North York General Hospital Policy Manual

Clinical Documentation NUMBER: II–280

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POLICY

The primary purpose of clinical documentation is to facilitate ongoing communication that promotes the continuity, quality and safety of patient care. It acts as an accurate and comprehensive record regarding patient status, interventions and responses to facilitate interprofessional team decision-making regarding the plan of care.[1] Moreover, it reflects the accountability required by health care professionals (HCP) to demonstrate the critical thinking and judgment required by professional regulations and standards. Documentation also serves as written evidence of the patient's episode of care.

DOCUMENTATION STANDARDS

1. The patient health record, both paper-based and electronic, must have a unique patient identifier.

2. All HCPs are required to apply documentation standards in accordance with their professional regulatory bodies, and in conjunction with organizational, program and/or unit-specific policies of North York General Hospital.

3. Documentation must ensure legislative requirements for consent, patient privacy and confidentiality as per NYGH Privacy and Data Protection policy.[2]

4. Documentation must be timely, chronological, and include the date and time care was provided. Entries must be recorded at the time of the patient encounter or as soon after the event as possible. Late entry into the health record must reflect the date and time of the event and the time of the late entry.[1]

5. Documentation must reflect a patient-family centred approach and include evidence of communication between the interprofessional team and the patient-family.

6. Documentation will be clear, concise, accurate, and relevant.

7. Documentation must reflect a comprehensive record of the clinical care provided in accordance with the HCP's standards of practice including the reason for the interaction, any relevant subjective or objective information, assessment, and care plan which incorporates the patient's health goals, interventions or recommendations, monitoring, follow-up and evaluation.

8. Documentation must clearly identify who provided the care and include a unique identifier (i.e. electronic or handwritten signature), with at least a first initial, last name and professional designation (abbreviation is acceptable).[1]

9. Documentation must be performed by the HCP who provided the care or witnessed the event. The exception is where a specific scenario has a designated recorder (i.e. cardiac arrest), or where one HCP assists another to provide care. Where a HCP is documenting information as a designated recorder, the recorder must identify the HCPs and their role or professional designation.

10. Modifications should be minimized in the health record and may only be made to the HCP's own entry. Modifications will be identifiable, e.g. paper documentation will consist of a strike through the entry with first initials, last name and professional designation. Modifications should not obscure or delete any previously recorded entry or data. Modification of another person's documentation is not acceptable. If an error in documentation has occurred, the HCP responsible will be notified to correct the error in a timely manner.

11. Communication between HCPs and non-urgent notifications to the HCP must be documented in the patient health record.

12. HCP should avoid the use of abbreviations. When abbreviations are used, the meaning should be clear to the HCP reading the health record or spelled out in full the first time the abbreviation is used.[3,7] HCP should not use abbreviations that are known to have more than one meaning in the clinical setting.[16]

13. Documentation standards for telepractice are the same as those when patient encounters are face-to-face. Telepractice is defined as the use of communications and/or computer technology to provide care and education to patients and families.[12] The type of communication should be identified, i.e. telephone, fax, email, video or audio conference.

DOCUMENTATION STANDARDS FOR STUDENTS

Roles, Responsibilities & Expectations

A. *Supervisor*

A supervisor is a staff or physician at NYGH who is responsible for the clinical supervision (direct or indirect) of a student. This may be synonymous with preceptor or clinical instructor. Appropriate supervision of students regarding standards and expectations for documentation must be provided by the supervisor. This includes:

a. Reviewing student documentation in a timely manner to ensure completeness, accuracy and in accordance with hospital and regulating bodies' standards. Feedback should be provided as required.

b. Documenting an addendum and correcting any discrepancies in a timely manner.

c. Co-signing or authorizing student documentation in accordance with profession-specific standards and requirements.

   i. Co-signing designates the person who provided the supervision and may signify:

      - Direct supervision occurred whereby the preceptor observed the assessment and interventions described in the student's documented entry and/or
      - Verification that the care provided by the student, which may not have been witnessed, has been documented.

   ii. When a student has established competence to perform a clinical encounter independently, a co-signature may not be required for specific professions as outlined by the regulatory bodies.

B. *Students*

a. Students must document the clinical encounter in accordance with their academic institutional policies, their regulatory bodies and adhere to the clinical documentation standards outlined in this policy.

b. Students must comply with their profession-specific process for indicating supervision, i.e. co-signing.

c. Student documentation may appear in an unauthorized status until the supervisor co-signs the record.

DOCUMENTATION STANDARDS FOR PRIVATELY EMPLOYED HEALTH CARE PROVIDERS

Privately employed regulated and unregulated health care providers are not provided access to document on the patient health record and will document according to the Privately Employed Regulated and Unregulated HCP policy.[14]

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