Documentation

Site Applicability

All Providence Health Care Sites

Practice Level

Designated Health Care Professionals (including Nurses and Allied Health) who document in the patient care record.

Exception: Providers: see Documentation Policy and College guidelines

Need to Know

Documentation:

1. Facilitates communication amongst team members about all occurrences of patient care;
2. A contemporaneous record of patient care;
3. Should be concise, accurate, and factual;
4. Demonstrates accountability; and
5. Supports and is part of quality improvement and research activities.

Documentation must meet all legal, regulatory (e.g. BC College of Nurses and Midwives) and Health Organization requirements in compliance with the Documentation Policy

Equipment and Supplies

PHC approved documentation forms (chart/chartlet) and/or approved Electronic Health Record (e.g. Cerner).

When using forms from FormFast/Cerner always be sure to use the PHC version of the form where it is identified

Guideline

1. All assessments and interventions are recorded in the Patient permanent medical record (paper or electronic).

2. All handwritten documentation on paper must be legible and written using blue or black ink.

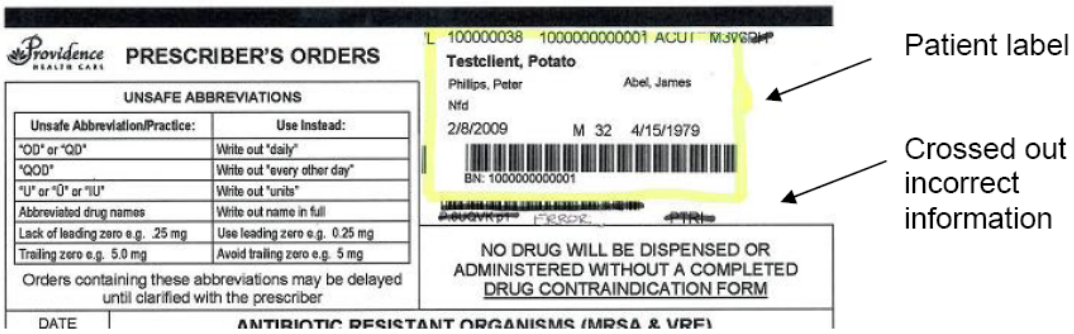
3. The use of abbreviations and acronyms is discouraged, and in some cases is not allowed (see Documentation Policy and DO NOT Use abbreviation list) except where permitted by a regulatory college.

4. All entries are to include a date, time and signature (initials where indicated), or equivalent electronic signature. Professional designation is included in paper documentation as per college requirements.

5. The patient's full name and at least two approved unique identifiers must appear on each page (both sides) of the paper health care record. If it is not pre-printed on the form, the health care worker manually applies a patient identifier label. A label or sticker must not obliterate or hide documentation already on the chart

6. No entries are to be obliterated or erased. Errors in handwritten or electronic documentation are updated according to the Documentation Policy

   If the incorrect patient label has been added to a printed form, strike through the incorrect information, write error, initial and date the change and place the correct patient label OVER the incorrect information being sure to cover the bar code. Any information not covered by the label should have line drawn through it with "error" written beside or above the line.



   Documentation in the electronic record that is **in error** (e.g. wrong chart) can be corrected via the "unchart" function, documenting the reason for the error (e.g. wrong patient chart).

7. For paper documentation, the Signature Sheet records the signature, full printed (legible) name and initials of the health care practitioner and is completed by anyone who is documenting in the paper chart and signing with initials only.
   For electronic documentation, access to the chart begins with logging into the system and denoting a relationship to the patient (Authentication).

8. Narrative Documentation:
   - Used to provide details about behaviour, an event, or care provided.
   - For paper documentation (or during a CST Cerner downtime), the Interdisciplinary Progress Notes are used for narrative documentation. In CST Cerner, narrative documentation can be completed using Narrative notes.

- The use of a documentation framework such as DAR (Data, Action Response) or SOAP (subjective, objective, assessment, plan) can be helpful to organise information in a structured and organized way.
- For steps to enter narrative documentation in CST-Cerner, See Appendix A

9. If an entry is late, or not in the order the care was provided, this must be noted and an explanation provided if reason not apparent (e.g. Downtime, Code Blue etc.).
    a. In paper documentation the words "late entry" and a rationale where appropriate, are added along with the date and time the entry is made.
    b. For electronic documentation of a narrative note, indicate when the care/event took place and include the words "late entry". For example: 'late entry for Code Blue which occurred at 12:10, date'. For entries in other PowerChart sections use the "add comment" function or respond to prompts (e.g. medication administration) to indicate the actual time the care or assessment took place. Include a rationale for the late entry as appropriate.

