Nova Scotia College *of* Respiratory Therapists

2020

NSCRT Documentation Guideline

Professional Practice Committee

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1. Introduction and Purpose

Introduction

Respiratory therapy practice is governed by NSCRT Code of Ethics and Standards of Practice. Professional accountability standards for RRT's related to clinical documentation are:

- Registered Respiratory Therapists (RRTs) shall be accountable for their practice and will act in a manner that is consistent with the Standards of Practice of the NSCRT. [1]
- RRTs will maintain effective communication with members of the healthcare team regarding the patient's status and progress.[2]
- RRTs will document all information relevant to the provision of care as per organizational policies and procedures.

Purpose of this Guideline

RRTs are members of the interprofessional team of clinicians who collaborate to provide safe, appropriate and ethical care to patients.

As such, RRTs have a professional responsibility to provide accurate and timely documentation in the health record.

This guideline outlines the principles of good documentation and current best practices to which RRTs are held accountable.

[1] NSCRT Code of Ethical and Professional Conduct
[2] NSCRT Standards of Practice

2. What is Clinical Documentation

"Clinical documentation is any manual or electronic notation in a patient record made by a clinician related to a patient's medical condition or treatment. Quality clinical documentation is the basis of accurate health data." [3]

High-quality clinical documentation **includes:**

- Unique patient identifiers such as name and home address
- Responsible physician or other health professional
- Admitting diagnoses or reason for referral
- Pertinent physical examination findings
- Lab results
- Procedures
- Diagnostic procedures and results
- Medical orders
- Monitoring strips and flowsheets
- Comorbidities while in hospital
- Discharge diagnoses, medications and active medical problems
- Arrangements for continuing care

Why Document?

Good documentation ensures that all members of the healthcare team involved in the patient's care have access to reliable, pertinent, and timely information. This supports evaluation of treatment and the patient's response to treatment, understanding patient needs and perspective, planning further interventions, and provides for continuity of care.

Documentation is also useful for quality assurance and can contribute to health research.

[3] Canadian Institute for Health Information

3. Six Essential Elements of Good Documentation

Documentation in a health record should provide the reader with sound understanding of care that has been provided to a patient to date. The health record is the primary communication tool among the health care team and is a legal document.

The following lists six elements of good documentation that reflect best practices in clinical documentation. RRTs must employ these elements of good documentation when entering information in a health record.

1. What Care was Provided

Document each patient interaction and the details related to the care provided, whether care was provided in person or by electronic means.

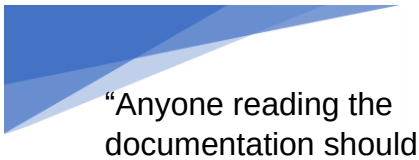
Effective documentation must be:

- Accurate – Document details describing exactly what care was provided. Avoid irrelevant details and use abbreviations approved by the employer. Include the correct date and time of the care.
- Complete – Include all pertinent information related to the care you provided.
- Factual - Include details that describe the specific care, such as vital signs, therapy modification, test results, observations, measurements, findings, patient status and outcomes.
- Objective – Document signs and symptoms as observed or stated by the patient. Avoid using subjective language such as “the patient responded well to treatment”. Rather, state “the patient’s oxygen saturations improved, and dyspnea was relieved”.
- Timely – Document as soon as possible following the care or when test results are received. If documentation must be delayed, ensure you document the time of the care and the time of the entry into the health record as a late entry.
- Legible – The health record must be readable by the health care team. Take the time to document with care.

2. Who Provided Care

It is critical to sign and date each entry in a health record with your name or initial and your professional designation. The full name and designation should be signed in a master list in the health record.

When using an electronic health record use your unique username/log-in when entering new information or making corrections.



"Anyone reading the documentation should be able to clearly identify the healthcare provider who performed the assessment, procedure or activity."

HIROC: A Guide for Healthcare Providers or

3. Who Received Care

In a paper record, ensure that the page you document on contains the patient name and identification number to increase the likelihood that it remains with the patient record.

When using an electronic health record ensure the correct name and identification has been selected before documenting.

