DOCUMENTATION POLICY

Summary of Changes

	NEW	**Previous**
All Sites	Pertinent assessments, interventions, and outcomes are documented in the health record.	Some charting "Within Defined Limits"
	Use only dark blue or black ink for completing paper documentation	Black, blue or red ink
	Consistent with patient and family centred care approach	Not specified
	Standardized date format DAY, MMM YEAR, e.g. 07 JAN 2016	Variable date formats.
	Requirements for proxy documentation and signing , co-signing and electronic signatures	Variable content for these requirements
VCH	Documentation Policy	Community of Care level Documentation Standards
PHC	Documentation Policy	No previous Documentation Policy. Various standards exist.
PHSA	Documentation Policy	Agency level Documentation Policies
		Community of Care level Documentation Standards

DOCUMENTATION POLICY

1. Introduction

1.1. Purpose

The purpose of this policy is to outline the general principles and requirements for documenting a patient's care within their health record.

1.2. Scope

1.2.1. This policy applies to:

a. All "**Designated Health Care Professionals**" [DHCPs] working across the Health Organizations (HO – specifically PHC, PHSA and VCH) who document patient information.

b. Paper or **electronic documentation** of **patient** information.

2. Policy

2.1. General Principles

2.1.1. The purpose of documentation is to chronologically record all occurrences of patient care; demonstrate accountability; and facilitate communication, quality improvement, and research.

2.1.2. All documentation must meet legal, professional/regulatory, HO standards and e-signature requirements.

2.1.3. Documentation must be completed using HO approved media (e.g. paper or digital/electronic format).

2.1.4. Discussions with the patient or substitute decision maker around preference for care should be reflected in the documentation.

2.1.5. The health record is a shared document between the patient, their substitute decision maker, and DHCPs.

2.2. Requirements for documentation

2.2.1. Accuracy

a. All patient documentation must be applied to the correct patient and correct encounter.

b. To ensure accuracy within the health record, DHCPs must:

i. Ensure they are accessing the EHR using their individual user name and password prior to entering documentation.

ii. Complete all required and relevant data/information fields applicable to the delivery of care.

iii. Verify with the patient any information copied into the health care record directly from another DHCP's documentation and indicate the original source.

iv. Ensure that written entries include day, month (written in letters) and year (e.g. 07 JAN 2016). Time must be captured using the 24h clock format (e.g. 0800). Exception: Systems that automatically complete the date in a system specific manner.

v. Not alter completed signed documentation entered into the permanent health care record.

vi. Ensure any **addendum** or error corrections leave the original entry legible and identifies the date, time, reason and person adding the addendum/making the correction.

2.2.2. Clarity

a. All documentation must be legible and use formal professional terminology, unless directly quoting from a patient, family member or friend.

b. Documentation must be relevant, succinct, factual, and use objective, precise language.

c. When documenting on paper dark blue or black ink must be used in order to support scanning of documents.

d. Use of abbreviations and acronyms is discouraged.

   i. Refer to the approved Abbreviations, Acronyms and Symbols (AAS) List for guidance.

   ii. For medication orders refer to the Orders Management Policy (to be written) regarding Institute for Safe Medication Practices (ISMP) Dangerous Abbreviations, Symbols, and Dose Designations.

2.2.3. Comprehensiveness

a. DHCPs must document in the health care record in accordance with the Health Record Policy and discipline specific standards.

b. Documentation must include pertinent assessment findings (normal or abnormal), interventions, and patient outcomes.

2.2.4. Timeliness

a. All DHCPs must document as close as possible to the time of the event or care.

b. All DHCPs must clearly identify, date and sign late entries at the time they occurred.

2.2.5. Privacy and Security

a. DHCPs must take all reasonable steps to protect a patient's personal information by complying with HO privacy, confidentiality, and security requirements.

2.2.6 DHCP Signing and Co-Signing Requirements

a. All documentation must be signed and/ or authenticated by the writer, or their designated proxy, including their designation (e.g. RN, RD, and MD), if required.

b. Each professional regulatory group sets standards for co-signing. Students, DHCP's and/or instructors co-sign according to their professional standards.

c. All entries in or for inclusion in the EHR such as: transcribed documents, computer generated documents created by direct information entry, transcription, M Modal (speech recognition software) which require authentication or verification, will be electronically signed by the author, co-signer or an assigned proxy.

d. Entries or reports containing documented contributions by multiple individuals must be authenticated by each contributor in a way that unambiguously identifies each individual's specific contribution.

