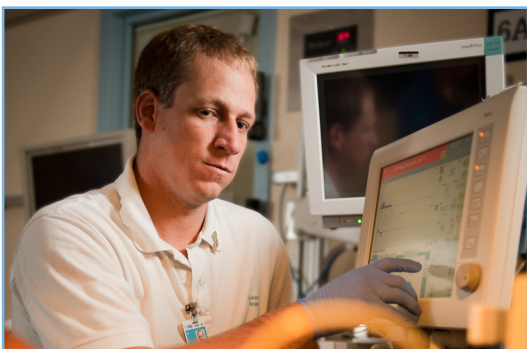
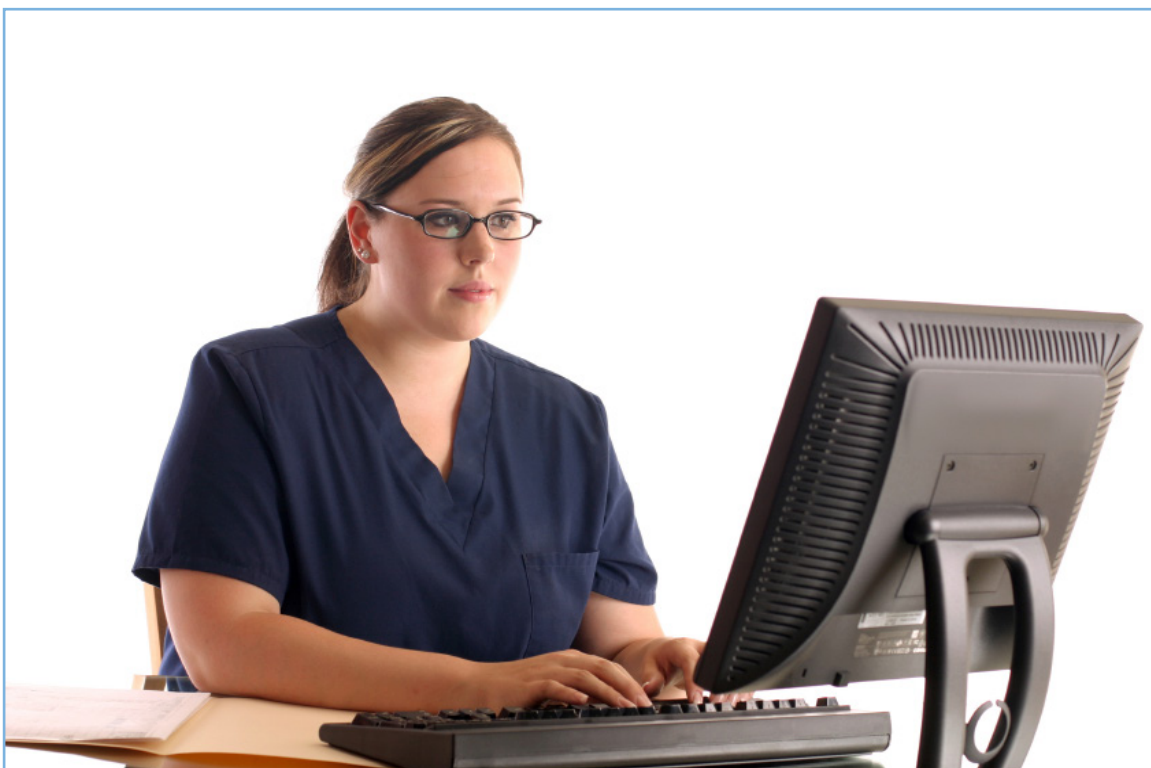


DOCUMENTATION

PROFESSIONAL PRACTICE GUIDELINE



PROFESSIONAL PRACTICE GUIDELINE

COLLEGE OF RESPIRATORY THERAPISTS OF ONTARIO (CRTO) PUBLICATIONS CONTAIN PRACTICE PARAMETERS AND STANDARDS SHOULD BE CONSIDERED BY ALL ONTARIO RESPIRATORY THERAPISTS IN THE CARE OF THEIR PATIENTS/CLIENTS AND IN THE PRACTICE OF THE PROFESSION. CRTO PUBLICATIONS ARE DEVELOPED IN CONSULTATION WITH PROFESSIONAL PRACTICE LEADERS AND DESCRIBE CURRENT PROFESSIONAL EXPECTATIONS. IT IS IMPORTANT TO NOTE THAT THESE CRTO PUBLICATIONS MAY BE USED BY THE CRTO OR OTHER BODIES IN DETERMINING WHETHER APPROPRIATE STANDARDS OF PRACTICE AND PROFESSIONAL RESPONSIBILITIES HAVE BEEN MAINTAINED.

