# Paper/Electronic Documentation Standards
(Vancouver Acute/Richmond)

**VA:** see also Interprofessional Documentation Manual

## Site Applicability

VGH, UBCH, GFS and Richmond

## Practice Level

**All** clinical staff such as RN, RPN, LPN, PT, OT, RD, SW, SL-P.

## Goal

With the introduction of electronic documentation the patient health record will now be a hybrid of paper and electronic documentation. These documentation standards apply to a paper only or a hybrid paper/electronic record.

## Policy Statement

### Standard 1.0 Privacy, Confidentiality and Security

All health care providers have responsibility to ensure that appropriate steps are taken to protect personal information at all times.

***Criteria***

1. All health care providers are expected to know and follow VCH policies and procedures for privacy and confidentiality and maintaining security of the system. Refer to Policy: Information Privacy and Confidentiality.
2. Never reveal or allow anyone else access to your user name or password.
3. Only access patient information that is required to provide care to that patient. Accessing patient information for purposes other than providing care is a breach of confidentiality.
4. Protect patient information displayed on monitors.
5. Log off when not using the system or lock when leaving the terminal.
6. Individuals are responsible for ensuring that any paper containing written or printed patient information is shredded or discarded in a confidential paper bin.
7. Locate printers in secured areas away from public access.
8. Retrieve printed information immediately.

### Standard 2.0 Collecting Patient Care Information

The patient care provider efficiently collects only necessary information from the most appropriate source.

***Criteria***

1. All health care providers are expected to know and follow the organization's policies and guidelines for paper and electronic documentation.

2. Education sessions must be successfully completed prior to performing electronic patient documentation.
   - **All staff:** Allied Health, Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses, and Patient Care Aids must attend and successfully complete PCIS Clinical Documentation education prior to beginning clinical work on a unit using PCIS Clinical Documentation.
   - **All students:** Allied Health, Registered Nurses, Registered Psychiatric Nurses, Licensed Practical Nurses, and Patient Care Aids must attend and successfully complete PCIS Clinical Documentation education prior to beginning clinical placements on a unit using PCIS Clinical Documentation.
3. Collect information directly from the patient whenever possible.
4. Collect information only if it has not been recorded by other professionals.
5. Collect patient information from external persons and agencies only if it is relevant to the current episode of care.
6. When information is collected from a source other than the patient, this must be indicated (e.g. chart, family).

## Standard 3.0 Recording Patient Care Information: Content

The patient care provider records information in the Health Record that is accurate, appropriate, and meaningful to the care of the patient.

### *Criteria*

1. Record Health Record information on approved paper forms or electronic screens, that is factual, concise and objective. Avoid bias and generalizations.
2. Write legibly in black or blue ink using a ballpoint pen. Use red ink when indicated on a specific form. Pencil must not be used on legal documents.
3. Record information with the intent that this information will be shared with the patient.
4. Record information that is pertinent to the current episode of care only.
5. Record information about the patient only, unless the information is relevant to the episode of care.
6. Identify the third party from whom information about the patient has been collected, and their relationship to the patient. When this information is particularly sensitive, indicate whether his/her identity may be released to the patient.
7. Document information from personal knowledge. Entries on paper forms or in the electronic system are made by the provider giving the care and not by other staff. For example, care aides must record actions and observations that fall within their job description. There may be variations in the practice of unregulated care workers at different sites. See Appendix A for documentation guidelines for a care aide.
8. When acting as a designated recorder in an emergency event, the recorder identifies the persons involved and the care provided. An individual who documents the care provided by another individual would do so only if they have been involved in or observed another giving care and would thus have personal knowledge of the situation. Documentation will indicate who observed the event or who performed the action and who did the recording.
9. In some situations unregulated care providers do not record in the paper chart or electronic system but instead report the relevant information about a patient to another regulated staff member, e.g. RN, LPN, PT, OT. That individual then documents the information reported along with the first name, last name initial and designation of the person reporting the information.
10. Document when a planned intervention is omitted indicating what was omitted and why. The reason for omission could include patient condition, absence of the patient or treatment refusal.
11. Record an accurate, factual account of an unanticipated, unexpected or abnormal incident and the interventions carried out. No reference to the completion of an Incident Report should be made in the Health Record. Refer to the Policy: Incident Management (Patient/Client/Resident).
12. Routine documentation of pages/calls initiated is not required. Lack of response to a page/call must be documented when a change in patient management is required or when an adverse event is

