College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

CONDUCT COUNTS!

Documentation

SCENARIO

Meet Jane. Jane loves her job, Jane loves her patients, charting...not so much. On this particular day, it was busy in Jane's unit. Jane was assigned to multiple patients and due to the busy nature of the morning, she didn't have time to document all her interventions and communication with patients. She was planning to chart during her lunch break, but then she found out her colleagues were going out to eat and decided to join them. At the end of her shift, Jane stayed late and caught up on her charting. However, as so often happens, a person's memory isn't the best at the end of a long 12-hour shift. Jane completely forgot to document a vital conversation she had with a patient's family about what the next steps would be in the care of the patient. This conversation included the family consenting to initiating invasive ventilation on the patient, who was unconscious at the time.

RESULTS

Sadly, that patient passed away the following week. About a month later, Jane was notified that a complaint had been made about her practice with the CRTO. It was alleged that Jane had failed to inform and receive consent from the family of the patient, (one of whom was the Power of Attorney (POA)), prior to initiating invasive ventilation.

As part of the mandatory follow-up done by CRTO, an investigation was launched into the conduct of Jane. Her co-workers were interviewed, but they could not shed any light on what occurred, as they were not in the room with the Jane and the patient's family. The patient's family members were interviewed, and all three stated that they did not have a conversation with Jane about treatment options and were not given a choice. CRTO investigators then combed through the health records of the patient, and to their surprise, there was no documentation regarding the conversation with the family or any documentation regarding the choice the POA made about the care of the patient. Only the fact that the intervention occurred was captured.

Jane was given an opportunity to respond, and, although she couldn't remember the specifics, she responded that she was certain she spoke to the family of the patient and clarified with them all options, and only proceeded with the treatment that the family thought was best.

With 3 witness statements of the family members stating that they were not advised of treatment options, and Jane's statement contradicting the account of the family, the Panel of the Inquiries, Complaints Committee gave more weight to the 3 different recollections of the event over that of Jane. The Panel concluded that Jane did not meet the Standards of Practice by failing to inform the family of treatment options and for not obtaining consent from the POA. Jane was asked to submit an essay on the importance of consent to treatment and communication with patient family. In addition, Jane had to complete a remediation program related to documentation. Jane was also asked to appear before the Panel to be cautioned about what had occurred.

PROFESSIONALISM

"Professionalism" or professional conduct is a term often used to describe the behaviours that are expected of individuals who hold a certain role in society. A "professional" is typically someone who has obtained skills that are recognized as requiring specific, intensive training and who applies those skills in a position impacting others (e.g., engineer, lawyer, RT, PT, MD, etc.). Professionals are often held to moral, ethical and legal standards because of this potential impact.

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EXPECTATION

Consider the following standard statement from the CRTO Standards of Professional Practice:

4. Therapeutic & Professional Relationships:

- Section 4.13: documenting **all** patient/client contacts as soon as possible, including the transcription of orders;

BOTTOM LINE

Chart, chart, and chart some more! It's an important aspect of the Respiratory Therapy profession. Not only is it best practice and helps with patient safety, but in this situation, it could have helped Jane a lot. Documenting as soon as possible, in the context of an investigation, is seen as being contemporises to the event. It can be relied on to be a more accurate representation of interventions and conversations than someone's recollection of that same event 2 months later. Jane has always paid attention to effectively communicating with patients and their families. But, a part of effective communication with patients and their families is to document the conversations, especially when consent to specific types of treatment is given. Remember, don't just document interventions, the CRTO reminds you that all patient contact should be document. If you didn't document it, as far as we know, it didn't happen!

RESOURCES

Documentation Professional Practice Guideline

CRTO Standards of Practice