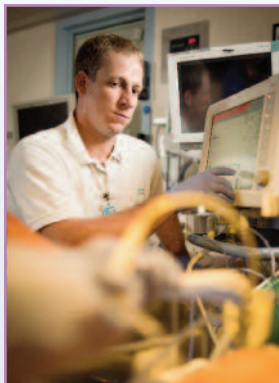
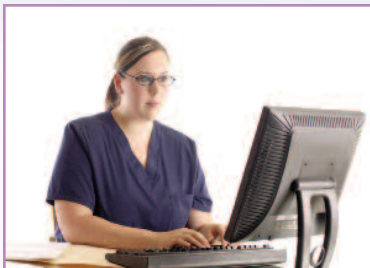


Documentation

PROFESSIONAL PRACTICE GUIDELINE



College publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists in the care of their clients and in the practice of the profession. College publications are developed in consultation with professional practice leaders and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

DECEMBER 2011

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INTRODUCTION

This Professional Practice Guideline (PPG) describes the professional and legal obligations of CRTO Members with respect to health records and documentation.

For the purpose of this PPG, the term 'health record' refers to the record of clinical care provided to the patient/client, including but not limited to flow-sheets, progress notes, laboratory results, medical orders and monitoring strips.

The term 'documentation' refers not only to what is recorded in a health record (charting) but also in equipment maintenance records, shift or transfer of accountability reports, worksheets, **kardex** and incident reports.

Various pieces of legislation (e.g., [Public Hospitals Act](#), [Independent Health Facilities Act](#), [Long Term Care Act](#), [Laboratory Licensing Act](#), [Personal Health Information Protection Act](#)) have requirements related to documentation in health records. An employer may also have policies and procedures related to documentation (e.g., charting by exception, **SOAP** charting, **DAR** charting). If legislation applicable to a Member's practice or an employer's policies and procedures are more restrictive than the College's standard of practice, a Member must follow the requirements of the legislation and should abide by the employer's policies and procedures. Where the legislation or employer's policies and procedures are more permissive than the College's standard of practice the Member must adhere to the College's standards of practice.

This practice guideline is intended to provide Members with information about the standards of practice related to documentation and to assist with documentation that is an everyday expectation of professional life. The College has also developed practice guidelines on the [Interpretation of Authorized Acts](#), [Delegation of Controlled Acts](#), [Responsibilities Under Consent Legislation](#), [Responsibilities of Members as Educators](#), and [Orders for Medical Care](#), that may have complementary and overlapping information related to standards for documentation.

THE PURPOSE OF HEALTH RECORDS AND DOCUMENTATION

Did you know...

Communication is an interprofessional practice competency.

Health care practitioners can support interprofessional collaborative practice by effectively using information and communication technology to improve interprofessional patient/client/community-centred care by assisting team members to:

- set shared goals
- collaboratively set shared plans of care
- support shared decision-making
- share responsibilities for care across team members
- demonstrate respect for all team members including patients/clients/families (CIHC. 2010 p.16)

Did you know...

It may be professional misconduct to contravene a standard of practice of the profession or a published standard of the College, or failing to maintain the standard of practice of the profession (see the [Professional Misconduct Regulation](#)).

The College's [Standards of Practice](#) document includes professional practice standards directly related to documentation for example:

- documenting all patient/client contacts as soon as possible, including the transcription of orders
- reporting and documenting all adverse events/near misses and intervening in situation where the safety or wellbeing of the patient/client is unnecessarily at risk

■ **Communication and Continuity of Care**

A primary purpose of health records and documentation is to facilitate the communication between health care providers to ensure the continuity of care. As a key mode of communication, any health care provider reading the health record must be able to understand what has been recorded. An accurate and comprehensive record of the patient status, interventions and responses acts to facilitate team decision-making regarding a plan of care.

■ **Professional Accountability**

Documentation also serves as written evidence of the care provided to the patient/client. As such CRTO Members are professionally accountable to the patient/client, your interprofessional colleagues, the employer and the College. Documentation is often an important factor in legal proceedings, law suits and College disciplinary proceedings. Complete and objective documentation provides legal evidence that may protect CRTO Members.

■ **Research**

Health Records and accurate documentation provide a valuable source of data for health research activities.

■ **Quality Improvement**

Documentation provides evidence to support facilities' and Member CQI activities such as length of stay (LOS) audits, chart audits, peer review, performance reviews, accreditation, benchmark studies and establishment of best practice.

