Chartlets

Site Applicability: *[headings are Calibri 14; use style "Heading 1"]*

PHC inpatient units where documentation is primarily completed in the Cerner Electronic Health Record

Scope:

- All staff accessing the patient hard copy chart

Need to Know:

A *Chartlet* is the name given to the physical patient record (replaces the previous two binders, or charts available pre-Cerner implementation).

A Chartlet is intended to be the place to house patient documentation that must exist on paper, including when:

- The required documentation does not exist in the Cerner system e.g. Interdisciplinary Signature Record
- The documentation is required in hard copy e.g. a consent form that the patient must sign
- Documentation provided from patients (e.g. Advance Care Plans); external sites or agencies
- Documentation completed on paper during a system downtime and is kept as part of the health record

With the exception of patient labels, documents in the chartlet are obtained and added to the Chartlet only when needed (on demand).

Documents are obtained from:

- Cerner FormFast printing application (uptime),
- VCH or Royal Printers Print Shop (ordered via Royal Printers)
- Printed/copied from the downtime toolkit. During a Cerner/Network downtime, documents from the "Downtime toolkit" are copied and placed in the chartlet as needed.

Chartlet Order:

1. Clear plastic sleeve - patient and lab labels in a plastic protector (each patient will need patient labels (for documentation – suggest 10), lab blood specimen labels (suggest 8) and lab non-blood specimen (e.g. urine) labels (suggest 4). These labels are used for paper documentation, during planned and unplanned downtimes and in emergency situations
2. Blue plastic sleeve – Advance Care Planning documents, downtime completed paper DNAR orders
3. Interdisciplinary Signature Record
4. Facesheet (patient information)

Dividers:

5. Legal documents (e.g. Mental Health Act Forms, Substitute Decision maker)
6. Consents
7. Discharge Planning/teaching
8. Assessments (e.g. any prescriber orders, allied forms, nursing documentation that is not in Cerner)
9. Diagnostics (e.g. ECG, transfusion records)
10. Miscellaneous (e.g. other downtime forms, EHS records)

Related Documents:

1. BCD-11-11-41002 -Documentation Policy
2. B-00-07-10008 – Documentation (guideline)

Definitions:

Downtime: Code Grey (system failure) affecting access (directly or indirectly) to the electronic health record and other clinical applications. For example Cerner PowerChart, the wireless network, internet, intranet, are not accessible or not functioning.

Uptime: when all systems are functioning as expected (no interruptions)

APPROVALS		
	Professional Practice	*November 28, 2019*
DEVELOPERS/OWNER		
(e.g. Developer Team Members)	*Professional Practice* *Clinical Clerk Education Coordinator*	*November 28, 2019*

REVISION HISTORY			
Revision#	Description of Changes	Prepared by	Effective Date
OO	*Initial Release*	*Professional Practice*	*November 28, 2019*
01	*Reviewed, minor revisions*	*Professional Practice*	*June 6, 2023*