RESOURCES AND REFERENCES ARE HYPERLINKED TO THE INTERNET FOR CONVENIENCE AND REFERENCED TO ENCOURAGE EXPLORATION OF INFORMATION RELATED TO INDIVIDUAL AREAS OF PRACTICE AND/OR INTERESTS. **BOLDED TERMS ARE DEFINED IN THE GLOSSARY.**

It is important to note if an employer's policies are more restrictive than the CRTO's expectations, the RT must abide by the employer's policies. Where an employer's policies are more permissive than the expectations of the CRTO, the RT must adhere to the expectations of the CRTO.

The CRTO will update and revise this document every five years, or earlier, if necessary. The words and phrases in bold lettering can be cross referenced in the Glossary at the end of the document.

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DOCUMENTATION

DEFINED

This Professional Practice Guideline (PPG) describes the professional and legal obligations of **CRTO Members** with respect to **Personal Health Records (PHR)** and documentation.

For the purpose of this PPG, the term Personal Health Record' or "PHR" 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 the PHR but also in:

- equipment maintenance records;
- transfer of accountability (TOA) reports;
- worksheets; and
- adverse event/critical incident reports.

There are various pieces of legislation that pertain to documentation, including (but not limited to):

- [Public Hospitals Act](#);
- [Independent Health Facilities Act](#);
- [Long Term Care Act](#);
- [Laboratory Licensing Act](#);
- [Personal Health Information Protection Act \(PHIPA\)](#);
- [Personal Information Protection and Electronic Documents Act \(PIPEDA\)](#); and
- [Excellent Care for All Act](#).

The CRTO's [Standard of Practice](#), which outlines the expectation of RTs when documenting states that:

“Patients/clients can expect that RTs keep complete, clear, timely, objective, and accurate records of the care provided and that privacy/confidentiality is protected.”

This *Documentation PPG* is intended to provide Members with information on the CRTO's expectations related to documentation. The CRTO has also developed several other relevant PPGs that may have complementary and overlapping information related to documentation, such as:

- [Interpretation of Authorized Acts](#);
- [Delegation of Controlled Acts](#);
- [Responsibilities Under Consent Legislation](#);
- [Responsibilities of Members as Educators](#); and
- [Orders for Medical Care](#).



MYTH:

“Only the information contained within a patient’s chart can be used in a court of law”

FACT:

All patient/client information that is either electronically or paper generated is part of the personal health record and can potentially be used in a court of law.

CHARTING STYLES

RTs may select any style of charting that fits with their practice, provided that it adheres to both the standards, expectations and requirements of both the CROTO and the employer. Examples of different charting styles are:

- DARP (Data, Action/Analysis, Response, Plan)
- SOAP/SOAPIE(R) (Subjective, Objective Data, Assessment, Plan, Intervention, Evaluation, Revision)
- Narrative charting, which includes progress notes and flow-sheets; and
- Charting by Exception

CROTO Members are encouraged to work with their employers and health records department to ensure that all the requisite documentation standards and requirements are met.

PURPOSE OF DOCUMENTATION

COMMUNICATION

The primary purpose of documentation is to facilitate ongoing communication that supports the continuity, quality, and safety of care. As a key mode of communication, any health care provider reading the PHR must be able to understand what has taken place, who was involved and what the outcome for the patient/client was. An accurate and comprehensive record of the patient status, interventions and responses helps to facilitate collaborative decision-making regarding the ongoing treatment plan.

EVIDENCE OF CARE

Documentation also serves as written evidence of the care provided to the patient/client. Complete, accurate and objective documentation is important for many reasons; one of which is that it provides essential evidence that is often required in legal proceedings (e.g., civil court), as well as the CRTO's complaints and discipline process.