THE PRINCIPLES OF HEALTH RECORDS DOCUMENTATION

Effective written communication or documentation is essential to the continuity of care of patients/clients. Regardless of the practice setting (ICU, home care, outpatient clinic, operating room (OR), diagnostics, research) the principles of documentation of the health record are the same. Although we acknowledge the challenges associated with documenting in areas such as the OR and home care, we encourage all Members to find solutions to these challenges. This might include developing a practice specific form or at minimum, using a generic progress notes form to document.

Did you know...

[SBAR](#) is an evidence based, structured communication tool supported by the [Canadian Patient Safety Institute](#) (CPSI) to improve quality of care and patient safety by enhancing effective interprofessional team communication. SBAR (Situation, Background, Assessment, Recommendation) can be used by health care professionals to communicate verbally and/or when documenting in the health record (CPSI, 2007).

You can use SBAR to communicate about patient care or an equipment malfunction... give it a try.

Effective documentation forms the basis of any health record and must be:

- clear, concise, comprehensive, cohesive and courteous
- accurate
- relevant
- objective
- permanent
- legible
- chronological
- timely

Standards

Effective documentation is essential to continuity of care and is the primary mode of communication among health professionals. There are eight basic standards related to documentation based on the expectation that anyone reading the record should clearly and specifically be able to determine:

1. what happened
2. to whom it happened
3. by whom it happened
4. when it happened
5. where it happened
6. why it happened
7. the result of what happened
8. that the documentation was entered in a manner that prevents or deters alteration

In practical terms, with respect to patient records, this means that no matter what type or kind of charting is used in your facility, anyone reviewing the chart must be able to determine that the above standards have been met. An employer's policies and procedures related to documentation should support the eight standards as outlined above.

APPLYING THE STANDARDS

What happened – Patient/Client Contacts

It is important to accurately and completely record what you saw, heard or did. The health record becomes the historical reference of activity and it must be easy for a person reading your entry to clearly understand exactly what happened.

The professional standard of practice is that every patient/client contact be documented.

Methods of patient/client contact include: in person, telephone, fax, mail, electronic mail, video conference, and telemetry.

A patient/client contact can include contact for the purposes of performing an examination, diagnostic procedure, therapeutic intervention or providing education to a patient/client and/or his or her family, caregiver and/or advocate.

Other examples of patient/client contacts include:

- clarification of a medical order with the prescriber;
- linking questions and answers between the prescriber and patient/client;

APPLYING THE STANDARDS (continued)

- guidance for preventative medication, follow-up, re-assurance and explanation of diagnostic and therapeutic procedures;
- obtaining consent;
- discussions with the patient/client, his or her family members, caregivers and/or advocates, regarding a patient/client's state of health and/or any recommendations made regarding the direction of the required care; and
- orders received from a prescriber and pursued by a Member are also considered patient/client contacts.

To whom it happened

Health records may become separated therefore ensure that identification information is on each page of the patient record. The standard is that anyone reading the documentation must clearly be able to identify the object of the activity.

By whom it happened

Anyone reading the documentation must clearly be able to identify the individual performing the activity or making the recording, while at the same time be assured that there is a unique identifier for that person (e.g., signature). This means that a CRTO Member should provide a signature at the end of the entry with at least a first initial, last name and professional designation (abbreviation is acceptable).

Initials and professional designation are sufficient when using an attached 'signature record'. If a signature record is not utilized, printed name should be included if a signature is not readily legible.

Do not document for someone else. There may be instances when it becomes necessary to document observations on care provided by others, e.g., a family member witnesses a patient/client fall, an unregulated care giver reports observations from his/her care, or documenting during a cardiac arrest. It has to be clear who had the first-hand knowledge of the event, who performed the activity and who recorded the activity.

Signatures

A signature (and/or initials) attests to the information provided and gives assurance that the record of activity, assessment, behaviour or procedure is accurate and complete. CRTO Members must not, under any circumstances, give permission to anyone else to sign their name to a document and Members must not sign someone else's name to a document.

Don't Forget...

To keep up with the signature sheet that links your initials to your name and designation. For example, you may have to 'sign in' with the date, your printed name, your signature your designation and your corresponding initials at the beginning of every shift to enable you to use your initials on a patient flow sheet.

