Standards for Development of Clinical Health Record Forms

Prepared by: Clinical Health Record Forms Committee
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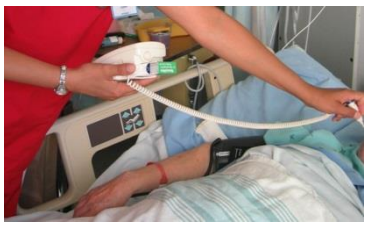


BETTER EVERY DAY

better health • better care • better value • better teams

INTRODUCTION

The Health Information Protection Act (HIPA) governs the collection, use, and disclosure of personal health information in Saskatchewan. To ensure compliance, Saskatoon Health Region has developed policies for documentation, access, disclosure, and retention of personal health information as well as the responsibility the region has in developing and maintaining Clinical Health Record Forms.

Documentation that contains the patient/client/resident name and/or personal health information will be classified into one of the following defined components:

II. COMPONENTS:

ASSESSMENTS/HISTORIES
- records that provide an initial assessment of patient/client/resident for service. Can be incorporated with plan of care but majority of document is assessment of functionality, physical or psychosocial characteristics. Usually considered to be the **first record with other documentation occurring on progress notes or flow sheets.**

CARE PLANS
- records that document a plan of care in some detail.

CONSENTS/RELEASES
- records that are legal authorizations of consent including release.

TRANSPORT
- records that are related to the transferring of patient/client/resident in road or air ambulance or from other agencies.

CONSULTS
- records that document the opinion of professionals such as a physician specialist, therapist, social worker, family life worker, special practice nurse. Usually one page with a recommendation for care.

DISCHARGE INSTRUCTIONS
- records that provide instructions and information to patient/client/resident about ongoing care requirements. For example hygiene restrictions, follow up appointments, and potential side effects.

FLOW SHEETS
- records that have repeating measurements for the same observations or treatments. Can be over a 24 hour period or over several days. **Usually have repetitive tick boxes or initial boxes. Examples are vital signs, in & out records.**

MEDICAL DIRECTIVES
- records to document a specific Medical Directive on a patient/client/resident's health record.

II. COMPONENTS (continued):

ORDERS

- records that document a patient, client or resident specific Practitioner order. To be differentiated from a consultation where a professional suggests treatment options.

PROGRESS NOTES

- records that are ongoing documentation of the clinical status of the patient/client/resident completed by multiple professions. Tend to be narrative and can also include specific event documentation such as a specific procedures.

REFERRALS/RESULTS

- *request for service. This form may also be used to document results of service.*

SUMMARIES

- *records that are a compilation of various other data or observations into a concise report upon completion of service.* ***Examples include discharge summaries.***

III. CHECKLIST

Please use this checklist to guide your decisions. If the answer is 'No' to any of these questions, please consider carefully the reason why.

	Circle One
1. Have you referred to the formatting guidelines in *Policy 7311-20-002 Clinical Health Record Form Standards*?	Yes/No
2. Does the formatting meet SHR the Standards for Development of Clinical Health Record Form Standards?	Yes/No
3. Are you consolidating/decreasing the number and types of forms in the chart?	Yes/No
4. Are you decreasing the charting time?	Yes/No
5. Have you considered "charting by exception" in the form?	Yes/No
6. Have you used check boxes?	Yes/No
7. Does this meet acceptable charting standards?	Yes/No
8. Did you ensure this information appears nowhere else in the chart?	Yes/No
9. Is this form a legal required part of the record to be stored for ten years or the age of majority plus two years for children?	Yes/No
10. Can this form be used by other units/services/agencies for documentation?	Yes/No
11. Have you consulted with the appropriate stakeholders: Directors/Managers? Physicians? Staff targeted to use forms? Other departments that may be affected by the form? Other care groups, agencies? Educators involved in staff training?	 Yes/No Yes/No Yes/No Yes/No Yes/No Yes/No
12. Have you informed the Desktop Publisher that you are replacing or revising the form?	Yes/No
13. Have you developed an implementation plan? - trial period? - written work standards for use of the form? - communication/notification process for the change? - evaluation/feedback?	Yes/No

IV. PAGE LAYOUT AND FORMATTING:

All clinical health record forms used for documentation of care services provided within Saskatoon Health Region must meet the standard requirements for accuracy of information, legibility, and reproduction value in order to meet legal responsibilities.