RESEARCH & QUALITY IMPROVEMENT

Aggregate data collected from a patient's PHR (e.g., chart audits; length of stay (LOS) audits) provides valuable information for health research activities. This research contributes to Continuous Quality Improvement (CQI) initiatives (e.g., Asthma Care Pathways, readmission outcomes) that are aimed at improving health care outcomes for all patients/clients.

PRINCIPLES OF DOCUMENTATION

Documentation is effective when it enables members of a patient/client's health care team to have access to the information needed to deliver optimal patient/client care (for both present and future needs). Regardless of the practice setting (ICU, home care, emergency, outpatient clinic, **primary care**, operating room (OR), diagnostics, research), the principles of PHR documentation are the same. The CRTO acknowledge the difficulties often associated with documenting in areas such as the OR, emergency, home care and patient transport. However, we encourage all CRTO Members to work with their employer to find solutions to these challenges.

Effective documentation forms the basis of any PHR and must be:

- Clear, concise, comprehensive and courteous;
- Non-discriminatory;
- Accurate;
- Relevant;
- Objective;
- Permanent;
- Legible;
- Chronological;
- Identifiable, containing a signature or audit trail that identifies the author;
- Timely; and
- Entered in a manner that prevents or deters alteration.

FOR EXAMPLE:

If three (3) attempts are required to successfully intubate a patient, then all three (3) attempts should be documented.

Conferring with other members of the health care team (including the patient/client's family members) regarding their orders or medical status is also considered to be a patient/client contact.

PATIENT/CLIENT CONTACT DEFINED

The professional standard of practice is that every contact between an RT and a patient/client must be documented. 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 their family, caregiver or advocate.

It is important to note that patient/client contact includes not only direct patient/client care, but also indirect contact regarding a specific patient/client, such as communication via:

- Telephone
- Fax
- Regular mail
- Email
- Electronic (including text, social media)
- Virtual (including video conference and telemedicine)



For information on the use of social media in professional practice, please view the [Use of Social Media by Respiratory Therapists Fact Sheet](#).

CONFIDENTIALITY & PRIVACY OF PERSONAL HEALTH RECORDS

All RTs must respect and protect patient /client confidentiality and privacy in every aspect of their practice. RTs can only share patient/client information with the consent of the patient/client, or as required where permitted by law. Personal health information should only be shared within the “circle of care” in the following circumstances:

- If reasonably necessary for the provision of health care (providing information to another member of the health care team)
- If required by law (e.g., as part of an investigation under the [Regulated Health Professions Act](#); reporting of suspected child abuse under the [Child and Family Services Act](#)); or
- To disclose a risk of harm as enabled [PHIPA](#) under section 40 (1) Disclosures related to risks, which states that:

40. (1) A health information custodian may disclose personal health information about an individual if the custodian believes on reasonable grounds that the disclosure is necessary for the purpose of eliminating or reducing a significant risk of serious bodily harm to a person or group of persons.

PHIPA provides specific guidance for handling the collection, use and disclosure of personal health information by information custodians. RTs who are employees of hospitals, or most other facilities, are not custodians but “agents” of organizational custodians. Therefore, it is the organizational custodian (employer) who is responsible for developing policies and procedures for the collection, use, disclosure, and protection of personal health information under *PHIPA*, and for ensuring compliance. As an agent, the RT must comply with the custodian’s privacy practices when acting on the custodian’s behalf, unless otherwise permitted by law.

RTs 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 therefore 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, such as:

- 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); and
- Leaving a patient’s health record unattended where it can be viewed by others (including a computer screen).

While less secure and reliable, many healthcare organizations continue to rely on fax machines for the transmission of patient information. 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;
- 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”; and
- Any outgoing fax is collected after transmission.

CIRCLE OF CARE – SHARING PERSONAL HEALTH INFORMATION FOR HEALTH CARE

PURPOSES [circle-of-care.pdf \(ipc.on.ca\)](https://www.ipc.on.ca/circle-of-care.pdf)

The term “circle of care” is not defined in *PHIPA*. However, 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](https://www.ipc.on.ca/).

PLEASE NOTE...

“Giving information about a patient or client to a person other than the patient or client or his or her authorized representative except with the consent of the patient or client or his or her authorized representative or as required by law” is considered to be professional misconduct. (s.11 [Professional Misconduct](#), O.Reg. 753/93).