2.2.7 E-Signature

a. The electronic signature (e-signature) is a legally binding means to identify the author of health record entries. The e-signature replaces the handwritten signature of the author, supports **nonrepudiation**, and is the preferred method of authenticating documentation in the EHR. All individuals who are required to use e-signature will sign and abide by the Electronic Signature Terms of Agreement (See Appendix A). The e-signature contains a date stamp.

b. The e-signature confirms content accuracy and completeness (with all the associated ethical, business, and legal implications) as intended by the author prior to distribution of the entry.

c. An e-signature must not be excised, copied, or otherwise transferred to falsify another record.

d. At the point of care
   i. If documentation of care is recorded by one individual for another when both are present (e.g. scribe role in an emergency trauma or code event) the document is e-signed by the scribe. Designation should be clearly noted for both the scribe and caregiver.
   ii. Back entry of data elements as required from original signed paper documentation (e.g. Code Blue Record, downtime information) into the EHR is excluded from signing requirements. The original document is signed and would be the legal record in such cases.

e. For final health record completion – In the event a medical staff member is protractedly absent leaving an unsigned electronic entry or documents, a qualified alternate signer should sign the entry or document. For medical staff, this is described in the HO Medical Staff Rules.

2.2.8. Requirements for proxy documentation

a. Charting for another DHCP (also called charting by proxy) is allowed in the following situations:
   i. Operative procedures, specimen collection, or other sterile procedures.
   ii. Trauma Resuscitations.
   iii. Emergency situations (e.g. Code Blue, Code White).
   iv. Downtime situations (electronic health record is unavailable).

2.2.9. Downtime

a. In the event the electronic health record is unavailable, DHCPs must document on approved alternate media as per system specific Downtime Policies/Procedures.

3. Responsibilities and Compliance

3.1. Responsibilities

3.1.1 DHCPs granted access to a patient's chart are responsible for documentation of patient care including observations, assessments, status, interventions and outcomes, according to the standards outlined in this document.

3.1.2 It is the responsibility of anyone signing in the EHR, a report or other document to know and understand the completeness and accuracy of the content they are signing.

3.2. Compliance

3.2.1. Compliance with this policy is expected. Anyone noting a violation of the policy may support others to locate and understand the policy and/or advise leadership of the need for education and support regarding the policy. After education and support is offered, and the person remains non-compliant, the HO may remove the person from their workplace position (job) up to and including termination of employment or privileges within the organization.

4. Related Documents

4.2. Related Standards / Guidelines / Forms

Electronic Signature Terms of Agreement (See Appendix A)

Documentation, Acute Care IDG1049 (PHC)

Interdisciplinary Documentation and Authentication Guidelines (Forensic Psychiatric Services Commission)

Paper/Electronic Documentation Standards (Vancouver Acute/Richmond)

4.3. Related Policies

Downtime Procedure

Information Privacy Polices (PHC)

Information Privacy Policies (VCH)

Health Record Policy

Orders Management Policy

5. Definitions

Addendum: Documentation or information attached or added to clarify, revise, or support the information in the original documentation.

Designated Health Care Professionals: refers to both **Regulated Health Care Professionals** and **Approved Non-regulated Health Care Professionals**.

a. **Regulated Health Care Professionals:** Professionals (including students) governed by regulatory colleges under the *Health Professions Act* e.g. Physicians, Midwives, Pharmacists, Nurses, and Dietitians. For complete list see BC Ministry of Health Professional Regulation.
b. **Approved Non-regulated Health Care Professionals:** Additional non-regulated professionals (including students) designated through the health organizations approval process (e.g. Medical Imaging Technologists, Cardiology Technologists, Care Aides).
c. **Students** in Designated Health Care Professions.

Documentation: Any written patient information that describes the care and or service provided

Electronic Documentation: Data that is recorded or stored on any medium in or by a computer or similar device. It includes display, print out or any other input of data (included but not limited to Dragon Speech Recognition.

Electronic Health Record (EHR): A computer-based electronic file that resides in a system specifically designed to support users by providing accessibility to complete and accurate health data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids.

Patient: Refers to patient, client, resident, or person receiving healthcare services.

Electronic Signature: A generic, technology-neutral term for the various ways that an electronic record can be signed. It is considered legally binding as a means of identifying the author of a medical record entry and confirms the contents are what the author intended.

Attestation refers to the act of applying an electronic signature to content, showing authorship and legal responsibility for that information.

Author refers to the individual who wrote the document or entered the content into a transcription system.

Authentication refers to the security process of verifying a user's identity with the system that authorizes the individual to access the system (i.e., the sign-on process). Authentication shows authorship and assigns responsibility for an act, event, condition, opinion, or diagnosis.

Digital Signature refers to a cryptographic signature (digital key) that authenticates the user, provided nonrepudiation, and ensures message integrity. This is the strongest signature because it protects the signature by a type of tamper proof seal that breaks if the message content was altered.