10. End of shift documentation and shift summary documentation of patient care over a few hours is contrary to the general principles and should be avoided. Our goal is to ensure timely communication in order to facilitate early intervention.

11. For inpatient, critical care and Allied Health Cerner electronic documentation, **Patient Key Activities** is a documentation field within Power chart (iView) to aid in transfer of care communication (shift handover). The intention of the Patient Key Activity component is to communicate clinically significant events or treatments in a concise, chronological order to share with the clinical team. Entries **do not replace** the documentation of assessments and interventions in other appropriate areas of the patient's chart (e.g. Interactive View and I&O).
    The Patient Key Activities field can be accessed in the "Shift Report/Handoff" section of iView bands. Note that only Nurses and Respiratory Therapists are able to document patient key activities. Other clinicians have read-only access to this information.

12. Documentation is concise, factual and uses objective professional language. Duplicate documentation (documenting the same information in two or more places) is not required.

13. When documenting that communication occurred with another care Provider/staff member or any other third party (whether by phone or in person), note the full name and discipline of the person being referred to (e.g. "Jane Smith, MD was notified") and the outcome of the call e.g. plan of care, orders etc.

14. Individual departments or clinical programs will determine if the supervising clinician must countersign a student's entry as per college or other requirements.

15. Other than in exceptional circumstances, (e.g. Code Blue) staff document their own care of the patient and not care that has been performed by others, including students.

16. Electronic documentation "task lists" (such as those used by nursing) should be reviewed and completed or amended as needed and at minimum prior to patient transfer of care (shift or unit transfer) or discharge.

17. During a planned or unplanned Electronic Health Record downtime, documentation will occur on approved PHC documentation tools found in the unit/area downtime toolkit and on the downtime application on the 724 Computers. For information on how to use the 724 applications see B-00-14-10007: Downtime – 724Access Downtime Viewer Quick Reference Guide.

18. Following a planned or an unplanned Electronic Health Record downtime, staff will "back enter" information required for ongoing system functionality or patient care as needed. This includes medications administered during the downtime. Refer to the Downtime and Recovery- Cerner Standard Operating Procedure.

19. Computerized Provider Order Entry can be performed remotely by authorized Providers. In an urgent/emergent situation and there is no reasonable alternative, Nurses and Allied staff may enter a verbal or telephone order on the Provider's behalf (exception, nurses are not to take verbal or telephone orders for PowerPlans)
    The verbal/telephone order is not complete until all the information is completed in the chart including managing any alerts or notifications and signing the order(refer to the telephone and verbal order policy)

Related Documents

B-00-07-14011 - Documentation Standards Physiotherapy

B-00-11-10024 – Telephone and Verbal Orders policy

B-00-13-12006 – Abbreviations Respiratory Therapy

B-00-13-14001 - Abbreviations Physiotherapy

B-00-16-10034 – Chartlets

B-00-16-10036 – Downtime and Recovery – Cerner

BCD-11-11-41002 - Documentation Policy

References

1. British Columbia College of Social Workers: Code of Ethics and Standards of Practice. Accessed January 23 2020 at http://www.bccollegeofsocialworkers.ca/registrants/code-of-ethics-and-standards-of-practice/

2. College of Dietitians of British Columbia: Standards, Ethics and Guidelines. Accessed at: http://collegeofdietitiansofbc.org/home/quality-assurance/standards-ethics-guidelines
3. College of Occupational Therapists of British Columbia: Practice Standards for Managing Client Information: (2019). Accessed January 23 2020 at: https://cotbc.org/library/cotbc-standards/practice-standards-and-guidelines/
4. College of Pharmacists of British Columbia: Framework of Professional Practice. (2006). Accessed January 23, 2020 at: https://www.bcpharmacists.org/professional-practice-policies-and-guides
5. College of Physical Therapists of British Columbia (2018*). Practice standard number 8: Documentation and Record Keeping*. Retrieved January 28 2020 from http://cptbc.org/wp-content/uploads/2014/04/Practice-Standard-1-Clinical-Records.pdf
6. College of Nursing Professionals of British Columbia: Documentation Practice Standard Publication 334 (September 2019). Canada, British Columbia. Available from https://www.bccnp.ca/Standards/all_nurses/harmonized/Pages/Default.aspx
7. College of Speech and Hearing Professionals of British Columbia. Clinical Practice Guideline Documentation and Records Management. Accessed at: http://cshbc.ca/wp-content/uploads/2019/02/CSHBC-CPG-04-Documentation-Records-Management.pdf
8. Moss, J., Andison, M., & Sobko, H. (2007). An analysis of narrative nursing documentation in an otherwise structured intensive care clinical information system. *AMIA. Annual Symposium Proceedings. AMIA Symosium, 543-547.*
9. Swan, W. I., Vivanti, A., Hakel-Smith, N. A., Hotson, B., Orrevall, Y., Trostler, N., Beck Howarter, K., & Papoutsakis, C. (2017). Nutrition Care Process and Model Update: Toward Realizing People-Centered Care and Outcomes Management. Journal of the Academy of Nutrition and Dietetics, 117(12), 2003–2014. https://doi.org/10.1016/j.jand.2017.07.015