When transporting confidential PHRs (e.g., from a home care company’s office to patient/client homes), Members should ensure that PHRs are kept out of sight and that vehicles are securely locked.

ELEMENTS OF DOCUMENTATION

CONTENT OF THE PATIENT/CLIENT PERSONAL HEALTH RECORD

Unless it is inconsistent with other legislation covering the health record, an acceptable patient/client's health record includes the following:

- Unique patient/client Identifiers, such as the patient/client's name and home address;
- Most responsible physician(s) (MRP) or other health professional(s), such as the name of the primary care physician;
- Reason for referral and diagnosis, if applicable; and
- Clinically relevant information regarding the patient/client, such as the date and time for each patient/client contact.

INACCURATE, INCOMPLETE OR FALSIFIED DOCUMENTATION

Documentation, or the lack of it, often plays a significant role in legal matters surrounding health care. In cases that are referred to the CRTO's Inquiries, Complaints and Reports Committee (ICRC), it has been noted that the amount of documentation is frequently not sufficient to accurately reflect what took place. All too often, there is little or no record of event or the RTs role.

PLEASE NOTE...

There have been several cases brought to the CRTO's attention where an RT has intentionally falsified a patient/client's PHR. This is a very serious offense, and it is essential that Members understand that the following is considered to be professional misconduct:

"Falsifying a record relating to the member's practice". (s.16 Professional Misconduct, O.Reg. 753/93).

CORRECTIONS TO THE MEDICAL RECORD

When it is necessary to correct an incomplete or inaccurate medical record, RT's must:

- Maintain the incorrect information in the record, label as incorrect (e.g. a strike through) and ensure that the information remains legible
- Date and initial the additions or corrections
- Notify any health care provider who may be impacted by the incorrect information

DICTATION

There are practice settings where an RT may be required to dictate their reports or chart entries. It is important that the reports generated are reviewed by the author for accuracy as soon as possible. RT's are encouraged to avoid the "dictated but not read" scenario.

ELECTRONIC HEALTH RECORDS (EHR)

Electronic Health Records (EHR) are electronic version of the paper chart, and therefore, are subject to the same professional regulations and standards as paper records (Paterson, 2013). EHRs often differ from one organization to another; however, they share some common elements:

- Unique identifiers (login and electronic signature);
- Audit trail to prevent alternation;
- Mechanisms to ensure security, privacy and confidentiality;
- System for backup and storage of data; and
- Process for sharing and transferring information.

USE OF TEMPLATES

The use of electronic record templates, particularly those with pre-populated fields, poses risks to accurate and complete medical records. In keeping with documentation requirements, RT's must verify that all entries are accurate, complete, and free from error.

ELECTRONIC COMMUNICATION

As the delivery of healthcare becomes more responsive and progressive, this type of communication has become vital. Methods such as email, text messaging, along with virtual healthcare through video conferencing platforms and telemedicine are considered to be patient/client interactions. Therefore, this type of contact must also be documented according to the same principles and standards as other forms of documentation. It is also important to document the mode of electronic communication (e.g. text, email). In addition, measures must be taken to protect the safety and security of this confidential information, such as those outlined in the CRTO Standards of Practice. RT's must "Protect against theft, loss or unauthorized use or disclosure of confidential patient/client personal information (e.g., passwords, encryption, systems for backup and storage, and processes for sharing/transferring information).

- Keeping login information confidential, passwords strong, and changing this information to align with your employer's policy;
- Sign off devices when not in use
- Using ID's, rather than patient identifiers, such as names, when communicating electronically
- Encrypting emails and/or other documents being transferred electronically that contains personal health or other confidential information.



For more information, please see the CRTO's [Orders for Medical Care PPG](https://www.crto.on.ca/Orders-for-Medical-Care-PPG) ([cрто.on.ca](https://www.crto.on.ca))

MEDICAL DIRECTIVES AND RT PROTOCOLS

If RTs are providing care under the authority of a medical directive, it is important to reference this in the patient/client's PHR and document the name and number of the medical directive. (e.g., Mechanical Ventilation Medical Directive, #00-001).