Digitized Signature refers to an electronic representation of a handwritten signature. The image may be captured by using an electronic signature pad, scanning a handwritten signature, or by digital photography.

Nonrepudiation refers to the ability to ensure that a party to a contract or a communication cannot deny the authenticity of their signature on a document or the sending of a message that they originated.

Proxy refers to another Designated Health Care Professional or in the absence of a DHCP, a HIM designate, who is authorized to sign documentation on behalf of the original author. Except in the case of the HIM designate, the proxy accepts responsibility for the content of the documentation

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Appendix A: Electronic Signature Terms of Agreement

Reference Copy below

Form available at http://shop.healthcarebc.ca/CST_Documents/ESig/ESigTermsOfAgreementStandard.pdf

fraserhealth Better health. Best in health care. | Providence HEALTH CARE How you want to be treated. | Provincial Health Services Authority Province-wide solutions. Better health. | Vancouver CoastalHealth Promoting wellness. Ensuring care.

ELECTRONIC SIGNATURE TERMS OF AGREEMENT		
AUTHORIZATION Health Information Systems – Transcription Services	**DATE APPROVED** VCH HAMAC – May 14, 2013 FHA HAMAC – June 12, 2013 PHC HAMAC – September 2014	**DATE REVISED** November 2014

AGREEMENT FOR THE USE OF THE ELECTRONIC SIGNATURE (eSig) ON TRANSCRIBED REPORTS BY AN INDIVIDUAL AUTHOR

Electronic Signature

1. An electronic signature is "a signature that consists of one or more letters, characters, numbers or other symbols in digital form incorporated in, attached to or associated with an electronic document";
2. A secure electronic signature is as an electronic signature that
   (a) is unique to the person making the signature;
   (b) the technology or process used to make the signature is under the sole control of the person making the signature;
   (c) the technology or process can be used to identify the person using the technology or process; and
   (d) the electronic signature can be linked with an electronic document in such a way that it can be used to determine whether the electronic document has been changed since the electronic signature was incorporated in, attached to or associated with the electronic document.

Your Liability

- ✓ By signing in the box below, you agree to the terms of the Electronic Signature Policy.
- ✓ You agree your electronic signature is the legal equivalent of your manual signature on the Agreement.
- ✓ You also agree to be bound by and liable for all use of your Electronic Signature, including unauthorized use by other persons with your knowledge or consent.
- ✓ You agree to use an Electronic Signature in lieu of a paper-based signature.
- ✓ You agree to review all documents for completeness and accuracy prior to electronically signing them within the designated time frame.
- ✓ You agree to notify Transcription Services when you are no longer working for the Health Authority and no longer require access to electronically sign documents.

Protection of Electronic Signature

✓You agree to keep your Electronic Signature and all of its components secret and safe or prevent unauthorized use. This includes, but is not limited to:

- memorizing and keeping safe and private the Username and Password included in your Electronic Signature;
- avoiding selecting number combinations which may be easy for someone else to guess (such as 1, 2, 3, 4) or which are easily associated with you (such as your birth date, address, and so on);
- avoiding selecting any part of another password, PIN, or code that you use for any other purpose;
- taking all necessary precautions to ensure that no one learns any component of your Electronic Signature.

fraserhealth Better health. Best in health care. | Providence HEALTH CARE How you want to be treated. | Provincial Health Services Authority Province-wide solutions. Better health. | Vancouver CoastalHealth Promoting wellness. Ensuring care.

ELECTRONIC SIGNATURE TERMS OF AGREEMENT - STANDARD

AUTHORIZATION	DATE APPROVED	DATE REVISED
Health Information Systems – Transcription Services	VCH HAMAC – May 14, 2013 FHA HAMAC – June 12, 2013 PHC HAMAC – September 2014	December 2015

This is a signed agreement for the use of Electronic Signature.

I understand that the Electronic Signature applied to a document under the Electronic Signature Policy is considered the legal equivalent to my handwritten signature or initials.

(Please sign within the box)

First Name and initial	**Last Name**
Health Authority and Site (i.e. VCH/VGH, PHC/SPH)	**Dictation ID/Billing #**
Phone #	**Email address**
Department Head/Witness (Signature)	**Date**

Please send completed forms to:

Transcription Services at 604-806-8257 or scan to Transcription at transcriptionalerts2@vch.ca

This agreement is supported by the Electronic Signature Standards Policy for the Lower Mainland Health Information Services. For further information please contact 604-806-9696

Any misuse or disregard of electronic signature policy will be reviewed and acted upon by Health Information Management.

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