DIRECTLY SUPERVISING ANOTHER CRTO MEMBER OR STUDENT RESPIRATORY THERAPIST (SRT)

An example of **direct supervision** would be a supervising RRT, physically observing and guiding the performance of arterial blood gas procurement by a RRT with the Term Condition, Limitation (TCL) on their certificate of registration that they “may only perform a controlled act, authorized to Respiratory Therapy, for the purpose of gaining competence in that procedure if performed under the direct supervision of a regulated health professional who is authorized to perform the controlled act.”

An example of **indirect (general) supervision** would be a GRT applying CPAP to a new patient/client while the supervising RRT is available in person within 10 minutes, to assist the procedure.

Did you know...

When RTs observe Student Respiratory Therapists i.e. SRTs (or other RTs practicing under direct supervision), they are required to co-sign all documentation. When documenting electronically this means that the RT and the SRT must ensure that they each have unique and permanent signatures attached to each entry. In some cases this may require each person to login separately with their own user IDs/usernames and passwords to indicate that they are separate people.

RTs must not chart on behalf of the person they are observing under direct supervision. Charting the name of the SRT's in a free text box under your name does not permanently link the SRT's to that entry.

If someone were to look back at the entry, it would appear that what took place was linked only to the RT who logged-in and charted. It must be clear who did what.

Where a student or Member is performing procedures under **direct supervision**, the Member or student must document in the patient/client's health record that they have performed the procedure(s) under 'direct supervision'. It is the responsibility of the Member or student carrying out the procedure(s) to ensure complete documentation of the patient contact in the patient/client record. This includes having the supervisor co-sign the entry in the patient/client record. Anyone reading the documentation must clearly be able to identify that the requirements of 'direct supervision' have been met. Furthermore, the Member/student's signature and that of the consigning supervisor's verifies the information provided and gives assurance that the record of the activity, assessment, behaviour or procedure is accurate and complete. (Reference: [CRTO's Supervision Policy](#))

The CRTO recognizes that common RT flow-sheets used in critical care areas such as ICU and NICU may not provide enough space to permit Members to explicitly state that the activity was done under direct supervision. We suggest that you may want to reference somewhere in the patient/client health record that where 2 initials are present, as indication that direct supervision took place.

Where activities or procedures are being done under general supervision, NO co-signatures or co-initials are required. Co-signing in this case may, in fact, be confusing, what does the co-signature mean? Only the person who performs the activity/procedure or who has the patient contact should document and sign the entry. For example, an RT student in their final rotation of their final year of study may be performing some activities under “general” supervision – i.e. the supervising RT is not physically accompanying and observing the activity. This situation would be acceptable if the SRT has proven themselves competent and accountable. In this situation, since the activity is being done under “general” supervision (not under direct supervision), co-signing is not required.

APPLYING THE STANDARDS (continued)

When it happened

Documentation should be timely and chronological. Common sense suggests that the longer the time between the activity and the recording of the activity, the more likely the possibility of errors. Health records must be completed as soon after the event as is possible and you are obliged to complete the record before you “finish your shift”. **DO NOT** document before giving patient/client care.

Documentation that is chronological lends credibility to the accuracy of the record. The date and time must be included in all entries and must be unambiguous. For example, 1:45 may be 1:45 a.m. or 1:45 p.m.; therefore the use of the 24 hour clock is encouraged. (For example 0145 or 1345).

Late entries must clearly be identified as late entries and note the time of the event and the time of the late entry as well as the appropriate identification. Documenting activities out of chronological order may suggest that the record is not accurate. This suggestion may be tempered by appropriately recorded late entries.

Never leave blank lines for someone else to insert notes. If there are blanks in your record remember to put a single line through the area to ensure yourself and anyone reading the record that there was no opportunity to alter the original record. Inserted text or text that extends beyond the recognized writing or recording area may also suggest that the notations were made as an afterthought or to cover-up activities.

Where it happened

The record should reference where the patient /client received the intervention unless the location is ‘normal’ for that patient/client. For example, if a treatment was administered in a sun room or patient recreation area, or if advice was given to a patient/client over the telephone, the record should state so.

Did you know...

RTs are required to document according to the same professional standards whether they are treating an in-patient or out-patient. For example whether you are taking an ABG in your hospital's ICU or in your hospital's outpatient PFT clinic, all of the standards for documentation must be met.

