QUINTE HEALTHCARE CORPORATION

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Documentation – Clinical Standards

Title: Documentation – Clinical Standards		**Policy No:**	**3.6.1**
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Approved By:	**Interprofessional Practice Committee**		

1. POLICY

Documentation is an essential component of safe and effective patient-centred care, and is a professional and legal responsibility of the health care provider (HCP). Interprofessional documentation contributes to a comprehensive health record that is used to document the plan of care, and delivery and evaluation of that care, in order to maintain and maximize the effectiveness of care.

Documentation at Quinte Healthcare Corporation (QHC) is consistent with legislation, best practice, and the applicable standards.

2. DEFINITION

Documentation Encompasses any electronically-generated information or paper-based information about a patient that describes the clinical information, care or service to the patient.

3. PURPOSE

Documentation should provide a clear picture of: the needs or goals of the patient/client; the health care provider's actions based on these needs and assessments; and the outcomes and evaluation of those actions. The health care provider must maintain confidentiality of patients' health information in accordance with Policy 4.2 Confidentiality.

Clinical documentation is legally required for the following reasons:

a. Indicates that the health care provider has applied clinical knowledge, skills, and judgment in accordance with professional standards of regulatory bodies and in accordance with QHC policies.
b. Provides a basis for care planning, coordination and communication of care so that the health care team has sufficient information to provide patient-centred, continuous care.
c. Provides a basis for analysis, evaluation of quality of care provided to our patients.
d. Provides a method to retrieve information for research, statistics (staffing, financial planning, patient acuity and utilization), quality assurance, and legal/risk management purposes. (Potter & Perry, 2018)

4. PROCEDURE

Documentation at QHC includes an electronic and manual paper component.

General clinical standards for all documentation (electronic and paper):

a. Health care providers and staff members requiring access to the electronic health record will be provided electronic user identification and will establish a self-chosen password. This user identification is provided by the Information Systems (IS) department. Documentation within the electronic record will display the author's electronic authentication, which represents the handwritten signature of the author.

b. The patient health record is interprofessional.

c. Charting by exception, also referred to as standards-based charting (Policy 3.16.8 Nursing – Standards Based Charting), is an acceptable documentation method where standard protocols, assessment parameters, policies and guidelines are in place.

d. Documentation communicates a complete record of the care provided including: assessments, interventions, treatments, planning, education, and evaluations as well as the patient's participation in the treatment/care plans. Documentation must clearly describe the health status of the individual and result of health services provided.

e. Documentation should be completed in a timely manner and as close to the actual time the assessment or delivery of care occurred. Documentation should be chronological and reflect the date and time that care was provided. The frequency of documentation and amount of detail are determined by: the clinician's professional and clinical judgement, the complexity and acuity of the patient's condition, the degree of risk involved in the proposed care or treatment, as well as according to the service standards of care for that

area (Policy 3.16.7 Nursing-Service Standards of Care. Documentation should never occur in advance of the care being provided.

f. Relevant, meaningful information, reflective of observation should be recorded in the patient's health record.

g. Refrain from documenting inferences or assumptions, personal opinions, critical opinions concerning other health care providers, patients or family members

h. Staff members are accountable for the accuracy of the information recorded.

Electronic Documentation

I. Documentation should be completed by the individual who performed the action or observed the event except when there is a designated recorder (i.e. resuscitation). When acting as a designated recorder, the recorder identifies the other persons involved and the care that they provided i.e. code blue or peri-operative charting.

II. Students documenting in the electronic health record should do so under the guidance and supervision of their clinical instructor. Although students are assigned a student login and password after receiving orientation to QHC's electronic documentation record, they do not chart autonomously. Students will not document in the electronic health record without supervision of their clinical instructor or appropriate supervising healthcare provider, until such a time that their instructor or supervising health care professional allows them to document independently. The printed name of the student and the healthcare provider offering supervision should appear on the master signature sheet

III. While QHC allows access to the functionality of the F5 key, it's purpose is to check prior documentation when comparing to the nurses' current findings. It is never appropriate to use the F5 key to copy documentation entered by someone else.

IV. Computers must not be left unattended with open accessibility to patient information and paper charts are to be stored in a designated location that protects privacy while allowing authorized access.

V. Where electronic documentation has been implemented, the paper process is not to be used except during computer systems downtime (Policy 3.6 Documentation Downtime – Electronic Documentation System). Note**:** In emergency situations, such as resuscitation, documentation may revert to paper format and subsequently be placed in the patient's paper chart.