occurring. In the event that repeat calls to the care provider (or calls to other providers), are necessary to ensure timely care, these additional steps taken need to be documented.

13. Staff supervising students maintain responsibility for the care of the patient. As such, staff that are supervising students are responsible for reviewing the student's documentation and identifying and documenting any discrepancies. Refer to Appendix B for discipline specific requirements for co-signing student documentation.
14. Allied health professionals must document that informed consent has been obtained from the patient for the intervention plan provided.
15. Students for all non-nursing disciplines must obtain informed consent from the patient prior to providing care. There must be documentation that this consent has been obtained.
16. Follow procedure for telephone orders as outlined in the Formulary (#4.2 Telephone/Verbal Orders), that is available on all nursing units as well as the VH pharmacy website: http://www.vhpharmsci.com/VHFormulary/index.htm
    **For Richmond the link is:**
    http://vch-connect/policies_manuals/pharmacy_richmond/Prescribing%20Policies/Pages/default.aspx
17. For programs that have an established process and protocols in place for providing telephone advice the documentation record must be approved and include the following information:
    a. Date and time of the call.
    b. Patient name and phone number.
    c. Date of birth of patient.
    d. A statement that is read to the patient at the outset of the conversation indicating what the professional can provide/advise on. The statement requires a place for initials.
    e. Information received from the patient including reason for the call, signs and symptoms described, the specific protocol or decision tree used to manage the call, the advice or information given, any referrals made, agreement on next steps for the patient and any required follow up.
    f. Confirmation with the caller regarding any actions to be taken.
    g. Name and designation of the professional dealing with the call.

## Standard 4.0 Recording Patient Care Information: Appropriately and Timely

The patient care provider ensures that the recorder, the patient, and the current episode of care are properly identified and entered in the Health Record. The patient care provider records information in the Health Record on a timely basis.

### *Criteria*

1. Abbreviations used must be listed on the VCH Regional Abbreviation list.
2. The paper signature record must be completed for proper identification when paper forms are used.
3. Record the date and time for all documentation entries. All dates in the Health Record will be in the organizational standard format: **dd/MMM/yyyy** (15 Jan 2007). The 24-hour clock format is to be used.
4. Entries made and stored in the electronic patient record are considered a permanent part of the health record and must not be deleted.
5. Entries completed by another health care team member must not be altered.
6. Record on paper forms or enter information into the system at the point of care or as soon after the care event as possible.
7. When documenting on **paper forms**:
    a. Sign or initial all entries in the space immediately following the notation.
    b. For all RN Initiated Activities (RNIAs), nurse practitioner orders, and when signing the Orders form, the standard is: first initial, last name and designation. NPs (Nurse Practitioners) must also include their college number. In all other areas throughout the Health Record, where space permits and it is appropriate, the signature format is: first

name, last initial and designation. For space limited forms such as flowsheets, initials are the standard.

c. Document entries in chronological order. All entries in the Progress Notes need to include the time the event took place, the notation, the recorder's first name, last initial and discipline/designation, and the time that the entry was made (if different).
d. Document entries not in chronological order as a "late entry". Late entries will be recorded in the next available space. Notations will not be inserted between lines.
e. Draw a single line through incorrect statements when a mistake is made in recording. Write 'error' above and date and initial. The original author must make the correction. The text written in error must still be legible. Never use any correction product to hide or obliterate notations.
f. Record on each line of the Progress Notes. No blank lines / spaces will be left between entries. When a blank line is inadvertently left, a line should be drawn through the blank line so that no entry can be made in that line.