Working in the community

RTs working in practice settings such as doctor's offices, dental offices or patient outreach clinics (e.g., asthma education/smoking cessation) are accountable to ensuring that all patient/client contacts are documented according to professional standards. It may be up to you to ensure that there is an appropriate charting system in place or to develop one. RTs are encouraged to use the College's standards of practice to support them in advocating for the tools they need to practice accountably.

APPLYING THE STANDARDS (continued)

Why it happened

The reason or purpose of the intervention should be included in your documentation. Is the intervention a routine visit, as a result of diagnostic tests, to perform diagnostic testing, as a result of an improvement or deterioration in status or as a result of a medical directive or an RT protocol? Why did you do what you did? If you are administering a plan of treatment, it would be appropriate to document why the plan of treatment is being initiated the first time and then only make note of "why" if there is a specific reason to.

The result of what happened

What was the result of your intervention? How did the patient/client respond to the intervention? What did you do or propose as a result of the intervention?

The documentation was entered in a manner that prevents or deters alteration

Health records must be created in a permanent format (e.g., using a pen instead of a pencil).

Corrections in a health record must be made in an honest and straightforward manner. Notes that have been erased or obliterated suggest that there is something to hide.

When you are correcting an entry make sure that the mistake is still legible (e.g., draw a single straight line through the entry). Initial the error and note that it is an error or draw attention to the correction. Do not use "white-out".

CONTENT OF A PATIENT/CLIENT HEALTH RECORD

Unless it is inconsistent with other legislation covering the health record such as the [Public Hospitals Act](#), the [Independent Health Facilities Act](#) or the [Long Term Care Act](#), an acceptable patient/client's health record includes the following:

- a unique identifier for the patient/client
- the patient/client's name and home address
- the patient/client's date of birth and gender
- the patient/client's health number
- the name of the primary care physician and any other health professional if applicable
- the name of any attending or referring physician or health professional
- the reason for referral if applicable
- the date and time for each patient/client contact
- a clinically relevant history of the patient/client
- information about every patient/client visit and examination, assessment intervention, diagnostic procedure performed by the Member and reasonable information about every clinical finding and assessment made by the Member (e.g., strip recordings)
- medical orders
- information about all advice and instruction given by the Member to the patient/client and/or family Member, advocate or caregiver by any method (e.g., in person, telephone, email)
- information about every referral of the patient/client by the Member to another health professional
- a financial record if the patient/client is charged a fee
- information about a procedure or plan of care that was commenced but not completed, including the reasons for non-completion and the original of any written consent
- any reason a patient/client provides for canceling an appointment

Privacy legislation requires that in accordance with the organization's policy and procedures, facilities must provide an opportunity for a patient /client to add his or her information if the patient or client disagrees with the content of the record. This may be accomplished by allowing the patient or client to read the record if they request and providing an opportunity for them to make notes in the record should they wish (Please see [CRTO Guide to Ontario's Privacy Legislation PHIPA](#) for further details).

ABBREVIATIONS

To be understandable, records must use standard abbreviations and be correctly spelled. Abbreviations may vary from place to place. It is the Member's responsibility to ensure that the abbreviations being used are accepted in the facility where the record is being used. The CRTO does not provide a list of acceptable abbreviations.

It is acceptable to use an abbreviation where it is spelled out in full the first time the abbreviation is used in a notation. Whenever numbers are used make sure units are included where needed to ensure that there is no potential for misinterpretation. When referring to drugs and drug dosages you must always include the units along with any numbers. Again it is accuracy and clarity that is the issue. In the interest of conciseness and accuracy only repeat information when it is necessary.

WHAT DO I DOCUMENT ABOUT CONSENT?

You are not required to document consent although you may choose, under some circumstances to do so. Typically the greater the risk associated with the intervention the more likely it is that one would document consent. When documenting consent you may note "Patient/client gave informed consent".

When written consent is required, by legislation or employer policy, for an intervention you are undertaking, the CRTO Member must ensure that there is a signed consent prior to the intervention being initiated. Refer to the practice guideline on [*Responsibilities Under Consent Legislation*](#) for more information on consent.

WHAT DO I DOCUMENT IF A PATIENT/CLIENT CHOOSES NOT TO ACCEPT A TREATMENT/INTERVENTION?

