Lead			
Emergency Department Nursing Lead			
Health Information / Medical Records Lead			
Information Technology / EHR Lead			
Privacy / Data Protection Officer			
Pharmacy Lead			
Clinical Governance / Patient Safety			
Legal / Risk Management Review			
Hospital Executive Approval			

DRAFT FOR LOCAL VALIDATION. Before implementation, align this protocol with local law, professional regulation, privacy, records retention, electronic-system capability, staffing, supervision, approved forms, and the hospital’s incident, consent, safeguarding, medication, transfer, and discharge policies.