4. When was Care Provided

Document the date and time of care or discussions. When documentation must occur later due to urgent care needs, you must also enter the time of the documentation. This provides better understanding of the sequence of events.

During an emergency a designated recorder documents the sequence of events with staff names. The RRT should review the record for accuracy.

However, if the RRT performs a procedure during the emergency, they MUST record the details of that procedure.

5. **Why the Care was Provided**

   Document the purpose of each encounter with the patient. Explain the reason for the encounter and the care that was provided in relation to the clinical situation.

6. **The Patient's Response and Outcomes**

   Document the patient's response to treatment and the outcomes, demonstrating that the treatment was monitored and evaluated.

The Legal Implications of Documentation

The health record helps to provide an accurate description of care delivery surrounding an episode which is the subject of complaint to a regulatory body or is the subject of a legal proceeding.

The health record can be used as evidence in either of these proceedings and is useful to the complainant, the healthcare professional or organization, and the courts for resolution. Good documentation can provide for the best overall outcome.

4. How to Document

Methods for Documenting Information in a Health Record

- **Narrative charting**: The most familiar method of documenting events, in a diary or story format and in chronological order. It is used to document the patient's status, care, and events.

  Example: Visited this patient to set up overnight oximetry. Will print results in the AM.

- **Data, action, response plan (DARP)**: A concise format for documenting assessment, therapy, and care plan.

  Example:

  Data - Pt SPO2 86%

  Action - started on O2 by nasal cannula at 2 lpm

  Response - SPO2 increased to 94%

  Plan - remain on O2 , will continue to monitor SPO2 Q1H

- **Subjective, Objective data, Assessment, Plan (SOAP)**: A concise format for documenting assessment, therapy, and care plan.

  Example:

  S- Pt appears SOB

  O- SPO2 is 85% on Room Air

  A- Pt requires supplemental oxygen

  P- started on O2 by nasal cannula at 2 lpm

- **Situation, Background, Assessment, Recommendations (SBAR):** A technique for communicating critical information that requires immediate attention and action concerning a patient's condition.

  Example:

  Situation: I am calling about Mr. M who is complaining of increased dyspnea
  Background: Patient is a 74 year old male discharged from the hospital with acute exacerbation of CHF
  Assessment: Breath sounds are decreased at the bases and the patient has bilateral edema of the feet.
  Recommendation: Would you like to increase the daily Lasix dose?

- **Charting by exception (CBE):** A format that may be used when routine care such as hourly vitals or ventilator checks, when care findings that are considered within normal/defined limits, are recorded in an abbreviated method as when using flowsheets.

  However, when there are significant findings or exceptions to the norms, document these in a narrative format.

  Special consideration should be given to charting by exception. As identified in case law, CBE can call into question whether care was provided if not used with caution. RRTs are accountable to comply with employer policies and are responsible to understand their employer policy related to CBE.

> *"The difficulty with charting by exception on a flow chart or graph is that when there are holes and blanks in the information, it leaves another observer wondering whether the observations were made but not charted, or not made at all... "*
> *Skeels (Estate of) v. Iwashkiw, 2006*

Respiratory Therapists should use the charting style that best reflects their practice and the patient needs, providing it complies with their employer's policy.

What to Document in a Health Record

All interactions related to the care of a patient must be documented. Interactions may be direct or indirect and may involve care to the patient or conversations with the patient, family, and/or other health providers.

Direct interaction is between the RRT and the patient in relation to their care. Direct interaction may be for the purposes of performing an assessment or examination, diagnostic procedure, therapeutic intervention; or providing education to a patient.

Indirect is when; the RRT interacts with other health care providers or family members regarding a patient's care. This interaction can be in person, by telephone, text or email. Be sure to document an indirect interaction and note that it was indirect.

The RRT should clearly document with whom they interacted and the nature of the interaction; including the date, time, and specific details.

Late entries or events recorded out of sequence may cast doubt on the accuracy and recollection of events. Documentation that occurs more than 30 minutes after an event is considered a "late entry". If documenting a late entry be sure to indicate that it is a late entry, document the time of the event, and document the time of the late entry.

Mistaken Entry

From time to time an entry into a health record is found to be an error. Never alter or delete any entry made by someone else. Hand-written errors should be promptly corrected by the original writer.

