Clinical Documentation: The Foundation of Health System Data

What is clinical documentation?

Clinical documentation is any manual or electronic notation in a patient’s chart made by a clinician related to a patient’s medical condition or treatment. Quality clinical documentation is the basis of accurate health data.

How clinical documentation is transformed into health data

1. Clinician charting
   Clinician sees patient and makes chart notes about medical conditions and/or treatments

2. Coding of chart
   Coding specialists use the International Classification of Diseases (ICD) and Canadian Classification of Health Interventions (CCI) to turn the discharge summary information into health data using a common language

3. Data submission
   Organizations submit data to CIHI, where it is validated

4. Release of data
   CIHI provides health data, through indicators, back to ministries, regions and facilities

5. Data and indicator use
   Ministries, regions and facilities use health data for performance management and quality improvement

6. Data-driven change
   New knowledge drives changes in health care practice

It’s important to remember that coding specialists cannot diagnose or make assumptions; they therefore rely 100% on what’s documented by physicians and nurse practitioners.
What makes for high-quality clinical documentation?

High-quality clinical documentation **includes** . . .

- Admitting diagnoses
- Pertinent physical examination findings
- Lab results
- Procedures
- Comorbidities while in hospital
- Discharge diagnoses, medications and active medical problems
- Arrangements for continuing care

High-quality clinical documentation **is** . . .

- Legible
- Accurate
- Complete
- Timely

High-quality chart documentation results in high-quality data!