Patients/clients have the right to refuse or withdraw their consent to treatment at any time provided they are deemed to be capable of giving or withholding consent (see [Responsibilities Under Consent Legislation](#) practice guideline). If a patient/client chooses not to accept a proposed intervention, document the:

- date and time
- a description of the proposed intervention and reasons given for it
- reason(s) given by the patient/client
- information that may have been given for the proposed intervention and the possible outcomes of patient/client not receiving the proposed treatment
- individuals that were informed about the patient's decision (e.g., prescriber)
- recommendation for alternatives if any.

If there is an immediate risk to the patient/client as a result of not receiving the intervention, the prescriber should be notified immediately but the decision of the patient/client must also be adhered to and supported.

CHARTING STYLES

Different facilities set their own requirements for documentation and evaluation, but all must comply with legal and professional standards. You may select a style of charting that fits with your practice provided that it adheres to these standards. If your facility has chosen a particular documentation style, ensure that you understand these requirements.

A traditional documentation style is the narrative form which includes progress notes and flow-sheets. Alternative documentation styles such as the Problem-Oriented Health Record (**POHR**), Focus charting (e.g., Data, Action, Response (**DAR**)), Charting by Exception (**CBE**) are all acceptable, provided efforts are made to meet the set documentation standards. [see glossary for a description of these alternative forms of documentation]

CERTO Members are encouraged to meet with their employers and health records professionals to ensure that the documentation standards are met.

ELECTRONIC HEALTH RECORD

The principles and standards relating to health records are the same regardless of whether you are using a written/paper record or an electronic health record (EHR). Some challenges to consider related to electronic health records are:

- security/access to information
- privacy and confidentiality
- the protection of critical information (e.g., which health care providers may 'see' information about mental health or abuse within the EHR)
- how health information is backed up and stored
- sharing of information/transfer of electronic information

Members are encouraged to liaise/communicate with their information technology (IT) and health records departments to examine the issue of concurrently meeting different health care professionals' standards of practice and to review organizational policies and procedures with respect to the privacy and protection of personal health information. It is up to RTs to advocate for documentation systems that meet their professional standards when challenges and gaps are identified.

To avoid any suggestion of alteration, EHRs must ensure that there is a system that maintains an audit trail. Each RT should have his/her own unique and permanent electronic signature that links them to their entries in the electronic health record. All types of patient contacts must be entered and it is strongly suggested that RTs have a place to include narrative text to accompany data entry of monitoring and results.

Another element to consider with the EHR audit trail is preserving the original content of an entry when a change or update is made. This concept is similar to drawing a line through a written entry and initialling the error on paper.

It is critical to ensure that there is a back-up system and plan in place in the event of an emergency or system failure. Consider where and how will you document if there is no access to the EHR.

Tips:

- Ensure that your electronic signature is unique and permanent
- Never share user IDs/login information, passwords or other access mechanisms or use someone else's
- Use passwords that are difficult to guess and change passwords frequently (or as required by institutional policies)

ELECTRONIC HEALTH RECORD (continued)

- Know who is authorized to access confidential information and specific areas of the patient's ERH at your workplace
- Log off when not using the system or when leaving the computer terminal
- Maintain privacy and confidentiality of information when electronic data is being printed or reproduced in hard copy (e.g., CD)
- Take care to ensure that all documents containing personal information that is displayed on the computer monitor cannot be viewed by unauthorized persons (i.e., that monitor screens are not visible from public areas, there is use of screen savers, and that you log off when you are not using the computer or leaving the terminal)
- Ensure your screen savers are password protected
- Ensure that your system does not permit you to delete information once you have entered it
- Know your limitations to accessing information only access patient/client records on a need to know basis
- Encrypt emails and/or other documents being transferred electronically that contain personal health or other confidential information
- Ensure that sufficient backup systems are in place to prevent any loss of information

Did you know...

You must obtain permission to access your own health records from the Health Information Custodian.

WHAT DO I DOCUMENT IF I DISAGREE WITH AN ORDER OR PLAN OF TREATMENT?

Subjective vs. Objective Documentation – Opinions vs. Facts

“the patient was sad” versus “the patient was crying” (observation)

“the patient appeared uncomfortable” versus “the patient complained of SOB and was dyspneic with movement” (symptom and sign)

“this treatment was not in the best interest of the patient” versus “the treatment was not performed because...” list the facts (your rationale remains factual)

“the doctor is aware” versus “I informed Dr. Smith of the change to the patient's status as charted in the flow sheet, by telephone” (details are accurate and complete)

Disagreements may arise between health professionals. There may be disagreements in a specific component of the care despite the fact that the outcome goals are the same. The treatment or intervention should always be in the patient/client's best interest. If you feel the proposed treatment or intervention is detrimental, your professional obligation is to the patient/client and your standards of practice and you should not perform the treatment or procedure. There are no activities authorized to respiratory therapists that cannot be performed by other regulated health professionals.

