College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

INACCURATE, INCOMPLETE OR FALSIFIED DOCUMENTATION

Practice FAQs **Summer 2015**

QUESTION

The other day one of the RTs in my department admitted that they completely forgot to do a blood gas. However, when I looked at the patient's chart I saw she had written that the patient had "…refused the procedure". I suspect that she lied in the chart to cover up her mistake. I am not sure if I should follow up with this or not.

ANSWER

As outlined in the recently revised *Documentation* Professional Practice Guideline (PPG), it is considered to be professional misconduct if an RT is found: "*falsifying a record relating to the member's practice*" (s.16 *Professional Misconduct*, O.Reg. 753/93).

The purpose of documentation is to provide a clear and precise record of what took place regarding a patient's care. Failing to document accurately – or worse, intentionally providing incorrect information – has the potential to cause the patient harm and is a very serious offense. In addition, all CRTO Members are accountable to the professional *Standards of Practice*, which states that an RT must "*refrain from making false, conscious, deliberately misleading or deceptive statements, orally or in writing*".

If you have a concern about an RT regarding documentation, or you wish to report a situation where documentation was incomplete, inaccurate or falsified, please contact the CRTO. On the CRTO website there is an online form for Submitting a Concern about an RT. You can also contact Melanie Jones-Drost (CRTO Deputy Registrar) at jones-drost@crto.on.ca or 416-591-7800 x 24 (1-800-261-0528).