When correcting errors on a paper record, this should be done by placing one single line through the incorrect entry so that it is still readable. The new entry should be written in the next available space. Initial the date and time of the corrected entry.

Be aware of and follow your institutional guidelines/policies regarding correction of errors.

With all documentation in a paper record, do not leave blank lines where someone else could insert notes. If there is a blank space, draw a single line through the area.

Electronic health record systems allow for alterations and deletions that will be captured in the Electronic Audit Trail. The audit trail will record every action that was taken including what part of the chart was viewed, any new entries created, and any modifications or deletion of existing data.

These corrected and deleted notes might not be visible in the record.

Correct mistaken electronic entries as per the processes outlined for the specific electronic health record system.

*An **Electronic Audit Trail** is a security record that provides chronological documentation of everyone that accessed the electronic chart, the date and time of access, and from where they accessed the chart.*

Co-signing When Supervising Others

An RRT may co-sign documentation that was made by another individual, such as a Student Respiratory Therapist (SRT), or an RRT with a restricted license. It is essential that the documentation include who performed each task and what degree of supervision was provided.

Direct supervision means an RRT observes and oversees another perform a competency, such as a Student RT (SRT).

Example: An SRT performs an arterial blood gas puncture under **direct supervision** by an RRT. The SRT would document the procedure in the health record, and state it was performed under “direct supervision” by the RRT. The RRT would then co-sign the documentation.

Indirect supervision

For documentation purposes, indirect supervision is specifically related to respiratory therapy students performing only the competencies in which they have demonstrated full competence. The RRT is within the clinical area but is not directly observing the Respiratory Therapy student.

> Example:
>
> A SRT in their final clinical rotation conducts a respiratory assessment of a patient. The supervising RRT is within the patient care area but not directly observing the procedure. The SRT would document the assessment in the patient's health record, stating the procedure was conducted under "indirect supervision" of a specific named RRT. The RRT would **not** co-sign the SRT documentation, as they did not directly observe the procedure and therefore cannot attest to the accuracy of the documentation.

NOTE:
*Co-signing documentation in a patient's health record implies **shared accountability**, so the person co-signing must have directly witnessed the procedure.*

Abbreviations

The NSCRT recommends that RRTs avoid using abbreviations in the health record unless the employer has defined acceptable abbreviations.

The Institute for Safe Medication Practices Canada has listed dangerous abbreviations and symbols that have been frequently related to medication errors in a "DO NOT USE" document. This information can be found at:

https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf

5. Special Considerations Related to Clinical Documentation

Confidentiality and Privacy; and Patient Access to Records

The Personal Health Information Act of Nova Scotia (PHIA) legislates the protection of personal health records. PHIA defines specific authority and accountability for “Custodians” and “Agents” and applies to both paper and electronic information.

Agents

Respiratory therapists who are employees of an organization that provide healthcare service to patients are considered “Agents” under PHIA. As Agents RRTs are accountable to their employer to adhere to employer policies and practices related to health records. Agents also have specified duties under the act:

- An agent must not use personal health information for their own purpose;
- An agent must notify their employer if they are aware that personal health information has been stolen, lost, or accessed by unauthorized persons.

RRTs must therefore be familiar with and comply with the employer/custodian policies regarding access, collection, use, and disclosure of personal health information of patients/clients of the employer. It is helpful for RRTs to understand their employer’s general responsibilities under the Act.

Custodian Responsibilities under the Personal Health Information Act

Custodians can be defined as an individual, such as a regulated health professional, or an organization that has custody and control over the personal health information which has been collected in the course of providing health care services. Custodians include: an individual regulated health professional, health authorities, health clinics, collaborative practices, continuing care facilities, pharmacies.

Custodians must take all reasonable measures to protect the privacy of personal health information whether paper records or electronic records.

Respiratory Therapists who practice independently providing direct health care service to patients and collect personal health information for the purpose of providing that health care, are considered “Custodians” under PHIA.

Custodians must provide for the following:

- Custodians must inform its “Agents” of their duties under the Act.