If a disagreement about treatment or intervention occurs be professional, and remain objective;

- do not involve the patient/client in the disagreement if at all possible
- contact the prescriber to discuss the rationale and reason for the difference of opinion
- document refusal to provide treatment and that notice was provided to the prescriber
- document your rationale for refusing to provide the treatment or intervention
- if refusal of treatment is potentially detrimental to the patient/client, contact the prescriber and try to negotiate an alternate care plan

For more information regarding documentation and orders for care including clarifying valid orders and transcribing verbal and telephone orders, please refer to the Professional Practice Guideline [Orders for Medical Care](#).

OTHER CIRCUMSTANCES

Medical Directives and RT Protocols

If CRTO Members are providing care under the authority of a medical directive they should reference this in the patient/client health record. To ensure continuity of care and appropriate communication to other team members the respiratory therapist should indicate in the patient record (e.g., medical order sheet or progress note/flow-sheet) that they have initiated a procedure/intervention according to the approved medical directive. It is a good idea to state the name of the medical directive and any corresponding number (e.g., Mechanical Ventilation Medical Directive, #00-001) It is also recommended that a copy of the medical directive be included in the patient record or if that is not feasible, reference to where this approved medical directive can be located.

Withdrawal of Care/Services Due to Abuse or Violence

Withdrawing or withholding care or services from a patient is not common and only used as a last resort in a strategic plan for managing abuse/violence but may become necessary if there is a significant threat or risk of serious injury to a Member of the staff, fellow patient or a visitor. Balancing the patient's interest in receiving care against the risk of harm to others is particularly difficult in situations where the care is necessary or time sensitive. Where it becomes necessary to withdraw or withhold care/services, documentation should include the following:

- the date and time
- your decision and rationale in addition to communicating this directly to the patient
- specifics as to why the care/service is being withdrawn
- the process used by you (i.e., employer established guidelines for managing violent or abusive behavior by patients) including all attempted efforts to resolve the situation
- the circumstances leading up to and including the withdrawal of care/service including the information given to the patient of the action that will be taken if the behavior continues
- the potential consequences of the withdrawal of care
- the expected standards that must be observed by the patient to return for care in the future if applicable
- an alternate provider of care/service or the efforts made to refer the patient to alternate providers (if appropriate)
- to whom you have notified (patient/client, physician, charge nurse, police, security, etc.)

For more information and scenarios regarding the ethics of withdrawing or withholding respiratory therapy care and services please refer to the College document [*A Commitment to Ethical Practice*](#).

A Code Blue or Code Pink Sheet may not provide enough space for you to document what you have done and to meet your professional standards for documentation. In addition, the observer/recorder may not have provided enough specific documentation to reflect what you did as the RT.

What if you encountered a difficult intubation for example?

You may need to provide a more detailed account of what happened, what you saw and what your actions were. RT specific documentation related to the difficult intubation will certainly be important when it comes time to transfer or extubate the patient.

Adding a separate entry to the patient's health record (e.g., in the patient progress notes) will facilitate interprofessional communication especially of details that could be key to safe patient care in the future.

Anyone looking back at the “story” of what happened during the code should be able to tell from the documentation that the RT used sound professional judgement and acted in the best interest of the patient at the time.

OTHER CIRCUMSTANCES (continued)

Cardiac arrests

Most hospitals have protocols and procedures for documenting cardiac and respiratory arrests. It is important to document all drugs administered, defibrillation attempts, endotracheal intubation and any other intervention you perform. The date, time and outcome of all interventions must be recorded.

You should document your activities at the arrest on the patient/client's chart. Alternatively, you may sign the arrest documentation with your name and designation to signify your agreement with the accuracy of the content of the record. If the arrest record needs to be modified to reflect your role at the arrest, you should ensure that the record is changed in an appropriate manner.

Transports

Documentation related to a patient/client transport should include the particulars of any interventions and/or monitoring performed during the transport and the details of the transfer of care at the end of the transport. The type of transport should also be documented (e.g., *intra-hospital, inter-hospital, air, land*).

