**Listowel Wingham Hospitals Alliance**

**LWHA Clinical Documentation Standards (2020)**

**Introduction**

Clinical documentation is a vital component of interprofessional practice and communication within a patient’s health record. Documentation is essential to promote safe, quality care through meaningful, clear, and concise communication.

Documentation:

* Provides episodic and longitudinal evidence of:
  + The patient’s perspective
  + The patient’s health history
  + The patient’s health status
  + Findings from examination and assessment
  + Clinical interventions and treatment modalities
  + Outcomes and evaluation
* Provides the basis for the plan of care and discharge
* Promotes continuity of care by allowing other team members access to information
* Facilitates a forum for interdisciplinary team communication
* Protects the legal interests of patients, clinicians, and the organization
* Supports analytics, auditing, and reporting
* Provides data for research purposes

**Definition of Terms**

**Downtime** – A period in which organizational software or hardware is temporarily unavailable

**Electronic Signature** – The unique digital identifier that authenticates an individual’s data entry when signed into the organization’s electronic software

**Health Care Provider** – All individuals who provide care to patients and document in the patient’s health record

**Health Care Team** – The health care professionals providing care to the patient (e.g. physicians, nurses, health disciplines professionals)

**Health Records** – Records of personal health information including but not limited to:

* Hard-copy health records/charts housed in Health Information Management or designated alternative locations (e.g., Radiology),
* Electronic patient records, and
* Diagnostic images and reports, lab specimens and reports, photographs, videos, sound recordings, microfilm or microfiche

**Regulated Health Professional** – A member of the College of a health profession as defined in the Regulated Health Professions Act or the Social Work and Social Service Work Act.

* Sign/Signature

**Standard** – Specifies uniform controls or requirements for an activity or practice based on accepted best practices and legal/regulatory requirements

**Purpose**

The following document outlines the standard for clinical documentation for all Health Care providers (HCPs) practicing within Listowel Wingham Hospitals Alliance (LWHA) and adheres to both legislative requirements and regulatory requirements accordingly. It serves to inform HCPs of their accountabilities when documenting and applies to all HCPs regardless of role, job description, or area of practice. This standard will ensure that HCPs across the organization are documenting their practice in a rigorous, accurate, consistent, and legal manner.

**Program Specific Standards and Guidelines**

It is recognized that additional documentation standards may be required to meet the needs of individual programs or services. The development of these standards may be guided by program-specific best-practice guidelines and research, but must align with legislative, professional, and corporate standards and policies. The development of such standards should be made in consultation with the HCP’s regulatory bodies and should be clearly outlined and accessible.

**Documentation Methodology**

The documentation of HCPs at LWHA follows the *Charting by Assessment* method where documentation captures all observations, clinical assessment, and interventions.

1. Documentation may be entered into the Electronic Health Record (EHR) in a number of different areas:
   1. Certain care points may have Power Forms that will be used to enter documentation (e.g. outpatient areas, admission history, screening tools, etc.). All findings from assessments should be entered on these forms where applicable.
      1. Some Power Forms have areas that are mandatory. These areas will be highlighted and are required to be completed before moving on.
   2. Ongoing documentation of various assessments will take place in iView – a section in the EHR that is systematically divided by various assessment bands and fields. Documentation entered into iView is then displayed like a continuous flow sheet.
   3. Documentation that requires narrative detail and broader depth may be documented in an electronic progress note. Examples of where electronic progress notes are acceptable include:
      1. Code situations
      2. Detailed conversations with patients and family
      3. Adverse events that require more detailed documentation
2. Each system will have an “Expected Normal Findings” section where RHPs can quickly and easily check off any normal findings. Any abnormal findings related to that system must also be documented in the sections following.
3. Normal and abnormal findings for subsequent assessments must also be documented. “Within defined limits” and “No change” statements are not acceptable forms of documentation.
4. Any documentation not entered into the patient’s EHR in a timely fashion is assumed to not have been completed by the RHP.

**General HCP’s** **Documentation Standards**

1. All patient care documentation will be entered by provider data entry, transcription, uploading, transmission from integrated devices, or through document scanning.
2. Documentation for all HCPs is expected to adhere to professional, legislated, and corporate standards
3. HCPs must safeguard personal health information and maintain confidentiality by adhering to legislated, professional, and corporate standards and policies
4. All documentation entries must be complete, truthful, accurate, and legible
5. HCPs must only document their own work and observations and are accountable for everything documented above their signature
6. HCPs are not responsible for documenting care given by other health care providers
7. The HCP should avoid ambiguity and judgmental adjectives by using the patient’s own words where relevant (e.g. Instead of documenting “feels better”, the RHP should document “the patient states that she is feeling better”)
8. Information within the patient’s health record should never be duplicated. There should always be only one source of truth
9. All HCPs documenting in the patient’s EHR must check-in and select their Provider Role and Default Relation to ensure a proper electronic signature
10. Timeliness
    1. Documentation must occur in chronological order
    2. Documentation is required to be completed as close in time as possible to the entry that is being documented to prevent inaccurate or omitted details of care
       1. All documentation should be completed during the RHP’s shift or working hours
    3. When documenting a late entry, the date and time of entry should be changed to reflect the time of when the care was provided. The EHR will time stamp the current date and time of entry as well to reflect that the documentation is actually a late entry.
    4. Documentation should never be done in advance of providing care
11. Corrections of errors
    1. Errors made on the EHR should be corrected by modifying the entry or providing an addendum to the progress note. The date, time, and modifier must be noted.
12. Abbreviations
    * 1. The use of abbreviations is strongly discouraged. Any use of abbreviations should strictly adhere to the following and be guided by the  [Approved Abbreviations Policy-LWHA](http://lwha-webserver/PolicyPage.aspx?cid=22616&lang=1)
      2. The term should be spelled out in full form, followed by its abbreviation in brackets for the first time it is used in an entry
      3. Abbreviations must never be used on Consent Forms or Certificates of Death
      4. Abbreviations, symbols, and dose designations found on the [Error Prone Abbreviations List](http://lwha-webserver/data/2/rec_docs/1568_Appendix_2_ISMP_Error_Prone_Abbreviations_List.pdf) must never be used in documentation
13. Documentation by Proxy
    1. Documentation should be completed by the RHP who performed the action or observed the event; however, certain circumstances require a designated recorder to document by proxy (e.g. during a code, emergency downtime, a RHP forgets to document before their end-of-shift). In those circumstances:
       1. A documentation entry must only be completed by a RHP with the relevant clinical knowledge and judgment
       2. The entry should be backdated to when the care occurred and specify that it has been documented by proxy on behalf of the RHP. The RHP’s name must be included.
14. Documentation by HCP students
    * 1. If a student is performing assessments or procedures under instruction, supervision, or direction, the student is responsible for documenting in the health record.
      2. The RHP providing instruction or supervision will review documentation of the student.
      3. Student and supervisors will recognize and adhere to college and organizational standards related to cosigning.