RETENTION OF PERSONAL HEALTH RECORDS

Members who are employed in Ontario hospitals should be aware that the [*Public Hospital's Act*](#) states that patient/client health records must be maintained for at least 10 years from the date of last entry in the record. In addition, the health records of patients/clients who were under the 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.

RTs 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.

ABBREVIATIONS

To be understandable, records must use standard abbreviations and be correctly spelled. It is acceptable to use an abbreviation where it is spelled out in full the first time it is used in a notation. Whenever numbers are used, make sure units are included where needed to ensure there is no potential for misinterpretation. When referring to drugs and drug dosages you must always include the units along with any numbers.

PLEASE NOTE...

Abbreviations may vary among different practice environments. 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.

DOCUMENTATION STANDARDS

Complete, accurate, objective and timely documentation is essential to the continuity of care and is the primary mode of communication among health professionals.

There are seven (7) basic standards related to documentation based on the expectation that anyone reading the patient/client's PHR should be able to clearly determine:

1. To **whom** it happened
2. **When** it happened
3. **What** happened
4. **Where** it happened
5. **Why** it happened
6. The **result of what** happened
7. **By whom** it happened

With respect to PHRs, this means that no matter what type or kind of charting is used at a particular 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 seven standards, as outlined above.

APPLYING THE DOCUMENTATION STANDARD

I. TO WHOM IT HAPPENED

The standard is that anyone reading the documentation must clearly be able to identify the patient/client who was the recipient of the health care services. Therefore, the PHR must contain Unique Patient/Client Identifiers, such as:

- Patient/client's name and home address;
- Patient/client's date of birth and gender;
- Patient/client's health number; and
- ID number.
- The patient/client's PHR must also include information as to who is/are the Most Responsible Physician(s) (MRP) (or other health professional(s), if applicable) such as:
 - The name of the primary care physician and any other health care professional (e.g., Nurse Practitioner); and/or
 - The name of any admitting, attending and/or referring physician or health care professional.
- Reason for referral and/or diagnosis.

PLEASE NOTE...

PHRs may become separated; therefore, it's important to ensure that required identifiers (e.g., name, date of birth, OHIP number) are on every page of the PHR and on each piece of document that pertains to that patient (e.g., ventilator flow sheet, overnight oximetry results).

II. WHEN IT HAPPENED

Documentation should be timely and chronological. Common sense suggests the more time that passes between the activity and recording it, the higher the possibility of errors. Documentation that is timely and chronological lends credibility to the accuracy of the record. The date and time must be included in all entries and must be unambiguous. The use of the 24-hour clock is encouraged.

PLEASE NOTE...

Health records must be completed as soon after the event as possible and you are obligated to complete the record before you “finish your shift”. Also, do not document before giving patient/client care.

LATE ENTRIES

If documenting after an amount of time has passed, the entry must clearly be identified as a late entry and should 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, and for that reason is not ideal. If using paper based PHRs, 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 there is not opportunity for the original record to be altered. Also, inserted text or text that extends beyond the recognized writing/recording area may also suggest that the notations were made as an afterthought or to conceal activities.

PLEASE NOTE...

A Late Entry is an 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.

III. WHAT HAPPENED

CLINICALLY RELEVANT HISTORY

An essential component of effective documentation is a comprehensive summary of the patient/client's clinical history. This should include such information as:

- date and time for each patient/client contact;
- information about every patient/client visit and examination, assessment, intervention, diagnostic procedure performed by the Member;
- information about every clinical finding and assessment made by the Member (e.g. ABG results);
- 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; and/or
- any reason a patient/client provides for cancelling an appointment, if applicable.

DOCUMENTING ABOUT CONSENT

Generally, there are three (3) situations that commonly arise regarding consent and documentation:

1. **Patient/client has provided their consent** to whoever proposed the treatment plan (usually the most responsible physician) and is someone other than the RT. This is commonly referred to as Third Party Consent. The patient/client appears to understand and agree to the plan. In this situation, the RT is not required to document consent, although in some circumstances it may be appropriate to do so. Typically, the higher risk associated with an intervention, the more likely an RT would document the consent.

FOR EXAMPLE:

A patient/client consents to a treatment plan that includes intubation and ventilation, if required. However, a family member feels that this course of action is futile and potentially harmful. The patient/client then goes into respiratory failure and the RT intubates them. In this scenario, it is likely important for the RT to document the conversation they had with the patient regarding their previous consent to the procedure.