Telephone Practice

The principles and standards related to documentation of telephone practice is the same as that for face-to-face practice. The following elements should be documented:

- time and date of the contact
- location of the caller (if applicable)
- name of the patient/client and their date of birth (DOB)
- name of caller and relationship to the patient/client, and whether the patient/client has consented to the call/email
- reason for the call
- information given by the patient/client or caller
- symptoms as described by the patient/client or caller
- advice or information given
- any follow-up required
- signature and designation

Consider using a log book for this purpose and advocating with your employer to develop standards around telephone and email practice.

OTHER CIRCUMSTANCES (continued)

Point of Care Testing

Record keeping for point of care testing should be treated in a way consistent with the legislation [and/or this guideline](#). Demographic information, date, time and identity and the credentials of the person performing the procedure must be documented [and included directly on the test results](#). Results obtained from the point of care testing should be clearly distinguishable in the health record from those obtained from other sources. Records of quality control results and proficiency testing performance should be maintained for each device.

CRTO Members are encouraged to seek clarification from their employers regarding any requirements when using thermal paper for printing test results (for example – bedside spirometers, oximeters and other diagnostic equipment). Thermal paper degrades over time and has a relatively short shelf life; therefore, many facilities are now stipulating that any test results printed on thermal paper should be photocopied to ensure the record is viable for the length of time the health record must be kept according to legislation.

Incident reports

An incident report is generally an internal document that does not become part of a patient health record. It is however, a record that is subject to all of the standards of documentation. If you complete an incident report, it is important to remember that the information about the incident should also be included in the patient/client's chart.

ADDITIONAL CONSIDERATIONS

Confidentiality and Privacy Issues

[Circle of Care – Sharing Personal Health Information for Health Care Purposes](#)

“The term “circle of care” is not a defined term in the *Personal Health Information Protection Act*, 2004 (PHIPA). It is a term commonly used to describe the ability of certain health information custodians to assume an individual’s implied consent to collect, use or disclose personal health information for the purpose of providing health care, in circumstances defined in PHIPA.”

To find out more visit the Information and Privacy Commissioner of Ontario at: www.ipc.on.ca

All Respiratory Therapists must ensure patient /client confidentiality. As such, Respiratory Therapists may only share patient/client information with the consent of the patient/client or where permitted by law. Examples include the sharing of such information if reasonably necessary for the provision of health care (providing information to another member of the health care team) or when the reporting of health information is required by law (as part of an investigation under the *Regulated Health Professions Act*; reporting of suspected child abuse under the *Child and Family Services Act*).

The *Personal Health Information Protection Act*, (PHIPA) 2004 provides specific guidance for handling the collection, use and disclosure of personal health information by information custodians. Respiratory Therapists who are employees of hospitals or most other facilities are not custodians but “agents” of organizational custodians. Therefore, it is the organizational custodian (employer) rather than the individual Respiratory Therapist who is responsible for developing policies and procedures for the collection, use, disclosure and protection of personal health information under the Act and for ensuring compliance. However, as an agent the Respiratory Therapist must comply with the custodian’s privacy practices when acting on the custodian’s behalf unless otherwise permitted by law. Respiratory Therapists who are self- employed or are employed by others who are not health information custodians (e.g., an insurance company, a school board, industry) are considered to be health information custodians and as such are responsible for developing a privacy policy and ensuring compliance with PHIPA.

Members are reminded that confidentiality is not limited to sharing of health records with others, and should consider other potential breaches:

- discussing a patient/client in a public place such as elevator/cafeteria
- viewing a patient’s health record without authorization (including your own or that of a family member)
- leaving a patient’s health record unattended where it can be viewed by others (including a computer screen)

Members should take extra care when *faxing and receiving faxes* containing personal health and other confidential information by ensuring:

- there is a confidentiality message on the fax cover sheet indicating that the information is confidential and if received in error the sender should be contacted and the fax destroyed securely without being read

ADDITIONAL CONSIDERATIONS (continued)

- the Fax number is confirmed by the recipient and double-checked by sender
- recipients are called in advance when a highly confidential fax is being transmitted
- receipt of fax is confirmed by the recipient
- the fax machine is securely located
- incoming faxes are distributed on arrival
- outgoing fax cover sheets are marked “confidential”
- any outgoing fax is collected after transmission

When *transporting* confidential health record information (for example from a home care company to patient/client’s homes), Members should ensure that health records are secured in a locked container, kept out of sight, and that vehicles are securely locked.

