POLICY:

Clinical documentation is required for the continuity of patient care activities and to serve as a legal record of the critical thinking and judgment used to describe events or discussions that have occurred between health care professionals, patients and/or their caregivers. It facilitates communication between the health care professionals and contributes to continuity of care. Both the paper and electronic chart are a critical part of the health record.

Documentation must include informed decisions about appropriate interventions for patients, drawing upon different sources of knowledge such as ethical knowledge, empirical knowledge, and patient preferences.

All health care professionals are required to meet documentation standards established by their Regulatory/Professional bodies, and in conjunction with unit/program specific and corporate Policies, Procedures and Service Specific Documentation of North York General Hospital.

Documentation will be clear, specific, concise, patient focused and relevant.

Regardless of the method, documentation must include a comprehensive assessment (when appropriate for their profession), patient care plan, interventions, and patient progress and/or reflect any changes in condition.

Entries must be documented chronologically and captured at the time of encounter with the patient (or as near to that as possible).

Late entries must reflect the date and time the care/intervention or assessment occurred.

Documentation must clearly identify who provided the care and the date and time care was provided.

It is acceptable to use an abbreviation where it is spelled out in full the first time the abbreviation is used in a notation.

PROCEDURES FOR CLINICAL DOCUMENTATION:

1. Health care professionals (HCP) are permitted to modify their own entries. In the paper chart, a modification of documentation does not delete the previous entry, it places a strike through the entry, with initials and a new entry will be entered with a reason as to the modified content.

2. HCP are NOT to unchart another HCP entry in the electronic chart. If an error in documentation has occurred, the HCP responsible for the documentation will be contacted and informed so that they may correct the error in a timely manner.
3. The electronic health record is accessible for late entry documentation up to 48 hours from the time of the patient assessment or event, regardless of whether the patient was discharged. Late entries in the electronic health record of more than 48 hours are permissible by following the procedure below:
   • The clinician will contact his/her Clinical Team Manager, leadership team delegate or department head to request access to the electronic health record if the late entry is 48 hours or more post patient assessment or event.

4. Nurses should document throughout their shift depending on the patient’s acuity and as per unit specific policies and procedures.

5. **Non-electronic Units** - Nurses are expected to review the paper chart throughout the shift, for orders and consultations in order to gain a clear picture of the patient’s health status. **Electronic Units** - Nurses are expected to review the electronic chart for new or pending orders every 2 hours.

6. Nurses who care for admitted emergency patients awaiting beds will have the ability to view and act on new orders and document on the electronic MAR only.

7. All members of the Interprofessional team have the ability to document on the following Electronic Documents:
   a. Interprofessional Progress Notes
   b. Interprofessional Family Meeting Notes
   c. Communication/ Notification PowerForms
   d. Sacrament of the Sick PowerForms
   e. Adult and Paediatric Patient History PowerForms  **Note:** The Adult or Paediatric Patient History PowerForm will be initiated by a Nurse and subsequently all team members can utilize the “Modify” function and add information as applicable.

8. The Discharge Planning Overview PowerForm is used by the Nurse; all other Interprofessional team members have Discharge Planning Readiness (discipline specific) and Discharge Planning Overview as sections within their PowerForms.

9. The Interprofessional Progress Note (IPN) must have a subject line reflective of the contents of the note. Subjective Objective Assessment Plan (SOAP) is the documentation methodology used for the IPN.

10. The IPN should only be used for the following situations:
   • When information cannot be captured on a PowerForm or in IView (e.g.: communication with families, family conferences, incident)
   • To document a code or any other emergency situations. **Note:** The IPN on Code Blue/Code Pink/Code Pink Adolescent will reflect “see cardiac arrest record” on paper. In CrCU documentation is done in IView indicating that “Code Blued Called”
   • To document verification of an allied health student entry on an Interprofessional PowerForm (e.g. student’s documentation on the Adult or Paediatric Patient History PowerForm has been reviewed and is accurate)

11. The Communication/ Notification PowerForm is expected to be used by all members of the team in the following manner:
   • Communication that has already occurred between HCP either in person or via the telephone is documented using the Situation, Background, Assessment, and Recommendation (SBAR) section of the PowerForm
Non urgent communication/notification for the physician is documented using the “Message for Physicians” section of this PowerForm.

PROCEDURES FOR STUDENTS AND INTERNS:

Students of Regulated Health Professions, Unregulated Health Care Providers and Dietetic Interns are to follow the policies and procedures for documentation as outlined above, with the following exceptions:

- All students, interns and post graduate trainees (Medical Residents) may document on profession specific PowerForms as appropriate and apply the “sign” function upon completion. These notes will remain in the “unauthorized” status until an instructor or preceptor reviews the documentation and applies their own signature. **Exception:** nursing students will have their documentation reviewed by their Clinical Instructor or Preceptor prior to entering the documentation in the chart. Their signed PowerForms will appear in an authorized format with the student’s signature attached.

- Students may document on Interprofessional PowerForms and apply the “sign” function upon completion. These notes are in “authorized” status. The instructor or preceptor is responsible for reviewing the student documentation upon completion and noting verification on the Interprofessional Progress. **Exception:** Nursing students.

- Verification of any documentation (including medication administration documentation) is not endorsed for nursing students as per the College of Nurses of Ontario (CNO). Nursing students are expected to review each clinical scenario with their instructor or assigned preceptor prior to documentation until such time as the nursing instructor or preceptor is confident in their ability to act independently.

- The College of Respiratory Therapists of Ontario states that where a Respiratory Therapy student is performing activities under indirect supervision, the supervising RT must ensure complete documentation in the patient record; however, the activities are NOT to be co-signed.

- Students are not permitted to initiate an Order of any kind.

- Nursing students under the guidance of a Clinical Instructor or Preceptor will implement orders that have been reviewed by the most responsible nurse.

- For Dietetic and Pharmacy Interns, when the interns reach the competent practice level, their privileges in Cerner will be changed to allow them to “sign” their forms in an “authorized” format. Interns will progress to initiating the Orders as listed for the profession. Progression to do this will be determined by the intern and preceptor.

PROCEDURES FOR PRIVATELY EMPLOYED EXTERNAL HEALTH CARE PROVIDERS:

Privately employed external health care providers are NOT provided access to document on the electronic health care record.

AGENCY NURSES

Hospital approved nursing agency nurses who have not been trained on Cerner PowerChart or iView training for CrCU must complete **Emergency Access Computer Based Training (CBT) Modules** prior to starting their shift. Temporary access granted will be limited and agency nurses will be required to
attend full training prior to any subsequent shifts. See Policy XVI-40 - Agency Electronic Access in Cerner.

For units/departments that are not using Electronic Documentation, it will be expected that documentation and order review be completed using paper documentation and verification processes.

REFERENCES:


College of Occupational Therapists of Ontario. (1999)