THIRD-PARTY CONSENT

The [Health Care Consent Act](#) also allows for a plan of treatment to be proposed by one health care practitioner on behalf of the health care team involved in the plan. This is referred to as “third-party consent” and is acceptable practice provided the consent is informed and obtained prior to initiating the treatment.

2. **It is unclear whether the patient has provided consent** and the RT is the one performing the procedure. In this situation, the RT is accountable for ensuring that third-party consent has been obtained. If the RT has any doubt whether informed consent has been obtained, it is their professional obligation to obtain it and to document accordingly.

FOR EXAMPLE:

A patient/client shows up with a requisition for a cardiac stress test in a business suit and seems to have no idea what the test entails. In this scenario, the RT can assume that third-party consent has not been obtained and should provide the necessary information in order to obtain informed consent.

PLEASE NOTE...

When employer policy requires written consent for a given intervention (e.g., Pulmonary Function Test), the RT must ensure that there is a signed consent prior to the intervention being initiated.

For more information please see the CRTO [Responsibilities Under Consent Legislation PPG](http://cрто.on.ca) (cрто.on.ca)

3. In any case where **treatment is given without obtaining consent**, RTs should document their opinions with respect to the patient/client's capacity, as well as all actions taken.

FOR EXAMPLE:

A patient/client arrives in Emergency obtunded and requiring intubation. They are unable to consent to the procedure; however, delaying this procedure will conceivably result in harm to the patient/client. In this scenario, it is permissible under the *HCCA* to provide the necessary treatment, but the RT should still document their opinions with respect to capacity and all actions taken to obtain consent from a substitute decision maker, if available.

DOCUMENTING PATIENT/CLIENT'S DECISION TO NOT ACCEPT A PLAN OF 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 PPG](#)]. If a patient/client chooses not to accept a proposed intervention, document the:

- date and time;
- a description of the proposed intervention and the reasons given for providing 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); and recommendations for alternatives, if any.

REPORTING ADVERSE EVENTS AND CRITICAL INCIDENTS

Adverse events are all unintended injuries or complications that occur during the provision of health care services. Critical incidents are adverse events so severe that they result in the actual or potential loss of life, limb or physical function.

A patient safety or adverse event report is a record subject to all of the standards of documentation. If you complete an incident report, it's important to remember that information about the incident should also be included in the patient/client's chart.

CARDIAC ARRESTS

Most hospitals have specific protocols and procedures for documenting cardiac and respiratory arrests. It is the RT's responsibility to accurately document their activities at these events (e.g., medication administered, defibrillation attempts, endotracheal intubation, etc.). The date, time and outcome of all interventions must be recorded.

PLEASE NOTE...

When signing a cardiac arrest record, it is important to understand that you are attesting to the accuracy of that record. If the arrest record needs to be modified to reflect your role at the arrest, you should ensure that the record is amended in an appropriate manner.

END OF LIFE DOCUMENTATION

As part of the health care team (and in collaboration with patients/clients and their families), RTs are often involved in some aspect of end-of-life care (e.g., answering family member's questions about what to expect when life support is withdrawn). When a patient/client is going through the process of withdrawing care, clear and accurate documentation is essential. Unfortunately, research has demonstrated that this often is not the case. For example, a 2011 study published in the BMC Palliative Care Journal found a lack of a systematic approach to the recording of discussions with patients or caregivers about these kinds of issues.

Some aspects that RTs should consider when documenting their involvement in end-of-life care are as follows:

- The support provided to the family in preparation for and during withdrawal of care;
- Any involvement in end-of-life discussion;
- Supportive care provided to the patient/client during withdrawal; and
- Any advance directives or expressed wishes of the patient/client.

FOR EXAMPLE:

An RT is providing to care to an individual who is in the final stage of their life and is required to take the patient/client off the ventilator and remove their ETT. In this situation, the RT's documentation should include not only these actions, but also the conversation they had with the family prior to, during and after the patient/client was taken off life support.

IV. 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 patient recreation area, or if advice was given to a patient/client over the telephone, the record should indicate this.

PLEASE NOTE...

RTs are required to document according to the same professional standards, whether they are treating an in-patient or out-patient. 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.