Definitions:

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.

Designated Health Care Professionals: refers to 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 and 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 Aids)

Electronic Signature: A generic, technology-neutral term for the various ways than 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

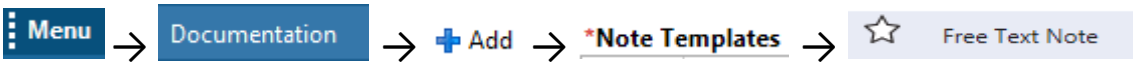
Narrative: a written account or summary of connected events (a story)

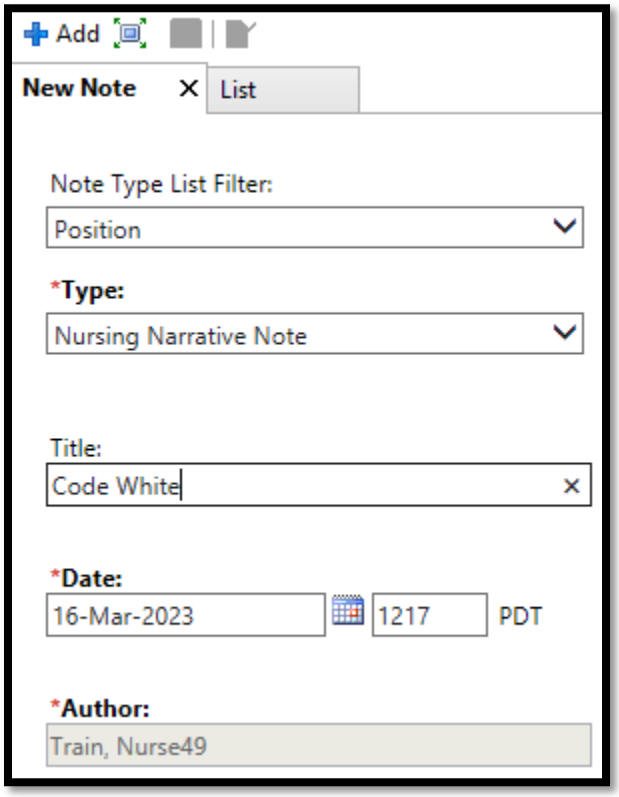
Patient: refers to patient, client, resident or person receiving healthcare services

Provider: refers to Physicians, Pharmacists, Registered Midwives, Nurse Practitioners and Provider Students

Appendix A: Narrative Documentation in CST-Cerner

- To enter narrative documentation in Cerner:
  A. Under Menu – click on 'Documentation' → +Add
  B. The 'New Note' page opens
  C. 'Title' → look under 'Note Templates'
     - if you cannot find the appropriate template for your documentation please scroll down the list and choose 'Free Text Note'
  D. Change Title from 'Free Text Note' to a title that helps easily identify the event by others e.g.) Fall or Post fall, Behaviour, Violence, Constipation, Overdose, Confusion, oral intake, Code White, Code Blue, etc.
  E. 'Note Type List Filter' – choose 'Position'
  F. 'Type' – choose Nursing Narrative Note'





Developed By:
Professional Practice, Providence Health Care

Persons/Groups Consulted:

Executive Director, Patient Safety & Quality Improvement and In-House Counsel

Professional Practice Committee

PHC Practice Consultants

PHC Nurse Educator Group

PHC Advanced Practice Nurses

Initial Effective Date:	JAN-2010
Posted Date:	19-APR-2023
Last Revised:	19-APR-2023
Last Reviewed:	19-APR-2023
Approved By:	PHC
	Professional Practice Standards Committee
Owners	PHC Professional Practice