College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

DOCUMENTATION

Practice FAQs **April 2012**

MYTH

Documentation means charting in the patient/client's medical record or chart.

ANSWER

In fact, the term 'documentation' not only refers to what is recorded in a medical or health record (e.g., the patient's chart) but also in the equipment maintenance records, shift or transfer of accountability reports, worksheets, the kardex and incident reports (*PPG Documentation*, 2011, p.3).

The CRTO is pleased to announce that the revised Professional Practice Guideline Documentation has been published on our website. Please *click here* to review the updated PPG which includes new information on documentation and:

- electronic health records,
- interprofessional communication,
- sharing of information and the circle of care,
- general vs. direct supervision,
- using communications tools to improve patient safety (e.g., SBAR), and
- subjective versus objective Charting.

In addition, the term 'documentation' can refer to keeping an account of your professional practice by keeping records of:

- giving and receiving *delegation*,
- competency and skills training you receive at work,
- certifications you achieve and maintain throughout your career (e.g., *CRTO Approved programs for Advanced Prescribed Procedures Below the Dermis*, ACLS, BCLS, CPR, NRP etc.),
- teaching, training and education that you provide as an *educator*,
- formal training and education that you participate in, and
- Quality Assurance activities in your PORTfolio learning log (e.g., self-evaluations, Take a Moment exercises, peer-reviews etc.).

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Committing to the standards of practice for documentation, and keeping good records of all aspects of your professional practice, demonstrates accountability to yourself, your patient's/clients, your peers and College, your employer and your profession.