Record Retention

Members who are employed in Ontario hospitals should be aware that the *Public Hospital’s Act* states that patient/client health records be maintained for at least 10 years from the date of the last entry in the record. In addition, the health records of patients/clients who were under age 18 at the time of the last entry ought to be retained for a minimum of 10 years from the day the patient/client turns 18.

Members working in other practice settings are encouraged to confirm their employer’s policies regarding record retention and to refer to legislation that outlines record retention provisions.

If there are no other legislative or employer requirements in place then we suggest that CRTO Members maintain patient/client health records for at least 10 years from the date of the last entry in the record. Health records of patients/clients who were under age 18 at the time of the last entry should be retained for a minimum of 10 years from the day the patient/client turns 18.

OTHER FORMS OF DOCUMENTATION

Kardex, worksheets, report sheets, quality assurance, maintenance records, stats (workload measurements) may be treated as part of a patient/client health record. Check with your employer for any policies or procedures around these types of documentation and always chart professionally and err on the side of caution.

GLOSSARY

College/CRTO	College of Respiratory Therapists of Ontario
CBE	“Charting by Exception” charting system used in patient/client health records. CBE requires a detailed plan of care or care map, and includes flowsheets, graphic records and progress notes that may take the format of SOAP.
DAR	charting “Data, action and response” format used in progress notes in a focus charting system
Document (verb)	To formally record information, usually in a permanent, legally acceptable fashion. It may be in an either written or electronic format.
Focus Charting System	A health record charting system which includes flow-sheets, checklists and progress notes that take the format of DAR (data, action and response).
HCCA	<u>Health Care Consent Act</u>
Kardex	Originally, the proprietary name for a filing system for nursing records and orders that was held centrally on the ward and contained all the nursing details and observations of patients that had been acquired during their stay in hospital. Although this system is no longer used for nursing records, since care plans are now held at the patient's bedside rather than centrally, the term ‘kardex’ continues to be used generically, for certain centrally held patient record systems.
Late entry	Entry into a record that is made more than thirty (30) minutes after the intervention occurred or when the entry is documenting events chronologically out of sequence
Medical Directive	A medical order for a range of patient/clients who meet certain conditions. The medical directive is the order and should therefore meet the criteria for a valid medical order. This includes the specific conditions which must be met for the medical directive to apply, a description of the patients it applies to, the name and description of the treatment/intervention being ordered, a lists of indications/contraindications, the identity of the individual(s) who are authorizing the medical directive (i.e. list of physicians) and a list of the individual(s) who are authorized to implement or carry out the order.

GLOSSARY

Patient contact	Contact for or with a patient/client and/or his or her family, caregiver and/or advocate for the purposes of performing an examination, providing a diagnostic procedure or providing an education, therapeutic intervention
PHIPA	<i>Personal Health Information Protection Act, 2004</i>
Prescriber	One who is authorized to order the administration of a treatment or intervention.
POHR	Problem-Oriented Health Record: a health record charting system which includes a plan of care, problem list and progress notes/discharge plans which take the format of “ SOAP ” (Subjective data, Objective data, Assessment data and Plan), “ SOAPIE ” (Subjective data, Objective data, Assessment data, Plan, Intervention and Evaluation) or “ SOAPIER ” (Subjective data, Objective data, Assessment data, Plan, Intervention, Evaluation and Revision/Recommendations).
RT Protocol	Respiratory Therapist Protocol: A type of direct medical order which outlines the framework and provides guidance for respiratory therapists to deliver care only to the patient/client they are ordered for. A common example of an RT protocol is one for ventilation-weaning whereby the RT may perform certain interventions/procedures on the patient/client based on pre-set parameters as outlined and described in the protocol.

REFERENCES

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NOTES:



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This practice guideline will be updated as new evidence emerges or as practice evolves. Comments on this practice guideline are welcome and should be addressed to:

Professional Practice Advisor

College of Respiratory Therapists of Ontario
180 Dundas Street West, Suite 2103
Toronto, Ontario
M5G 1Z8

Tel (416) 591 7800
Fax (416) 591-7890

Toll Free 1-800-261-0528
Email questions@crto.on.ca