Practicing in the community

RTs work in a wide variety of practice settings (e.g., doctor’s offices, dental offices, patient education clinics). Regardless of the practice setting, all RTs are accountable for ensuring that all patient/client contacts are documented according to the required professional standards.

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. 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 it must be kept, according to legislation.

PATIENT/CLIENT 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., intrahospital, interhospital, air, land).

TELEPHONE PRACTICE

The principles and standards related to documentation of telephone practice is the same those 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; and
- signature and designation.

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

V. 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're 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's a specific reason to.

OBJECTIVE DOCUMENTATION

Objective documentation consists of unbiased observations and witnessed signs that a patient/client displays, as well as symptoms that have been directly stated by the patient/client. Information documented in the PHR should be a factual representation of what actually occurred (objective), as opposed to the RT's interpretations of the events (subjective). Documenting subjective comments can be harmful to both the patient/client's well-being (can impede effective communication) and to the RT's professional reputation. Below are some examples of objective and subjective statements.

Table 1: Examples of Objective vs. Subjective Documentation

OBJECTIVE	SUBJECTIVE
"the patient was crying"	"the patient was sad"
"the patient complained of SOB and was dyspneic with movement"	"the patient appeared uncomfortable"
"the treatment was not performed because..." list the facts	"this treatment was not in the best interest of the patient"
"I informed Dr. Smith by telephone of the changes to the patient's status as charted in the flow sheet"	"the doctor is aware"

PLEASE NOTE...

Patients/Clients and/or their family members have a legal right to access medical records. Therefore, any personal judgements and opinions that an RT might have should not be part of a PHR.

VI. THE RESULT OF WHAT HAPPENED

It's essential that the outcome of every intervention is captured in the PHR. This gives the entire health care team the ability to know what was done and whether the intended therapy goals were met. This information is invaluable in guiding future treatment decisions, and should include such information as:

- the result of the intervention;
- the patient/client's response to the intervention;
- whether the treatment objectives were met;
- proposed plan as a result of the intervention; and
- the RT's plan for follow up, if applicable.

FOR EXAMPLE:

An RT has been asked to initiate BiPAP on a patient/client who has elevated PaCO₂ levels and is nearing the end of a terminal illness. Both the patient and the RT agree to the treatment plan, although the RT feels the benefits of the therapy will be limited. When documenting, it is important to include not only the intervention itself, but also the treatment goal(s) and plan (e.g., how long the patient/client will remain on BiPAP; when the treatment plan will be reassessed; how and when the RT plans to follow up on the patient/client's progress).

VII. BY WHOM IT HAPPENED

SIGNATURES

Anyone reading the documentation must be able to clearly identify the individual performing the activity or making the recording, while making sure 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).

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

PLEASE NOTE...

If using a paper-based **signature record**, initials and professional designation are sufficient. If a signature record is not used, a printed name should be included if a signature is not easily legible.

CO-SIGNING DOCUMENTATION WHEN SUPERVISING OTHERS

When an RRT is supervising another individual [usually a Student Respiratory Therapist (SRT); however, it may also be an RRT who has Terms, Conditions and Limitations (TCLs) on their certificate of registration], it is essential that the documentation accurately reflect the following:

1. What degree of supervision was provided; and
2. Who performed each task and who provided supervision.

Direct Supervision occurs when the SRT (or Member with TCLs) performs a controlled act with the RRT observing and overseeing the task. In these cases, the student (or Member with TCLs) must document in the patient/client's PHR that they have performed the procedure(s) under "direct supervision". The supervising RRT must then co-sign the entry in the patient/client PHR stating that the documented activity took place "under direct supervision". An example of direct supervision would be a supervising RRT, physically observing and guiding the performance of arterial blood gas sample being drawn by an SRT.

PLEASE NOTE...

The CRTO recognizes that common RT flow-sheets used in critical care areas (such as ICU and NICU) may not provide enough space for 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 two (2) initials are present, this indicates that direct supervision took place.

General Supervision involves those situations where a determination has been made that the SRT (or Member with TCLs) can perform a given controlled act independently. Where activities or procedures are being done under general supervision, the supervising RRT must not co-sign the student's documentation. The reason for this is that co-signing means the RRT is attesting to the accuracy of the documentation. If they did not witness the task(s) performed, they have no absolute way of knowing if the documentation is correct. Only the person who performed the activity/procedure or has the patient contact should document and sign the entry.