**Management of paper documentation in the patient’s Health Record**

1. Paper documentation may be used in the following circumstances:
   1. When a form has not been created electronically in the EHR
   2. During expected and unexpected computer downtime
   3. During a critical event (e.g. cardiac arrest)
   4. In clinical areas where electronic documentation is currently not implemented
   5. For required and non-electronic forms that are external to the organization
2. In the event of a planned or emergent downtime of the EHR, HCPs will follow the documentation practices outlined in the LWHA Downtime Procedure
   1. Documentation following downtime will be transcribed back into the patient’s EHR as per the corporate downtime procedure (*appendix LWHA Downtime Procedure*)
3. All remaining paper documentation will meet the following criteria:
   1. Will be recorded on an organizationally approved form.
   2. All paper documentation will be written in blue or black ink.
   3. Documentation entries will not be separated by blank space. Any blank space will have a line drawn through it.
   4. Liquid paper, white-out, or labels will never be used to correct errors.
   5. A demographic label will:
      1. Be placed on the upper right hand corner of all pages found within the patient’s paper health record. If the paper is doubled-sided, both sides will have a demographic label.
      2. Information on the demographic label will agree with both the information found in the EHR as well as on the patient’s armband.
   6. All documentation entries require the date, time, signature or initials, and the professional designation of the RHP.
      1. When documenting the date and time on paper aspects of the Health Record:
         1. LWHA’s format will be used.
         2. The 24 Hour time format will be used.
      2. HCPs will sign all documentation entries on the paper health record with either a signature or initials. This signature will also appear in the Signature Profile in the patient’s Health Record.
      3. The HCP’s professional designation will follow their signature (e.g. RN, RPN, RRT, RPT, etc.). HCP students will use an approved designation based on organizational and school policy (e.g. a 3rd year Western/Fanshawe student’s designation would read WFNIII).
   7. Late entries will be avoided, but if necessary, will be titled “LATE ENTRY” and marked with the current date, as well as the date and time of the intervention.
   8. Errors made on the paper health record will have a straight line drawn through the error, along with the initials, the date of the correction, and the word “error” above the mistake (e.g. ~~bright red blood per rectum~~. Error - J. Doe, RN, 2017-01-01).

**References**

**Relevant Health Care Professional College Standards**

College of Speech Language Pathologists

[College of Dietitians of Ontario. (2017). *Professional Practice Standards for Record Keeping.* Standards of Practice.](https://www.collegeofdietitians.org/Resources/Standards/Record-Keeping.aspx)

[College of Nurses of Ontario. (2008). *Documentation*. Practice Standards.](https://www.cno.org/globalassets/docs/prac/41001_documentation.pdf)

[College of Occupational Therapists of Ontario. (2016). *Standards for Record Keeping*. Standards for Practice.](https://www.coto.org/docs/default-source/default-document-library/record-keeping-standard-jan1.pdf?sfvrsn=10)

[College of Physiotherapists of Ontario. (2017). *Record* *Keeping*. Standards.](https://www.collegept.org/rules-and-resources/record-keeping)

[College of Respiratory Therapists of Ontario. (2015). *Documentation.* Professional Practice Guidelines.](http://www.crto.on.ca/pdf/PPG/Documentation.pdf)

[Ontario College of Social Workers and Social Service Workers. (2008). *The Social Work and Social Service Work Record* in the Code of Ethics and Standards of Practice Handbook.](http://www.ocswssw.org/wp-content/uploads/2018/01/Code-of-Ethics-and-Standards-of-Practice-January-2018.pdf)

**Legislation**

[Excellent Care for All Act](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_10e14_e.htm)

[Personal Health Information Protection Act](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm)

[Public Hospitals Act](http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90p40_e.htm)

[Public Hospitals Act, Regulation 965](http://www.e-laws.gov.on.ca/html/regs/english/elaws_regs_900965_e.htm)

**Relevant Corporate Policies**

[LWHA COPPS - Confidentiality](http://lwha-webserver/PolicyPage.aspx?cid=19790&lang=1)

LWHA COPPS – Downtime Procedures

[LWHA COPPS - Downtime Inpatient Nursing Forms](http://lwha-webserver/Default.aspx?cid=22882&lang=1)

[LWHA COPPS - Privacy Policy](http://lwha-webserver/PolicyPage.aspx?cid=20463&lang=1)

[LWHA COPPS - Approved Abbreviations](http://lwha-webserver/PolicyPage.aspx?cid=22616&lang=1)