- Obtain patient consent that is specific to the collection, use, disclosure, retention, and disposal of personal health information. Patient consent for collection, use, and disclosure to those within the patient’s “circle of care” can be knowledgeable implied consent. This consent must be freely given, knowledgeable, and related to the specific information at issue.

The term “circle of care” is defined as:

“Individuals and activities related to the care and treatment of a patient. Thus, it covers the health care providers who deliver care and services for the primary therapeutic benefit of the patient and it covers related activities such as laboratory work and professional or case consultation with other health care providers.”

Industry Canada Guidelines for the Health Care Sector

- To ensure that individuals understand consent for the above, agents should provide a notice of purpose for the collection of personal health information. This can be as a poster displayed in an office or an addition to a consent form.

- Have a written privacy statement regarding information practices and provide information on how to request access to or correction of the individual’s record and how to make a complaint.

- Make reasonable efforts to comply with a request from a client to limit or revoke the right to collect, use, and/or disclose personal health information.

- Consent may need to be obtained from a substitute decision-maker if the individual lacks the capacity to make the decision to consent.

- Have a written retention/destruction schedule for personal health information.

- Ensure personal health information in custody is protected from theft, loss, or unauthorized access.

- Report a breach of privacy to the client if the custodian believes the breach is likely to cause harm or embarrassment to the individual.

Individuals have the right to request the following from a custodian:

- to receive or view a copy of the individual's personal health information (with exceptions)
- that corrections be made to personal health information that is not accurate, complete or up to date
- a record of who has accessed the individual's personal health information on an electronic information system (a record of user activity)
- that specific personal health information not be provided to other health care providers
- to be advised if a breach of the individual's personal health information has occurred
- to make a complaint to the custodian about a concern related to access, correction or another privacy issue under the Act
- to request a review by the Review Officer of the custodian's decision or actions

Disclosure of personal health information to members of an individual's family is limited to the presence, location, and general condition of the individual on that day. Disclosure is not permitted if the individual has indicated they do not want to be contacted by a particular person.

Example

Janet calls the hospital and identifies herself as the mother of a person she understands has been admitted to the hospital. She gives her son's name, and asks for his location and general condition. The patient, who was conscious when admitted, specifically told the nurse that he did not want his family to know that he was in hospital.

The hospital would be justified in withholding information from Janet.

DHW: PHIA Toolkit for Custodians

Additional considerations for Regulated Health Professionals

- Collection, use, and disclosure of personal health information must be limited to the minimal amount of information that is needed to achieve the purpose for which it is collected, used, or disclosed.
    - Example: An RRT is preparing to perform an arterial blood gas (ABG) puncture. The RRT should understand if there are any safety considerations, they need to verify the prescription and purpose of the procedure, and document the instruction to the patient, and the procedure.
- Regulated healthcare professionals should access only the personal health information the healthcare professional requires to carry out their duties and responsibilities, according to organizational policies.
    - Example: RRTs should only access personal health records of patients they are currently caring for.

*****Note: RRTs in private practice are advised to refer to the PHIA Toolkit for Custodians *****

www.novascotia.ca/DHW/PHIA

Telehealth Documentation

Telehealth provides a venue to share information and deliver services remotely. This service is rapidly emerging and includes communication among healthcare providers, between providers and patients, and includes communication by telephone, voicemail, email, or through audio-video technology.

RRTs using telehealth services to communicate should use only software and devices that meet employer confidentiality and security standards. They must also follow employer protocols for leaving voicemail and email communication with patients or providers.

All patient-specific service, interaction, or information shared and/or obtained using telehealth services must be documented in the health record as with a face to face interaction. It should be identified as telehealth communication.

When using electronic health records, a patient who is not registered at the time of interaction can be registered as a telehealth consult, to provide a location for the health record to be attached. Each occurrence must be documented as a separate event and should always include

full names and designations (if applicable) of all parties involved, and how they were contacted for the interaction, including their corresponding phone numbers or emails (if applicable).

Free and informed patient consent must be obtained for all telehealth interactions, except in situations of implied consent.

Documentation of Patient Consent or Refusal of Treatment

Consent to treatment must be obtained from the patient or substitute decision maker to administer health care. Consent must be informed and voluntary.