1. 8.5" x 11" white 20 lb. bond paper. Colored paper does not photocopy well and will not be approved for clinical forms.

2. Bound pages (booklets) are not permitted as a clinical form (multiple pages are acceptable).

3. Design the form for filing and retention value: shading should be minimized and used only in headings. Shading in all other areas is discouraged.

4. All Clinical Health Record Forms must meet SHR's Visual Identify Guidelines for font use and logo placement (see Communication InfoNet site). Print should not be larger than11-point font, except for titles and headings. Font size is dependent on amount of information to be included. Recommended font sizes are indicated on the form template below. Century Gothic is the preferred font.

5. All forms shall include the information shown below.

Top Left Corner of First Page

- Saskatoon Health Region, Saskatoon, Saskatchewan followed by tick boxes for RUH, SCH, SPH, and Other
- SHR logo to appear in top left hand corner
- Name of the Department, if applicable (upper case font)
- Name of Form (upper case font)
- Page 1 of _____ (if multiple pages)

Top Left Corner of Additional Pages

- Name of Form (upper case font)
- Page __ of __ (if more than one page)

Top Right Corner of First Page

Approved patient/client/resident label to be placed in top right hand corner. A slightly lighter font is used in order for a sticker to be placed on top.

Top Right Corner of Additional Pages

A space for patient/client/resident identification. Both sides of every page must have patient/client/resident label.

IV. PAGE LAYOUT AND FORMATTING (continued):

Bottom of Each Page

- Form number assigned by Desktop Publisher
- CHRFC approval/revision date assigned by Desktop Publisher
- Distribution if applicable

5. All forms should have a 1.18" x 3.15" space to allow for patient/client/resident identification e.g. hand written, sticky patient/client/resident label, or digital patient/client/resident identification from Forms on Demand.

Line 1: Name: _____
Line 2: HSN: _____
Line 3: D.O.B.: _____

6. Allow adequate space for signature/initials, date (when required), and other individual informational items.

7. Allow adequate line space for documentation on the form (e.g.: for handwriting and/or typing).

8. Use check boxes to reduce writing.

9. Margins on each page will follow the following format:

   - Allow 0.5 inches margin on the **top** of the form.
   - Allow 0.5 inches margin on the **right side** of form.
   - Allow 0.75 inches margin on the **left side** of the form to allow placement in a three ring binder. Note: if the form is double-sided, the margins on both sides of the form will reverse (0.75" on the right and 0.5" on the left).
   - Allow 0.1 inch space on the **bottom** of the page for Desktop Publisher use only. This space will include the form number and approval date.

Century Gothic is the preferred font for forms

0.5" ↕

SASKATOON HEALTH REGION (10 pt.)
Saskatoon, Saskatchewan (10 pt.)

↕ 1.18"

❑ RUH ❑ SCH ❑ SPH Other _____

3.15" ↔

NAME OF DEPARTMENT_____ (12 pt.) (if applicable)

NAME OF FORM (14 pt.)

Page 1 of ____ (10 pt.) (if applicable)

0.75" ↔

0.5" ↔

Signature: _____ Date: _____ (10 pt.) (if applicable)

Form # _____ Date _____

0.1" ↕

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0.5" ↕

NAME OF FORM (14 pt.)

Page _____ of _____ (10 pt.)

↕ 1.18"

3.15" ↔

0.5" ↔

0.75" ↔

Signature: _____ Date: _____ (10 pt.)(if applicable)

Form # _____ Date _____

0.1" ↕

Note: Margins are set up as they should be if the form is double-sided. If the form will not be double-sided, use the same margins as page 1.