Paper Documentation

a. All documentation is to be labelled with a minimum of two patient identifiers as per Policy 3.18.3 Patient – Patient Identifiers and Identification Armbands. The paper chart will have a sticker with the patient demographic information applied to the top of each page.

b. Students will not document in the paper patient health record without supervision of their clinical instructor or appropriate supervising healthcare professional, until such time as the student's supervisor deems the student competent to chart on their own. The printed name of the student and the healthcare professional offering supervision should appear on the master signature sheet.

c. Documentation must be concise, legible and written in blue or black ink and readable on any photocopies. Illegible notes may lead to misinterpretations by health care providers.

d. Do not leave empty lines where another person could add documentation. If there are empty lines the author should draw a line from the end of the entry to their signature.

e. All corrections must be dated, timed and signed and the original entry must remain visible and retrievable.

f. Errors are corrected by drawing a single line through the error, with initials included and ERROR clearly marked at the line. Entries are not to be corrected by erasing or obliterating. The error must remain readable. Do not use whiteout.

g. Entries must include date and time and are to be signed with the author's first initial, last name and professional designation/title. Initials are acceptable on specific clinical forms if there is a corresponding signature record identifying the printed name, initials, signature and the professional category of the care provider (i.e. computerized medication administration record (CMAR), perioperative count).

h. Where appropriate, minimize the use of abbreviations, and comply with Policy 2.1 Abbreviations – Do Not Use List of Symbols, Acronyms and Dose Designations.

i. Health care providers must document with the understanding that the patient/substitute decision maker (SDM) has the right to access the patient's health record. Requests for access to, or correction to, the medical record are managed through the unit manager (Policy 2.23.2 PHI (Personal Health Information) – Access to Personal Health Information).

Documentation Modules

NUR.BEG (eDoc) is a module of the Meditech system that will automatically default the time of documentation to a date of "Today" and time of "Now" once any documentation is filed. This is reflective of recorded time.

a. All HCPs listed here access electronic interventions prefixed with their appropriate designation:
   - N (Nursing); *NOTE Personal Support Workers (PSWs) use nursing interventions
   - PFC (Patient Flow Coordinator)
   - PT (Physiotherapy)
   - PTA (Physiotherapy Assistant)
   - OT (Occupational Therapy)
   - OTA (Occupational Therapy Assistant)
   - TR (Recreational Therapy)
   - RRT (Respiratory Therapy)
   - SLP (Speech and Language)
   - SL-CDA (Speech and Language Assistant)
   - CN (Clinical Nutrition)
   - CNDT (Clinical Nutrition Diet Technician)
   - ST- (student)
   - DVSA- (DVSARP Nurse)

b. Clinical notes are added using Focus Note documentation: F (Focus), A (Assessment), I (Intervention), O (Outcome). All focus notes should be entered using a focus (title) provided in the NUR module.
   - Focus notes are completed at admission, discharge and transfer of a patient.
   - Focus notes are used to elaborate on "significant findings" not captured within other documentation.

c. Correction of electronic documentation in the NUR Module using the Edit functionality:
   - "VH" View History is a functionality that allows you to view all activity that has occurred on a particular intervention. This function also allows Edit or Undo of information recorded.
   - If charting must be completed retrospectively, ensure that the time is changed to reflect when the intervention was completed. Use the "DI" Document Intervention function when the date and time both need to be changed and use the following format: T (today's date), T-1 (yesterday) or T-2 (day before yesterday).
   - All documentation will display an occurred and a recorded time once filed.
   - A late entry can be made on the day of and for three days (T- 3) after the care/event occurred. Late entry beyond three days requires the HCP notify their manager. The manager will contact Information Systems (IS) department, whereby IS will contact MEDITECH to expand the documentation access parameters. The HCP must make changes during this time to undo the incorrect documentation and then document the correct information. The documenter should indicate in the note what the reason is for the late entry?

EDM.BEG (EDIS) is a module of the Meditech system that will automatically default the time of documentation to a date of "Today" and time of "Now" once any documentation is filed. This is reflective of recorded time.

a. All documentation will display an occurred and a recorded time once filed.

b. If charting must be completed retrospectively, ensure that the time is changed to reflect when the intervention was completed. If the date and time both need to be changed use the following format: T (today's date), T-1 (yesterday) or T-2 (day before yesterday).

c. Correction of electronic documentation in the EDIS Module using Meditech functionalities:
   - "Edit/Amend" allows the user to edit or amend their **own** documentation. When the edit or amendment is filed the word will display grayed as follows *****EDITED*****
   - "Undo" allows the user to undo their **own** documentation. Once filed the word will display grayed as follows *****UNDONE*****
   - Correction of a note in EDIS: Edit/Amend provides an amend note window. Once the amendment is filed, the word will display grayed as follows *****AMENDED*****
   - Undo - allows the user to undo their **own** note. Undo provides a prompt: "do you wish to undo this note". Once filed the word will display grayed as follows *****UNDONE*****

APPENDICES AND REFERENCES

Appendix A: Process for editing documentation when the patient has been discharged from hospital for more than 3 days.

References

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