assessment skills to clarify and identify the person's health problem, birthing/parenting support and related needs. The needs might relate to care while an inpatient or it might relate to their needs when they go home.

It is essential that an interprofessional collaborative approach is used to plan care that is person-centred. Communicating effectively together (and with the person receiving care) enables healthcare team members to support and complement one another's services and avoid duplications and omissions in planning and coordinating care. Nurses and midwives in their various roles can advocate for that person's holistic needs to be met through effectively documenting needs, making referrals through face-to-face meetings and consultation with other professionals. This chapter discusses the different ways nurses and midwives properly document care, report care and how they formally confer with others to ensure people's continuity of care needs are met.

In Australia and New Zealand, the current healthcare system requires that all nurses and midwives are competent in documenting their client's care to ensure continuity of care, that legal records are kept about the care given so that the documentation can also provide a trail and evidence for evaluating and auditing the effectiveness of the care given (Blair & Smith, 2012). Documentation of care is therefore an important source of reference and communication between all health professionals including nurses and midwives, with implications for continuity of care and interprofessional collaborative practice. The health standards set by government accrediting bodies in Australia and New Zealand has specific guidelines for documenting clinical data and care. Nurses and midwives need to document concisely, and have a system of non-duplication and evidence-based care to ensure quality and safety. The following section explores documentation and some of the different ways and systems of documenting care that are used in our healthcare services.

DOCUMENTING CARE

Documentation is any written or electronically generated legal record of all pertinent interactions with the client that describes the care and services provided to that person. Documentation is a written record of the healthcare professional interacting with the person on all levels of care including assessing, identifying health problems, and planning, implementing and evaluating care. Increasingly sophisticated management information systems (MIS) are becoming available to manage patient-specific data and information, as well as provide access through clinical databases for evidence-based practice. The data obtained from a MIS are used to facilitate person care, serve as legal records, help in clinical research and support decision analysis. The aim of these systems is to create an environment that supports timely, accurate, secure and confidential recording and use of patient-specific information.

MIS can include traditional patient records in hard copy to patient records and data systems that are electronic. In the recent years, there has been a strong shift to healthcare services using and trialling different electronic MIS.

Nurses or midwives are required to document care in a variety of systems, all of which are reviewed regularly and revised so that the end goal of the most efficient, effective and cost-effective quality care can be delivered to clients. The nurse or midwife needs to ensure that due to these processes of quality improvement, the most up-to-date forms, documents and systems are utilised so that there are no errors in delivery of care. Organisations and healthcare services will have a process of document and system control to ensure records are accurate. Check with your organisational policies and procedures to comply with their standards. You are expected to practise according to these specific policies and professional standards.

Patient record

The **patient record** is the written record of a person's progress and care and a compilation of health-related data. The manner in which a patient's record is documented and filed reflects the specific policies of the healthcare facilities in which nurses and midwives work.

Electronic health records

The increasing integration of health records and information systems is providing benefits for clinicians and people by allowing for the delivery of more efficient care; and for the healthcare system through the collection of better data for policy development and resource allocation. Shared **electronic health records (EHR)** provide efficiencies throughout the healthcare system. A patient's record needs to be created once only, saving hours of time clinicians currently spend re-entering basic details such as names, addresses, birth dates, medical history and things like allergies and current medications. A *personally controlled electronic health record (PCEHR)* is an electronic system of storing a patient's records that can be accessed within eHealth systems under the governmental health services in Australia and New Zealand. These are not yet compulsory and people must register to have their own record system established electronically. There are strong security and safeguards in place to keep information safe (Department of Health, 2015; Manage My Health, 2015), just as there are processes in place to ensure the information can be shared when required. There has also been development of smart device applications (apps) that facilitate the use of these programs. The increasing use of computerised PCEHR systems to store and analyse data has necessitated the development of policies and procedures to ensure the privacy and confidentiality of information. Policies should specify what types of information can be retrieved, by whom and for what purpose. Consent is necessary for the use and release of any stored information that can be linked to the person.

The development of electronic transfer of health and health-related data between