	DOCUMENT NAME	DOCUMENT NUMBER
	THE HEALTH ESTABLISHMENT MUST RECORD INFORMATION RELATING TO THE EXAMINATION AND HEALTH CARE INTERVENTIONS OF USERS	

VERSION	**1**	
COMPILED BY		**DATE**
AUTHORIZED BY		**07/2025**
NEXT REVISION DATE		**07/2027**

Clinical Assessment and Management Plan Documentation

1. PURPOSE & SCOPE

To ensure that all user health records reflect a complete, legible, and accurate clinical assessment and management plan in accordance with the **National Health Act** and **HPCSA ethical guidelines**.

Applies to all health care providers (doctors, nurses, and allied health professionals) who conduct clinical consultations or procedures at the practice.

2. RESPONSIBILITIES

Job description of person responsible	Duties
Health Care Providers	Must complete health records at the time of each consultation.
Practice Manager	Audits compliance monthly and reports any deficiencies for remediation.
Administrative Staff	Files records securely and ensures all fields are completed where applicable

3. PROCEDURE

Required Clinical Documentation

Each user health record (manual or electronic) must include:

No.	Component	Description
1.	**Date and Time of Consultation**	Clearly documented at the beginning of the entry.
2.	**Presenting Complaint(s)**	Recorded in the user's own words where possible.
3.	**History of Present Illness**	Includes duration, progression, and relevant background.
4.	**Medical History**	Chronic illnesses, surgeries, allergies, medications.
5.	**Clinical Examination Findings**	Vital signs, general and system-specific examination findings.
6.	**Provisional/Final Diagnosis**	Based on clinical judgment and supporting findings.
7.	**Investigations Ordered**	Lab tests, imaging, or any diagnostic assessments.

No.	Component	Description
8.	**Treatment/Management Plan**	Medications prescribed, interventions performed, follow-up.
9.	**Referrals Made**	With reason and destination. Copy to be kept in record.
10.	**Clinician Signature, Date, and Name**	With designation (e.g. Dr, RN) and contact number if external referral.
11.	**Informed Consent (if applicable)**	For any procedures, documented or filed with the entry.
12.	**Legibility**	Must be in **non-erasable ink**; no erasure fluid is permitted. Electronic entries must be traceable.

Electronic Records

- Use secure, access-controlled EMR systems.
- Each entry must be **user-specific**, time-stamped, and not alterable without a visible audit trail.

Audit Procedure

- The Practice Manager must select **three records monthly** for internal audit using a checklist covering the above components.
- Gaps must be corrected and discussed with the provider.
- Audit results are filed and submitted to the practice governance committee.

Training

- All clinical staff to receive orientation on documentation standards upon hire and annually thereafter.
- Updates shared in staff meetings or via internal memos when necessary.

Review and Compliance

- Non-compliance is escalated to senior clinical leadership.
- This SOP must be reviewed **biennially** or earlier if there is an update in legal or regulatory requirements.

4. INTERNAL SUPPORTING DOCUMENTATION

Document	Number	Retention period	Location

5. ATTACHMENT

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Receipt Acknowledgement for this SOP

I have read and been informed about the content, requirements, and expectations of this policy for this practice. I understand that if I have questions, at any time, regarding this policy, I will consult with my immediate supervisor or my Human Resources staff members. Please read the policy/procedure carefully to ensure that you understand the policy/procedure before signing this document.

Employee Signature	Employee Printed Name	DATE	Employee Signature	Employee Printed Name	DATE