PLEASE NOTE...

General (indirect) Supervision requires that the supervising RRT is ready and available to be "*personally present*" within 10 minutes if assistance is required. (CRTO [Supervision Policy](#))

FOR EXAMPLE:

An RT student in their final clinical rotation is performing an arterial blood gas under "general" supervision (i.e. the supervising RT is not physically present and observing the activity). Since the activity is being done under "general" supervision in this situation (not under direct supervision), the student must sign their own documentation and the RRT should not co-sign.

INTERDISCIPLINARY DOCUMENTATION

RTs very often work as part of a multidisciplinary team that collectively provides diverse and overlapping health care services. As with any well-functioning group, effective communication within and outside of the team is vital. In order to facilitate this communication, many health care facilities have moved towards more integrated, interdisciplinary documentation records.

PLEASE NOTE...

It is important that you 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). It must be clear who had the first-hand knowledge of the event, who performed the activity/intervention and who recorded the activity.

ADDITIONAL CONSIDERATIONS

DOCUMENTING A DISAGREEMENT WITH AN ORDER OR PLAN OF TREATMENT

If an RT does not believe that a particular order or a proposed plan of treatment is in the patient/client's best interest, it is their professional responsibility not to proceed with the intervention. In addition, the RT is expected to:

- remain objective and not involve the patient/client in the disagreement, if at all possible;
- contact the prescriber to discuss the rationale for the difference of opinion, and any suggested alternative plans; and
- provide comprehensive documentation appropriately, which includes:
 - the rationale for their refusal to provide treatment;
 - when notice was provided to the prescriber and details about discussion with prescriber, if applicable; and
 - suggested alternatives, if applicable.

WITHDRAWAL OF CARE/SERVICES DUE TO ABUSE OR VIOLENCE

Withdrawing or withholding care/services from a patient is not common and only used as a last resort in a strategic plan for managing abuse/violence. However, it 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;
- the rationale for withdrawal of care/services;
- 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;
- how and when information relating to the withdrawal of care/services was provided to the patient/client (e.g., verbally, in writing);
- 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 potential consequences of withdrawing care;
- the expected standards/behaviors that must be adopted by the patient/client in order to have care/services resume in the future, if applicable;
- an alternate provider of care/service or the efforts made to refer the patient to alternate providers (if appropriate); and
- who you have notified of the situation (patient/client, physician, charge nurse, police, security, etc.)



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

GLOSSARY

Agents (of the Health Information Custodians) is defined in the *HCCA* in relation to a health information custodian, as “...a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian...”

CERTO Member a Respiratory Therapist who is registered with the CERTO; including Graduate Respiratory Therapists (GRT), Practical (Limited) Respiratory Therapists (PRT) and Registered Respiratory Therapists (RRT).

Charting by Exception (CBE) a charting system used in patient/client health records. CBE requires a detailed plan of care of care map, and includes flowsheets, graphic records and progress notes that may take the format of SOAP/SOAPIE(R) (Subjective, Objective Data, Assessment, Plan, Intervention, Evaluation, and Revision).

Focus Charting System a charting system which includes flow-sheets, checklists and progress notes that take the format of DARP (Data, Action/Analysis, Response, and Plan).

Health Information Custodian (HIC) defined in the *HCCA* as “...a person or organization described in one of the following paragraphs who has custody or control of personal health information...”.

Medical Directive is 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.

Narrative Charting is when data is recorded as progress notes, supplemented with plan of care flow sheets.

Personal Health Records (PHR) is the record kept by HICs who provide health care and may be in either a paper-based or computerized format.

Primary Care including, but not limited, to Family Health Teams, Community Health Centres, various agencies, such as the Canadian Mental Health Agency.

Problem-oriented Charting (POHR) a charting system which includes a plan of care, problem list and progress notes/discharge plans which take the format of “SOAP/SOAPIE” (Subjective data, Objective data, Assessment data, Plan, Intervention and Evaluation).

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**College of Respiratory
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**Ordre des thérapeutes
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This Professional Practice Guideline will be updated as new evidence emerges or as practice evolves. Comments on this guideline are welcome and should be addressed to:

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