8. When documenting in the **electronic system**:
   a. When entering data into the electronic system from an assessment or intervention that occurred at an earlier time or date, the time or date fields must be changed to reflect the time and date of the assessment/event. Note: the system limitation is 72 hrs prior. The audit log will track the time and date of the actual entry.
   b. When data is entered in error, the information must be corrected by the original recorder and a reason provided. Note: the system limitation is 72 hrs prior.
   c. When entering or updating of information is required more than three days in the past, a call must be made to the Help Desk for the individual to be given 'temporary' (12 hours) access to document beyond the three days prior.
   d. During a planned or unscheduled downtime, documentation is completed on paper forms. Refer to Downtime Procedures. When the electronic system is functional again, information recorded on paper is entered into the electronic system by the same individual who recorded it on paper. The information recorded on paper forms remains in paper format when the downtime **exceeds four hours or crosses over the end of the shift**.
   e. When manual recording on paper is used during a planned or unscheduled downtime, the electronic patient record must indicate that information is documented on paper. When the electronic system is functional, a notation must be entered for each patient in the Communication/Events chart tab that documentation for the specified date and time period exists on paper.
   f. When a patient is discharged during a downtime, the discharge documentation is completed on paper. When the electronic system is functional, a notation must be entered for the discharged patient in the Communication/Events chart tab that documentation for the specified date and time period exists on paper. **This must be completed prior to the patient being discharged from PCIS**.

## Standard 5.0 Recording Patient Care Information: Process

Pertinent information on the patient's condition, goals and progress toward expected outcomes and significant changes are recorded by the health team. Entries in the health record demonstrate the decisions and actions related to identified problems and variances.

### *Criteria*

1. Documentation includes assessment, problem identification, goals, interventions, a plan of care, evaluation and the patient's response to care including variances from expected outcomes.
2. The documentation model is a modified version of Charting By Exception. This means that when findings are recorded from assessments that fall within defined ranges at the beginning of a shift, only exceptions to this are recorded thereafter.
3. The frequency of documentation is determined by patient condition, care requirements and program standards.

4. **For units on paper documentation only:**
    a. All patients are required to have a completed Admission Assessment. The unit needs to complete the Patient Admission Assessment form when the patient is admitted from the emergency department or directly from a critical care area. When patients have been through the Pre- admission Clinic or have a completed admission assessment form from another unit, the Patient Admission Assessment form does not need to be completed.
    b. Assessments and care provided are recorded on the appropriate paper forms.
    c. When a systems assessment is completed, the information is recorded on the appropriate flowsheet or Clinical Pathway. If there is no change in patient condition for these parameters throughout the shift no further documentation is required.
    d. Nurses' Notes / Interdisciplinary Progress Notes are used when flowsheets do not adequately describe the assessment or interventions.
    e. All patients are required to have a completed Plan of Care.
    f. Discipline specific assessments can be completed on admission or on an ongoing basis.
5. **For units on electronic documentation:**
    a. All documentation will be viewed on line. Reports are printed only for external transfer to another facility or to a non electronic unit. If any PCIS reports labelled "Not for Permanent Storage in Health Record" are printed and information is hand written on the paper, this paper will not become part of the permanent Health Record.
    b. On discharge units are responsible for ensuring that any PCIS reports labelled "Not for Permanent Storage in Health Record" are removed from the chart and shredded or discarded in a confidential paper bin prior to sending the chart to Health Records.
    c. On admission to the unit (either direct admit, or from the emergency department, PAR, ICU, or another unit) the following information must be entered into the electronic system.
        - arrival information date and time
        - vital signs
        - systems assessment (within defined limits)
    d. On admission to the unit (either direct admit, or from the emergency department, PAR, ICU, or another unit) the following information needs to be entered into the electronic system if the information is not already in the system or on paper. This information can be obtained from current paper sources such as the emergency department admission forms, the Pre-admission Clinic Nursing Assessment or the Admission Assessment from another unit.
        - admission history
        - allergies
        - medication history
        - aggressive/violence alert (mandatory)
        - CAGE (mandatory)
        - risk for falls (mandatory)
        - domestic violence (mandatory)
        - precautions (e.g. isolation, cytotoxic)
        - discharge screen (mandatory)
        - patient belongings
    e. Functional assessments can be completed on admission or on an ongoing basis.
    f. When a systems assessment is completed at the beginning of each shift, the information is entered on the "Within Defined Limits" screen. If the patient meets all of the criteria listed, no other documentation for these categories is required. If there is no change in patient condition for these parameters throughout the shift no further documentation is required.
    g. When a systems assessment is completed at the beginning of each shift, the information is entered on the "Within Defined Limits" screen. If the patient does not meet all of the criteria listed, 'Exception' is recorded and further documentation is required in the appropriate assessment. Ongoing assessments are documented as they relate to patient problems.