Consent is not required in an emergency situation whereby the patient is at risk of sustaining serious bodily harm if treatment is not administered or is experiencing severe suffering.

Consent is understood as Implied Consent or Express Consent.

Patients may withdraw consent at any time or refuse specific or all treatment**.**

Implied consent: In health care, consent is often implied based on the words and/or behaviors of the patient.

Implied Consent Examples

A patient who attends diagnostic testing appointments implies consent

You explain a procedure to the patient, for example: an arterial blood gas, and they present their arm for puncture.

Express consent can be verbal or written:

When providing a treatment that is painful, or carries significant risk, the patient should be asked to express their consent.

Verbal expressed consent may be obtained when requesting to perform a procedure in an office or at the bedside and should be documented in the health record.

Written Consent Example

A patient undergoing a surgical procedure is required to sign a written consent form to Express their consent.

Patients who refuse treatment or withdraw consent

A capable / competent patient has a right to refuse to follow the advice given. When treatment is refused it must be documented in the health record.

This documentation should include:

- Date and time
- Information given about the proposed intervention and the possible outcomes of the patient not receiving the proposed treatment
- Patient's reasons for refusal of treatment
- Recommendations for alternative treatment options
- Names of individuals informed about the patient refusal/ withdrawal

Sharing Information via Fax or Email

Good Electronic information Practices

- Passwords are your electronic identity. Do not share your password and change it frequently. Use multiple characters that will not be easily guessed.
- Always log out of the system when you are finished or away from your computer
- Mind your monitor – face it away from public areas
- Do not use regular email to send Personal Health Information
- Encrypt data when transporting it
- All mobile devices should be encrypted and securely stored
- Data should be stored to a secure network drive or cloud and encrypted. Do not store data to the computer hard drive
- Your access can be audited anytime to ensure only information you need to be aware of is accessed

Good Fax Practices

- Mark the document Confidential
- Include a cover page with the Sender's name, telephone and fax numbers, the number of pages being sent and a confidentiality statement
- Verify you have the correct fax number. It is important to ensure Fax numbers are accurate and up to date
- Before proceeding with a transmission, visually verify the number is correct on the machine, whether manual or pre-programmed
- Check the fax transmission was sent properly
- Locate the fax machine (s) in a secure area with controlled access
- Notify a sender immediately of a fax received in error and return or destroy the received document
- If you are expecting something by fax, especially if it is sensitive, treat it like a meeting; set a specific time to receive it
- Don't leave original material in the fax machine

Difference Between Legal Documents and Transitory Reports

Transitory reports include any type of temporary record that is only used short term for the purpose of completing a routine action or task. These documents may be necessary to complete current work but have no further use.

Transitory reports have no medical importance or lasting legal significance once their immediate purpose is complete. They are not part of any official record keeping system and should be destroyed in confidential waste as soon as they are no longer in use.

Examples of transitory documents are:

- Any temporary record that is used short term to complete a current action/task.
- Brief summary of patient needs. Not detail oriented.
- Phone messages, post it notes, departmental records

6. Appendix

Definitions

- Accountability: acknowledgement and assumption of responsibility for decisions and actions completed within one's scope of practice.
- Telehealth: The distribution of health-related services and information via electronic communication and telecommunication technologies.

7. References

- Personal Health Information Act of Nova Scotia https://novascotia.ca/dhw/phia/PHIA-legislation.asp
- PHIA-complete-toolkit https://novascotia.ca/dhw/phia/documents/PHIA-complete-toolkit.pdf
- The Canadian Medical Protective Association
- Documentation Professional Practice Guideline 2015, College of Respiratory Therapists of Ontario (CRTO)
- Capital District Health Authority (NSHA) policy and procedure July 2014 , Administration Manual
- Industry Canada's Guidelines for the Health Sector
- Personal Health Information Act: Questions and Answers for Registered Nurses, CRNNS
- Strategies for Improving Documentation 2017: Health Insurance Reciprocal of Canada (HIROC)
- ISMP Canada: Do Not Use: Dangerous Abbreviations, Symbols, and Dose Designations
- https://www.ismp-canada.org/download/ISMPCanadaListOfDangerousAbbreviations.pdf