h. All patients are required to have a completed Plan of Care either on paper or in the electronic system.
i. When transferring a patient from an electronic documentation unit to a paper based unit, the following information will be printed and sent in transfer. The receiving unit will use this printed information as the starting point of the paper chart. This includes:
    - the electronic transfer form
    - printed copies of everything electronic for the current admission
j. When transferring a patient to another facility, a Transfer Report is generated. Copies of appropriate documents can also be printed as required.
k. When there are documentation system updates, an alert will come up when the user logs on. Users will be required to verify that they understand and are competent in using the new component of the system after it is updated. The user will be notified of an update change with a pop-up screen that will activate with the user logon. The user has four logons to verify review and competency with the changes prior to being locked out of the system.

## Documentation

Appendix A - Patient Care Aide Documentation (updated April 2009)

Appendix B - Co-sign Student Documentation

## References

Board of Registration for Social Workers in BC. Code of Ethics and Standards of Practice. July, 2006

Canadian Society of Respiratory Therapists. Standards of Practice. March 2007

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## Revised by

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## Date of Revision: March 2009

## Appendix A
## Patient Care Aide Documentation

A PCA is to document any tasks that they have performed on the appropriate paper forms or electronic screens outlined below. The assignment of these tasks is the responsibility of the RN/RPN/LPN. A PCA can only be assigned tasks that are within their job description. For more information, please see the Vancouver Acute Baseline Nursing Skills and Competencies document.

For most units, typical PCA activities include:

| Task | Documents on Paper Form | Documents on Electronic Screen |
|---|---|---|
| Temperature – oral, axilla, rectal | Vital signs record | Vital signs screen |
| Pulse – radial only including pulse rhythm (regular/irregular) | Vital signs record | Vital signs screen |
| Respiratory rate | Vital signs record | Vital signs screen |
| Height & Weight | Vital signs record, Clinical Path | Vital signs screen |
| Bowel movement | ADL flowsheet, Patient Care flowsheet, Clinical Path | Routine Assessment: ADL screen |
| Wash/shower/bath | ADL flowsheet, Patient Care flowsheet, Clinical Path | Routine Assessment: ADL screen |
| List personal belongings/equipment | Belongings/equipment list form | Admission History: Belongings screen |
| Diet intake – amount taken, assistance required | ADL flowsheet, Patient Care flowsheet, Clinical Path | Routine Assessment: Nutrition screen |
| Oral intake volume for patients on detailed fluid balance | Fluid Balance Record | Intake and Output screen |
| Output: empty, measure and record only voided urine and foley catheter drainage | Fluid Balance Record, Clinical Path | Intake and Output screen |
| Administer enemas and suppositories | MAR. The Care Aide must write ‘given’, their initials and include the designation ‘PCA’. The RN/RPN/LPN also initials the MAR when obtaining the suppository and giving it to the Care Aide to administer. | |

**PCAs cannot:**

- Calculate or record shift or 24 hour fluid totals on the Fluid Balance Record
- Document in the Nurses’ Notes/Progress Notes

## Appendix B
## Co-sign Student Documentation

**September 2006**

**Professions that require Professional Preceptors Co-sign Student Clinical Documentation**:

Audiology
Dietetics and Clinical Nutrition
Occupational Therapy
Physiotherapy
Recreation Therapy
Respiratory Therapy
Social Work
Speech & Language Pathology

**Principles:**

- The professional is accountable to their client(s) for the delivery of safe, ethical practice.
- The professional is accountable for what is assigned to a student and the provision of adequate supervision, commensurate with knowledge, skill, experience and demonstrated competency (may be based on the student's progress in the curriculum – e.g. first year, second year etc.).
- The professional is accountable for ensuring the client and team is informed about services being provided by a student and the student's accountability to the supervising professional.
- The key is recognizing accountability, exercising good judgment and recording this adequately.

**What does the co-signature mean?**

Co-signature demonstrates evidence of:

- Accountability
- Judgment
- Consent
- Confirmation
- Suitability
- Corrective Action (as required)

A review of assessment or progress notes and records developed by the student is one tangible manner of demonstrating that supervision is in place. A professional co-signature provides evidence of this review and **accountability** for the supervision.

However, not all students require the same degree of supervision based on knowledge, skill, competency level, experience (even over the duration of the fieldwork placement) and complexity of clients (generally graded from less acute and straight forward cases to more critical or complex cases). Therefore, it is a matter of organizational policy whether all entries into the health record need to be co-signed. For example, if the professional felt the student was ready for independent assessment/intervention, and documentation of that on the record, signing clearly as "student professional" would be adequate. This presumes, that the supervisor/preceptor has observed the student, assessed the competency level and consequently has confidence that the level of responsibility is commensurate with the capability of the student and complexity of the client. With the exception of Physiotherapy, none of the regulatory bodies/associations have policies that require co-

signature for 100% of entries. Rather, they have guidelines that speak to the use of professional **judgment** in the provision of the correct level of supervision and a demonstration of an evolution of student independence in clients' charts. The College of Physiotherapy of BC requires professional co-signature to all student entries in the health record. Whether co-signed or not, the regulatory bodies/associations expect evidence of adequate supervision plans, appropriate to the education/competency of each particular student. If a complaint about a student came in, the jurisdiction for the colleges would be around adequate supervision.

Co-signature also enables **consent** early in the process, as it differentiates between provider and supervisor. It provides heightened awareness to team members regarding who is carrying out the intervention and creates understanding regarding the student's role and that of the supervising professional. Co-signature immediately links student to staff preceptor, thereby enabling communication. Clients must be made aware that a student is providing service, it must be made clear what the assessment or intervention is, who will be supervising, how they will be supervising and how often they will be supervising. These elements of informed consent must be documented in the client's record and co-signed by the student and preceptor.

The co-signing of clinical records provides **confirmation** that what is documented did happen. Moreover, it demonstrates that the supervising professional concurs with the clinical reasoning, analysis and decisions of the student in the choice of intervention; that the content of services provided was valid, relevant and **suitable** for the client.

*If, through a review of the notes and recording of the student, there were something the supervising professional did not agree with in the assessment, analysis or care plan for a client, this would impact the accountability to the best interest of the client. The professional would have the responsibility to ensure **corrective action** was taken. Obligation also exists then, to addend and co-sign documentation to include a record of the alternate action. With the presumption that the professional has adequately established the correct level of supervision for the student in the first place, and the scope of "independence" the preceptor will provide to their student is reasonable, the likelihood for corrective action is reduced. Additionally, many preceptors review informal notes or 'drafts' of recording, for students deemed to have lesser degrees of independence, prior to formal documentation on health record, also reducing the likelihood of alterations or corrections to the record.*

* This document was developed in collaboration between Vancouver Coastal Health, Office of Professional Practice and all the related provincial licensing bodies and associations of the professions named herein